

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

ORIGINAL

PRINTED: 03/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/20/2014
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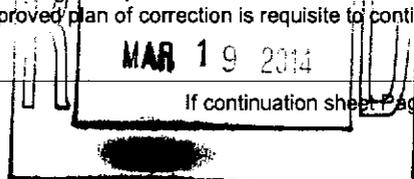
NAME OF PROVIDER OR SUPPLIER ST WILLIAMS HOME FOR THE AGED	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SOUTH 9TH STREET MILBANK, SD 57252
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F 000	<p><i>Addendums noted with an asterisk per 3/14/14 telephone to facility administrator. KR/DOH/INF</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 32355 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/18/14 through 2/20/14. St. Williams Home For The Aged was found not in compliance with the following requirements: F156, F176, F221, F241, F250, F280, F311, F323, F329, F441.</p>	F 000	F156 The facility has communicated with the on-site coordinator for therapeutic services to emphasize the importance of the facility being given adequate notification of the intent to discontinue therapy consistently. This communication generally occurs at the weekly (interdepartmental) "Medicare Meeting". Notes during the meeting were generally taken by a nurse who was present and then typed afterwards. To assure that discussion about the anticipated discharge from Medicare coverage is documented, a format for taking notes during this meeting was developed prior to the March 4, 2014 meeting and anticipated date is noted on form. If a resident is receiving skilled nursing services (and no therapy services) that meets criteria	4/10/14
F 156 SS=B	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p>	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Sr. Mary Walker* TITLE *Administrator* (X6) DATE *3/17/2014*

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 noted above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156	F156 (continued) for Medicare coverage and the need for this type of care is coming to an end, the Director of Nursing (DON) or her designee will be responsible for documenting resident/family contact in the electronic record. In addition, discussion about anticipated discontinuation of therapy services that occurs at the Medicare Meeting, email correspondence will be sent to the on-site coordinator by each therapist prior to to discontinuing therapy. There is an on-site visit ("Quarterly Client Meeting") between nursing, financial, and administrative personnel of the facility and management of the therapeutic company at the facility on March 17, 2014. It will be emphasized during this meeting that this notification if absolutely required. The time frame the facility will request for communication to occur by		

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F 156	<p>Continued From page 2</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on record review and interview, the provider failed to ensure two of three sampled residents (4 and 8) had been notified in a timely manner that medicare services would be ending. Findings include:</p> <ol style="list-style-type: none"> 1. Review of resident 4's notice of medicare non-coverage notices revealed her skilled nursing services had ended on 2/1/14. The verification for receipt of the notice had been signed by the Power of Attorney (POA). There had been no date or documentation on the form to indicate when or how the POA had been notified. 2. Review of resident 8's medicare non-coverage notices revealed her skilled nursing services had ended on 1/8/14. The verification for receipt of the notice indicated the business office manager had left a voicemail for the POA on 1/7/14. The notices had been signed by the POA on 1/10/14. <p>Interview on 2/20/14 at 8:10 a.m. with the</p>	F 156	<p>F156 (continued) therapy staff will be increased to allow 48-72 hours whenever possible (in order to assure proper notification to the resident/resident decision maker). Documentation about phone notification (including date and time Medicare coverage will end) will be entered into the section of the resident's electronic record for family/guardian contact. The therapeutic site coordinator will compare electronic correspondence regarding termination of therapeutic services for any given individual and assure that facility notification occurred on a timely and consistent basis. A written record regarding the termination of Medicare services will continue to be maintained in the business office. This process of assuring that a resident/legal representative is notified of a change in services and charges will begin after the March 17, 2014 meeting. Compliance</p>	

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F 156	Continued From page 3 business office manager revealed: *The Medicare Non-coverage notices had not been delivered in a timely manner. *The POA should have been notified two days prior to the coverage ending. *The Medicare Non-coverage notices should have been delivered to the POA two days prior to the services ending. *She had difficulties with the therapy department notifying her in a timely manner when their services would be ending. This had caused some of her notifications to the POA to be late. Interview on 2/20/14 at 8:25 a.m. with physical therapist H confirmed the therapy department had not always notified the business office manager of when their services were ending in a timely manner.	F 156	F156 (continued) with this corrective action will be monitored through a collaborative effort and ongoing communication between the site manager and the business office manager. Any discrepancies regarding resident/family notification will be presented at the weekly "Medicare Meetings" and a summary of findings will then be reported at the Quarterly Client Meetings for at least 6 months and thereafter it will be determined whether this monitoring continues to be warranted.		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on record review, interview, observation, and policy review, the provider failed to ensure one of one sampled resident (4) had periodic assessments completed to self-administer medications. Findings include: 1. Review of resident 4's treatment administration record and complete medical record revealed:	F 176	* CFO will report to QA. KR/SDDH/MF F176 Resident #4 had a self-medication assessment completed on March 14, 2014 and it was determined that this individual is not able to self-administer medications. To assure that a resident who has been deemed safe to self-administer medication continues to be competent	4/10/14	

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F 176	<p>Continued From page 4</p> <p>*A physician's order dated 9/4/12 for "May have Aspercreme [a pain-relieving creme] topical [on top of skin] at bedside."</p> <p>*A physician's order dated 9/4/12 for "May have Bactroban [a skin treatment that kills bacteria] topical at bedside."</p> <p>*There was no self-administration of medication assessment completed by the interdisciplinary team for her in the medical record.</p> <p>Review of resident 4's 2/18/14 care plan revealed there was no documentation for self-administration of medication nor periodic assessment of appropriateness of being self-administered.</p> <p>Review of resident 4's monthly Medication Regimen Review by the consultant pharmacist from 1/29/13 through 1/24/14 regarding the Aspercreme and Bactroban medications revealed there had been no recommendations regarding the continued need for self-administration of those medications.</p> <p>Review of resident 4's Minimum Data Set assessment on 1/12/14 revealed she was limited in making concrete (solid) requests.</p> <p>Interview on 2/19/14 at 4:30 p.m. with the director of nursing (DON) and the administrator regarding resident 4's self-administration of medication revealed: *She had no longer been able to self-administer the medications due to a recent decline in her physical health status. *In the past she would have been able to apply the medications to her skin. *There had been no periodic self-administration of medications assessments completed.</p>	F 176	<p>F176 (continued) to have medication/ medicated creams readily available, the facility adopted a process wherein a self-administration assessment will be completed during or before the resident's assessment reference dates. If it is deemed safe for a resident to administer his/her own oral medication, inhaled medication, topical preparation, etc. this will be entered into the electronic medical record and will be reviewed by the interdisciplinary team through the care planning process. During staff meetings that occurred at the facility during the week of March 10, 2014 all staff were told that they should question nursing staff about whether it is appropriate for a resident to have a medication, cream, ointment, inhaled, or over-the counter preparation in his or her room/possession.</p>		

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F 176	<p>Continued From page 5</p> <p>Interview on 2/20/14 at 9:00 a.m. with the consultant pharmacist, the DON, and the administrator present regarding resident 4's self-administration of medication revealed: *The pharmacist had reviewed the orders monthly and she had made sure the medications had been available. *She had not made recommendations on self-administration of medications as that had been the nursing department's responsibility.</p> <p>Observation and interview on 2/20/14 at 8:45 a.m. with certified nursing assistant (CNA) G in resident 4's room revealed: *One tube of Aspercreme in a side table's top drawer next to her bed labeled with her name and the directions for use. *One tube of Bactroban in a side table's top drawer against the wall in front of her bed labeled with her name and the directions for use. *The Aspercreme was used on her knees. *The Bactroban was used on her groin area. *She had been unable to apply the medications herself for a long time. *The CNA had been informing the charge nurse when she had applied either of the products to the resident's skin.</p> <p>Review of the provider's 9/1/12 Administration/Self-Administration of Medication policy revealed: *A resident would have been permitted to self-administer medication when this had been deemed safe and appropriate by the interdisciplinary team. *A formal assessment should have been conducted using the form entitled "Medication Self-Administration Assessment Form."</p>	F 176	<p>F176 (continued) If a resident is not deemed safe to self-administer medication, a complete self-administration assessment is not necessary. The Director of Nursing (DON or her designee) will track that assessments are completed for all residents prior to the completion of the next MDS and that residents who have been deemed safe to self-administer have at least one additional assessment during the following quarter. Findings will be reported to the Leadership/QA committee on a monthly basis for the next 3 months and then quarterly thereafter. The Leadership/QA committee will determine the frequency at which this monitoring should continue.</p> <p><i>* DON will report to QA. KR/SDDO/HMF</i></p>		

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F 176	Continued From page 6 *The resident should have been reassessed on an annual basis unless the interdisciplinary team had determined that this would have been appropriate to have completed on a more frequent basis.	F 176			
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure five of five sampled residents (4, 5, 6, 9 and 11) had completed assessments for the use of side rails. Findings include: 1. Observation of resident 9's bed from 2/18/14 through 2/20/14 revealed there was a one-half side rail on his bed. Interview on 2/20/14 at 9:30 a.m. with resident 9 revealed they used the side rail when he was in bed. It had always been pulled up. Review of resident 9's entire medical record revealed there had not been a side rail assessment completed. Surveyor: 32331 2. Observation on 2/18/14 at 5:25 p.m. in resident 4's room revealed two half side rails on her bed in the up position. Resident was in a wheelchair	F 221	F221 The side rail assessments have been completed, care plans updated, and physicians' orders received from residents 4,5,6,9 and 11. Members of the nursing staff understood that, because a half-rail does not prevent an individual from exiting a bed, it would not be considered a "physical restraint". It has been clarified with all staff that a side rail of any type and length is considered a physical restraint. The facility has now adopted a process where a side rail assessment will be completed during or before the resident assessment reference date for any resident who is newly admitted, experiencing a significant change in status, or on a quarterly basis. The DON or her designee will monitor that the assessments are completed prior to the next MDS.	4/10/14	

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F 221	<p>Continued From page 7 beside the bed.</p> <p>Review of resident 4's complete medical record revealed: *She had been admitted to the facility on 7/21/93. *A physician's order dated 3/15/13 "Single full side rail (R) [right], Single half side rail (L) [left] for positioning." *There were no assessments to indicate the use of the half side rails as restraints.</p> <p>Review of resident 4's 2/18/14 care plan revealed: *She was at risk for falls with potential for accidental injury. *Two half side rails were to have been used when in bed.</p> <p>Review of resident 4's Minimum Data Set (MDS) assessment on 10/16/13 and 1/12/14 revealed restraints were coded zero for bed rail usage.</p> <p>Observation on 2/20/14 at 8:45 a.m. in resident 4's room revealed she was seated at a forty-five degree angle in her bed. The half side rails, with one facing the room side of the bed and one on the wall side of the bed were both in the up position.</p> <p>Interview on 2/19/14 at 4:30 p.m. with the director of nursing (DON) and the administrator regarding resident 4's two half side rails on her bed revealed: *She had needed them on her bed for security and for positioning. *There had been no quarterly or periodic assessments completed for their usage on her bed. *There needed to have been periodic</p>	F 221	<p>F221 (continued) Findings will be reported to the Leadership/ QA committee on a monthly basis for the next 3 months and then quarterly thereafter. The Leadership committee will determine the frequency at which this monitoring should continue.</p> <p><i>*DON will report to QA. KR/SDDH/MF</i></p>		

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F 221	<p>Continued From page 8 assessments completed for their usage.</p> <p>3. Review of resident 5's complete medical record revealed: *She had been admitted to the facility on 2/10/05. *A physician's order dated 2/27/13 "Double half side rails when in bed for positioning." *A Restraint/Side Rail Protection Device Assessment form had been last completed on 5/21/12 to indicate the use of two quarter side rails.</p> <p>Review of resident 5's 1/20/14 care plan revealed: *She had a decline in self-care ability. *Two side rails were to have been used for assistance with repositioning.</p> <p>Review of resident 4's MDS assessment on 10/22/13 and 1/14/14 revealed restraints were coded zero for bed rail usage.</p> <p>Interview on 2/19/14 at 4:30 p.m. with the director of nursing (DON) and the administrator regarding resident 5's two side rails on her bed revealed: *She had needed them on her bed for positioning. *There had been no current quarterly or periodic assessments completed for their usage on her bed. *There needed to have been periodic assessments completed for their usage.</p> <p>Surveyor: 12218 4. Observation at 5:00 p.m. on 2/19/14 of resident 11's bed revealed a half side rail was pulled up and in place on the upper part of the outer side of the bed. The resident was sitting in her recliner.</p>	F 221			

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F 221	<p>Continued From page 9</p> <p>Review of resident 11's 2/11/14 care plan did not state the need for side rails but revealed the following:</p> <p>*Problem: At risk for falls with potential for accidental injury.</p> <p>*Approaches included:</p> <ul style="list-style-type: none"> -Low bed with locked wheels. -Behavior management with frequent observation and redirection. -Transferred with assistance of one. <p>*Problem of self-deficit of Activities of Daily Living (ADL) function.</p> <p>*Approaches included:</p> <ul style="list-style-type: none"> -Limited assistance of one for bed mobility, grooming, dressing, bathing, and repositioning. -Extensive assistance of one for transferring, toileting, and ambulation with physical therapy. <p>Review of resident 11's medical record revealed she:</p> <ul style="list-style-type: none"> *Was admitted on 1/23/14. *Had a history of falls. *Had no physician's order for side rails. *Had no assessment for the need for side rails. <p>Interview at 11:15 a.m. on 2/20/14 with the administrator revealed:</p> <ul style="list-style-type: none"> *The bed in resident 11's room had side rails. *She thought resident 11 had been put in that room because it was close to the nurses station. *She was not aware the side rails were suppose to be up for resident 11. <p>Surveyor: 22452</p> <p>5. Review of resident 6's 3/15/13 physician's orders revealed "Single half side rails times two."</p> <p>Review of resident 6's 1/28/14 care plan</p>	F 221			

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F 221	Continued From page 10 revealed: *"At risk for trauma and falls with potential for injury." *Sensor alarm. *Bed in lower and locked position. *Limited to extensive assistance of one staff for bed mobility. Interview on 2/20/14 at 10:00 a.m. with the director of nursing regarding resident 6 revealed: *An assessment for the use of the two half side rails on her bed had never been completed. *The resident had slept in her recliner the past two months and not in her bed. *The physician's order for the use of the two half side rails should have been discontinued. *The care plan should have addressed the side rails when she was using her bed. *The care plan had not been updated as she was now sleeping in the recliner chair instead of her bed. 6. Review of the provider's undated Protective Devices and Restraint Use policy revealed: *Examples of restraints include bed rails (side rails). *Comprehensive assessments and care planning would indicate that a need existed for some type of restraint.	F 221			
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241	F241 The facility policy regarding eating environment was revised and emphasis was added to including that all residents seated at the same table will be served at the same time when feasible.	4/10/14	

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

PRINTED: 03/03/2014
FORM APPROVED
OMB NO. 0938-0391

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F 241	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Surveyor: 26180</p> <p>Based on observation, interview, and policy review, the provider failed to ensure the dignity of residents were maintained as evidenced by:</p> <p>*Failing to serve all residents sitting at the same table within an acceptable time frame of each other.</p> <p>*Administering eye drops in the dining room to two of two sampled residents (2 and 16).</p> <p>Findings include:</p> <p>1. Observation on 2/19/14 at the breakfast meal revealed: *Resident 19 received her meal at 7:52 a.m. -Her tablemate resident 18 and a visitor at that table received their meal at 8:04 a.m. -Another tablemate resident 3 received her meal at 8:12 a.m.</p> <p>2. Another observation at that same meal revealed: *Residents 2 and 23 received their meals at 7:53 a.m.. -They were being assisted with their meal by a certified nursing assistant. *The other feeding assistant arrived at 8:05 a.m. to feed residents 12 and 20. -They had not received their food until 8:09 a.m.</p> <p>3. Observation on 2/20/14 at the breakfast meal revealed resident 18 and a visitor had completed eating their breakfast before their tablemates, residents 3 and 19, received their meals.</p> <p>Surveyor: 32355</p> <p>4. Observation on 2/19/14 from 11:45 a.m. through 12:35 p.m. of resident 6 in the main</p>	F 241	<p>F241 (continued)</p> <p>It is recognized that there may occasionally be psychosocial or physical issues necessitating that a resident be served an early tray, but resident seating will be continually monitored and adjustments made to allow that individuals can be served their food together. It was noted that on occasion there are multiple residents seated at the same table who all require assistance with feeding, but a limited number of staff available to feed. Staff were advised, during the directed in servicing that was held during the week of March 10, 2014, that it is possible to engage a couple of individuals in an alternative activity (i.e. watching the news, listening to music, etc.) rather than having all of them sitting at the dining room table if there are not yet an adequate number of staff readily available to feed them at a specific time.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 241	<p>Continued From page 12 dining room revealed: *At 11:45 a.m., she was sitting at the dining room table. *She had shared a table with two other unidentified tablemates. *At 12:05 p.m. the two unidentified tablemates had been served their meal. *At 12:30 p.m. one of the tablemates had completed her meal and the other tablemate was almost done with her meal. *At 12:35 p.m. resident 6 had been served her meal.</p> <p>Surveyor: 22452 5. Observation on 2/18/14 at 5:47 p.m. of resident 16 revealed: *She was sitting at the supper table eating her meal. *There were other residents at the table eating. *Licensed practical nurse (LPN) A informed her she had eye drops for her. *The resident did not respond and LPN A removed her eyeglasses and administered the eye drops.</p> <p>Interview at that time with LPN A regarding resident 16 revealed she administered the eye drops to her at the table because by the time the resident was done eating her supper meal she would no longer be on duty.</p> <p>6. Observation on 2/18/14 at 5:53 p.m. of resident 2 revealed: *She was sitting at the supper table eating her meal. *There were other residents at the table eating. *Registered nurse (RN) I informed her she had eye drops for her. *The resident did not respond and RN I removed</p>	F 241	<p>F241 (continued) The medication administration policy was updated to clarify that eye drops may not be given in the dining room. The medication administration times for eye drops were reviewed and were rescheduled (when possible) to be instilled during the early morning and/or late evening in accordance with the physician's orders and resident preference. The DON or her designee will monitor medication administration in the dining room at random times, several times weekly for at least 3 months to ensure that eye drops are not given under any circumstances while a resident is in the dining room. The DON will report her findings to the Leadership/ QA committee on a monthly basis for 3 months. The Leadership committee will determine the frequency at which this monitoring should continue.</p>		

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

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F 241	Continued From page 13 her eyeglasses and administered the eye drops. Interview at that time with RN I regarding resident 2 revealed she administered the eye drops at the table because the resident received another dose of the eye drops again at bedtime. Interview on 2/19/14 at 9:45 a.m. with the director of nursing regarding the above revealed eye drops should not have been administered in the dining room. Review of the undated Resident's Bill of Rights revealed: ***"You have the right to privacy and confidentiality in a long-term care facility." ***"Have only authorized staff present during treatment or activities of personal hygiene." ***"When you enter a long-term care facility, you must be treated as an individual with respect, dignity, and consideration."	F 241			
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure medically related social services for one of one sampled resident (9). Findings include:	F 250	F250 In the situation that was cited in survey findings, the Social Services Director had not received a telephone message about the absence of a counselor. She has since contacted this professional and they arranged that social services will receive a telephone call and/or electronic correspondence from a professional providing psychiatric services/ counseling to a resident. The Social Service Director will make efforts to reschedule the appointment(s) when possible, notify the	4/10/14	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 250	<p>Continued From page 14</p> <p>1. Review of resident 9's care plan revealed he had a: *Diagnosis of schizophrenia. *Potential for depression and anxiety. *Potential for mood swings, disruptive behaviors, low energy, and problems concentrating.</p> <p>Interview on 2/18/14 at 2:15 p.m. and again on 2/20/14 at 10:30 a.m. with licensed practical nurse (LPN) A regarding resident 3 revealed: *This resident had many psychosocial issues. *He dealt with many family issues and that contributed to mood and behavioral changes. *He could be very nice one minute, and then abruptly his behavior changed. *He sometimes called the nurses station from his room.</p> <p>Interview on 2/20/14 at 8:40 a.m. with the social services director (SSD) regarding resident 3 revealed: *She confirmed the above psychosocial concerns identified by RN A. *He had in the past been seen monthly by a psychiatrist. -That psychiatrist retired two years ago. *Since then he had received bi-monthly counseling from a counselor at [name of agency]. -Her notes were all kept in the medical record. -If I could not find her notes she could call the counselor and have her send them. -The more she thought about it she could not recall that she had recently received any of the counselor's progress notes. *At 10:30 a.m. she reported she had called the counselor. -She had been told she had not been to see this</p>	F 250	<p>F250 (continued) resident(s) of the change, and document the arrangements in the residents' electronic medical record. The Social Service Director will monitor the scheduled times for psychological services/ counseling and note any absence and/or a resident declining to participate; her findings will be reported to the Leadership/QA committee on a monthly basis for 3 months. The Leadership committee will determine the frequency at which this monitoring should continue.</p>		

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

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F 250	Continued From page 15 resident since December 2013 due to personal medical issues. -This SSD was unaware of that. -They did not have a back up plan for obtaining mental health counseling under those circumstances. Interview on 2/20/14 at 10:45 a.m. with LPN A revealed: *She was unaware the counselor had not been to see resident 9 for over two months. *She thought they had a physician order for counseling. Review of resident 9's 10/29/07 physician orders revealed an order to "Consult with [name of agency] for counseling services. Review of the provider's undated medically related social services policy revealed: *Based on the comprehensive assessment, a resident with medically-related Social Service needs shall receive appropriate treatment and services to address the identified issue. *Specific medically-related Social Service issues include: -Behavioral issues. -Emotional issues. -Family issues/involvement.	F 250			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280	F280 As pertains to the situation about care planning for resident #3, during the Directed In-Service Training completed by the facility during the week of March 10, 2014 all staff were reminded of the need to thoroughly complete ALL documentation regarding	4/10/14	

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

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F 280	<p>Continued From page 16</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: 26180 Based on record review, interview, and policy review, the provider failed to ensure care plans for two of two sampled residents (3 and 10) were reviewed and revised as changes occurred. Findings include:</p> <p>1. Review of resident 3's nurse's notes revealed she had multiple falls in her room from May 2013 through January 2014.</p> <p>Further review of the above falls revealed there was no evidence they evaluated/investigated the following: *When was the last time the resident had been toileted. *When was the last time the resident had been repositioned. *What medications could have contributed to the fall. *How long had she been in her bed or</p>	F 280	<p>F280 (continued)</p> <p>each fall (including the information under the "fall investigation" tab in the electronic charting system (ECS) in addition to the "fall incident report". The importance of consistently documenting circumstances surrounding a fall need to be conveyed to the nurse completing the post-fall assessment was stressed. When staff know the details surrounding the incident, it is possible to make appropriate changes to the care plan that could help prevent a future fall and/or implement approaches that could decrease the chance of a serious outcome should a fall occur. The Director of Nursing will be responsible to monitor falls and track them and assure that the fall investigation has been completed. The fall investigation will include (whenever the information that is available/possible to</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 280	<p>Continued From page 17 wheelchair? *Was her call light within reach since each time she fell they re-instructed her to use the call light. *Had they checked her for orthostatic hypotension (low blood pressure)? *Was she in pain prior to the fall and was that why she was attempting to reposition herself. *Who the staff person was that was responsible for the resident at that time.</p> <p>Review of resident 3's entire medical record revealed she had not been on a restorative program.</p> <p>Review of resident 3's care plan revealed: *She had dementia (memory problems). *On 12/17/13 and 1/25/14 they identified she had fallen. *Interventions included: -Assure pain management. -Instruct to call for help. -Sensor alarm (that alarms when the resident moved). -Floor mat next to bed. *There were no resident specific interventions that addressed: -A toileting program. -A repositioning schedule. -How her pain had been managed. -How to effectively get her to use the call light if she was confused. -What specifically caused her agitation.</p> <p>Interview on 2/19/14 at 5:00 p.m. with the director of nursing revealed: *The care plan had addressed interventions to prevent an injury when the resident fell. *It had not addressed ways to prevent the falls.</p>	F 280	<p>F280 (continued) determine) information regarding when the resident was last toileted, repositioned, received medication that could have contributed to a fall, how long the resident had been in bed/in wheelchair, whether the call light was within reach, and whether there were additional assessments to determine whether the fall was influenced by a medical condition such as orthostatic hypotension, low blood glucose level, vertigo, pain, weakness, urinary tract infection, etc. as it pertains to the situation at hand and the actions (or presumed actions/symptoms possibly experienced) of the resident.</p> <p>Resident #10 has been evaluated by the OT on multiple occasions since the time of her admission. Clarification as to the times at which her brace on her left forearm and left foot are to be applied and removed will be</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 280	<p>Continued From page 18</p> <p>Review of the provider's September 2012 Resident Care plan policy revealed: **Each resident shall have an individualized care plan so that he/she will receive the care necessary to enable him/her to achieve (or maintain) the highest practical level of physical, mental and psychological well-being." *The care plan will be updated as needed for any change in the resident's condition and review by the interdisciplinary team after each assessment."</p> <p>Surveyor: 33488 2. Interview and medical record review on 2/20/14 at 10:20 a.m. with registered nurse (RN) E regarding resident 10 revealed: *The resident wore a brace to her left forearm and left foot since her admission in July 2013. *The care plan had not specified when the braces were to be applied and removed except as stated or that the resident wore any such braces. *Restorative care that was required by the resident had not been written on the care plan for the certified nursing assistants (CNAs) to follow. *She agreed it was the provider's responsibility to update and revise the care plan as often as necessary to reflect resident's individualized needs. *She agreed the care plan had not been individualized. *She further agreed it had not been revised or updated.</p>	F 280	<p>F280 (continued) requested from OT and these details will be entered into the resident's care plan on or before March 31, 2014. In the future, residents requiring a splint/brace will be referred for an OT evaluation as indicated at the time of admission unless there is detailed documentation by the physician as to the body part on which a brace/splint is worn and time at which it is to be applied/removed on daily basis. Specific recommendations will be entered into the resident's care plan.</p> <p>Monitoring that care plans have been updated to include appropriate measures to prevent a fall after an incident and/or when there is a recommendation for a (continued next page)</p>		
F 311 SS=E	<p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS</p> <p>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p>	F 311			

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

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F 280	Continued From page 18 Review of the provider's September 2012 Resident Care plan policy revealed: **"Each resident shall have an individualized care plan so that he/she will receive the care necessary to enable him/her to achieve (or maintain) the highest practical level of physical, mental and psychological well-being." *The care plan will be updated as needed for any change in the resident's condition and review by the interdisciplinary team after each assessment." Surveyor: 33488 2. Interview and medical record review on 2/20/14 at 10:20 a.m. with registered nurse (RN) E regarding resident 10 revealed: *The resident wore a brace to her left forearm and left foot since her admission in July 2013. *The care plan had not specified when the braces were to be applied and removed except as stated or that the resident wore any such braces. *Restorative care that was required by the resident had not been written on the care plan for the certified nursing assistants (CNAs) to follow. *She agreed it was the provider's responsibility to update and revise the care plan as often as necessary to reflect resident's individualized needs. *She agreed the care plan had not been individualized. *She further agreed it had not been revised or updated.	F 280	F280 (continued) Brace/splint will be the responsibility of the Director of Nursing or her designee. Findings will be reviewed at the weekly "Medicare Meetings". If it appears that a resident could benefit from formal therapeutic services and/or the "fun fitness" program to increase a resident's strength, mobility, and/or comfort the recommendations will be made for a PT and/or OT evaluation at that time. The DON will report a summary of the findings from the weekly reviews to the Leadership/QA committee on a monthly basis for 3 months. The Leadership committee will determine the frequency at which this monitoring should continue.		
F 311 SS=E	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.	F 311	*DON will monitor all falls. KR/SDDOH/JMF		

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F 311	<p>Continued From page 19</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, and record review, the provider failed to ensure the recommendations from the therapy department for restorative care programs had been followed for four of four sampled residents (6, 7, 9, and 10). Findings include:</p> <p>1. Review of resident 7's medical record revealed: *A 11/11/11 readmit date. *Diagnoses of cancer, diabetes, atrial fibrillation (irregular heart beat), arthritis, and weakness. *He had a recent change of status causing an increase in weakness. *He had been seeing the physical therapist for strengthening. *He had been set-up on a restorative care program by the therapy department.</p> <p>Review of resident 7's 12/4/13 care plan revealed: *He was to have been walked to the dining room and two additional times a day with staff assistance. *On 7/23/13 he was to have done: -Active range of motion (AROM) exercises three times per week. -NuStep (machine for exercising) three times per week. -Gait and transfer training everyday.</p> <p>Review of resident 7's restorative care documentation from 12/25/13 through 2/16/14 revealed he had: *Ambulated eight times.</p>	F 311	<p>F311 The facility is transitioning the responsibility for a nurse having interest in carrying out restorative programs and she will complete assessments pertaining to mobility/restorative care. The nurse or another designee will begin with the assessments for residents #6, 7, 9 and 10 and these will be completed on or before April 10, 2014. After the assessments for residents identified in the survey process are completed, the nurse will complete assessments for individuals who have previously had recommendations for restorative programs and/or fun fitness made by therapeutic staff. Other residents will have an assessment completed during the resident's assessment reference dates to determine if the individual is likely to benefit from a formal restorative program and/or fun fitness activities.</p>	4/10/14	

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

PRINTED: 03/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2014
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F 311	<p>Continued From page 20</p> <p>*Exercised on the NuStep five times. *No other type of exercising had been documented.</p> <p>Interview on 2/19/14 at 10:25 a.m. with the activity director revealed: *There was no restorative program in the facility. *The activity department had been responsible for providing an exercise group four times a week. *The CNAs had been responsible for any individualized exercise programs. *Referrals had been made to the therapy department with any decline in capabilities shown by the residents.</p> <p>Interview on 2/20/14 at 10:15 a.m. with the director of nurses (DON) confirmed the above interview with the activity director. She did not have the staff to oversee this program. Surveyor: 22452 2. Review of resident 6's 4/17/13 physician's orders revealed "Discharged from physical therapy (PT). She will begin a restorative program six times a week."</p> <p>Review of resident 6's 4/25/13 physician's orders revealed "Discharged from skilled occupational therapy (OT) services."</p> <p>Review of resident 6's 1/28/14 care plan revealed: **"Restorative care program one time a day on six days of the week." **"Standing: Marching, side kicks, toe raises, and semi-squats, 2 sets of 10 to 15." **"Seated: Pillow squeeze, long arc quads, hip flexion, red theraband knee flexion and belt push. Two sets of 10 to 15." **"Left lower extremity may require active assistive</p>	F 311	<p>F311 (continued)</p> <p>This nurse (or a designee) will work with the therapy staff and other members of the nursing staff to assure that the resident has care and services that assist in improving or maintaining physical strength and mobility. The physician will be contacted for orders as necessary. The nurse overseeing restorative programs will be responsible for communicating with other members of the nursing staff to assure that care planning is update and current, that mobility/strengthening activities are occurring, and that documentation is entered in the electronic charting system. The nurse (or a designee) will be responsible for completing an assessment prior to any scheduled MDS to determine whether the resident is indeed showing any benefit/ maintaining strength balance mobility as part of the regular assessment process.</p>		

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

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F 311	<p>Continued From page 21 range of motion (ROM)." **"Restorative care walking plan: One to two times a day as tolerated. Fifty to one hundred feet as tolerated." **"Front wheeled walker with contact guard assist with gait belt." **"Goal is for patient to consistently ambulate 100 feet with front wheeled walker with contact guard assistance of one staff with gait belt to meals."</p> <p>Review of resident 6's 4/17/13 through 2/19/14 nurse aide documentation flow records revealed no documentation to the above had been completed. Surveyor: 26180 3. Review of resident 3's nurse's notes revealed: *On 5/20/13 she was found on the blue mat on the floor beside her bed. -She had fallen out of her wheelchair. -She was "repositioning or self-transferring without assistance." *On 6/16/13 she was was found on the floor next to her bed. -She was "repositioning or self-transferring without assistance." *On 8/5/13 she was found on the floor next to her bed. -She later complained of pain in her right leg/thigh area and was sent in for an X-ray which concluded there was no apparent injury. *On 10/8/13 she was found on the floor. -She was "repositioning or self-transferring without assistance." -She fell out of her wheelchair. *11/26/13-She slid from her chair and was lowered to the floor. *12/8/13-She was found on the floor in front of her recliner with the foot of the recliner still elevated.</p>	F 311	<p>F311 Her findings will be reported to the DON and consult with director of therapy services as necessary. The DON will report about 1) how many residents have been assessed, 2) decisions that have been made as to whether a resident would be likely to benefit from a restorative care program or fun fitness, and 3) whether there has been a measurable impact upon the status of residents receiving these services until all residents have had at least one assessment completed; the report will be made to the Leadership/QA committee on a monthly basis for 3 months and quarterly thereafter for at least 6 months. The Leadership/QA committee will determine the frequency at which this monitoring should continue.</p>		

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

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F 311	<p>Continued From page 22</p> <p>*12/17/13-She fell forward from her chair and landed in a sitting position with her back against the wall.</p> <p>*1/25/14- She had a fall to the floor.</p> <p>*2/12/14-She was observed on the floor.</p> <p>-She was "repositioning or self-transferring without assistance."</p> <p>-She fell out of her wheelchair.</p> <p>*She was in the bathroom and fell off the toilet.</p> <p>Review of resident 3's therapy documentation revealed PT and OT had completed screens on her in December 2013 following falls. They made no recommendations and stated "Resident demonstrates poor rehabilitation potential unable to follow one step commands."</p> <p>Interview on 2/20/14 with the consulting physical therapist revealed:</p> <p>*When a resident had dementia (decline in mental process) and did not have rehabilitation potential, the therapists would not work with them.</p> <p>*They had not worked with resident 3 according to their documentation on a positioning program.</p> <p>Review of resident 3's entire medical record revealed she had not been on a restorative program.</p> <p>Interview on 2/10/14 at 11:50 a.m. with resident 3's son revealed:</p> <p>*He came to visit his mom several times during the week.</p> <p>*He walked with her in the facility.</p> <p>*He had even taken her home and she was able to walk into his home.</p> <p>*He wanted to see his mom walked in the facility by staff, but that was not happening.</p>	F 311			

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

PRINTED: 03/03/2014
FORM APPROVED
OMB NO. 0938-0391

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F 311	<p>Continued From page 23</p> <p>Interview on 2/20/14 at 11:00 a.m. with the director of nursing confirmed there was not a restorative program in place for resident 3. Surveyor: 33488</p> <p>Interview on 2/19/14 at 4:25 p.m. with resident 10 and her family revealed: *She had been admitted to the facility in July 2013 following a stroke that caused weakness on her left side. *Restorative therapy had been ordered upon admission on 07/18/13 by the physician. *The family stated she had never received restorative therapy to their knowledge. *They were concerned about "her left side getting weaker. That's why we brought her here, for the therapy." *She wore a brace on her left forearm while awake and a brace to her left foot at night to prevent contractures of her hand and foot (an abnormal, often permanent shortening of muscle in an arm or leg that results in distortion or deformity.)</p> <p>Interview and medical record review on 2/20/14 at 10:20 a.m. with registered nurse (RN) E and licensed practical nurse (LPN) B regarding resident 10 revealed: *LPN B stated the CNAs were responsible for providing restorative therapy to the residents. *LPN B could not provide any documentation restorative therapy had been completed as ordered. *RN E agreed: -It was the responsibility of nursing staff to make sure physician's orders were followed and the resident received that care. -The resident 10's therapy had not been added to the care plan.</p>	F 311			

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

PRINTED: 03/03/2014
FORM APPROVED
OMB NO. 0938-0391

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F 311	<p>Continued From page 24</p> <p>-The care plan was not individualized for the resident and had no therapy or specific instructions on the resident's braces.</p> <p>Interview and medical record review on 2/20/14 at 11:10 a.m. with the consulting PT H regarding resident 10 revealed:</p> <p>*An order had been placed upon admission for resident 10 to have restorative therapy in July 2013.</p> <p>*The consulting physical therapist made recommendations in July, 2013 based on a physical assessment of resident 10.</p> <p>*These recommendations had been given to the provider's nursing staff to carry out restorative care.</p> <p>*He stated it had been "frustrating" for him as the provider had not followed the physician's orders or his recommendations as they had a hard time finding staff that would provide these specialized cares.</p> <p>*To his knowledge:</p> <p>-No restorative therapy had been provided to any residents requiring this service by the provider prior to this survey for the above mentioned reason.</p> <p>-No restorative therapy had been provided specifically for resident 10.</p> <p>Review of the Functional Mobility/Restorative Care/Fun Fitness policy dated 1/10/14 revealed restorative therapy should be performed by staff at least fifteen minutes per day, six days per week to allow the residents to maintain or improve their highest mental, physical and psychosocial functioning.</p>	F 311			
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323			

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

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F 323	<p>Continued From page 25</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, label review, and policy review, the provider failed to ensure: *Appropriate measures were put in place to prevent falls for one of one sampled resident (3) with multiple falls. *Appropriate use of the whirlpool tub safety belt while bathing residents. *Storage of chemicals in a secure location. Findings include:</p> <p>1. Review of resident 3's nurse's notes revealed: *On 5/20/13 she was found on the blue mat on the floor beside her bed. -She had fallen out of her wheelchair. -She was "repositioning or self-transferring without assistance." *On 6/16/13 she was was found on the floor next to her bed. -She was "repositioning or self-transferring without assistance." *On 8/5/13 she was found on the floor next to her bed. -She later complained of pain in her right leg/thigh area and was sent in for an X-ray which concluded there was no apparent injury. *On 10/8/13 she was found on the floor.</p>	F 323	<p>F323</p> <p>1) Further investigation into Resident #3's most recent fall was completed. It was noted that the C.N.A. on duty had Transferred this resident off of the toilet and back into her wheelchair. She was insistent on sitting in her room despite the C.N.A. having encouraged her to come out and join other residents in an activity. The resident declined. After the C.N.A. went to attend the needs of another resident, this resident apparently took herself back into the bathroom and attempted to transfer herself from her wheelchair onto the toilet. This was when her son walked into the room and found her on the floor. During the Directed In-Service Training completed by the facility during the week of March 10, 2014 staff were reminded of the need to thoroughly complete ALL documentation regarding each fall (including the information under the "fall investigation" tab in the</p>	5@ 4/10/14

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

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F 323	<p>Continued From page 26</p> <p>-She was "repositioning or self-transferring without assistance." -She fell out of her wheelchair. *11/26/13-She slid from her chair and was lowered to the floor. *12/8/13-She was found on the floor in front of her recliner with the foot of the recliner still elevated. *12/17/13-She fell forward from her chair and landed in a sitting position with her back against the wall. 1/25/14- She had a fall to the floor. 2/12/14-She was observed on the floor. -She was "repositioning or self-transferring without assistance." -She had fallen out of her wheelchair. *She was in the bathroom and had fallen off the toilet.</p> <p>Review of resident 3's February 2014 Medication Administration Record revealed she was on: *BuPropon-an antidepressant. Dizziness was a potential side effect of that medication. *Quetiapine Fumarate/Seroquel (Antipsychotic). A potential side effect was weakness and drowsiness.</p> <p>Further review of the above falls revealed there was no evidence they evaluated/investigated: *When was the last time the resident had been toileted. *When was the last time the resident had been repositioned. *What medications could have contributed to the fall. *How long had she been in her bed or wheelchair. *Was her call light within reach since each time she had fallen. *Had they checked her for orthostatic</p>	F 323	<p>F323 (continued) electronic charting system (ECS) in addition to the "fall incident report". The importance of consistently documenting circumstances about falls was emphasized and staff were reminded that factors and circumstances surrounding a fall need to be conveyed to the nurse completing the post-fall assessment. It was noted that the frequency with which a particular individual engages in actions that cause a sensor or alarm to sound would be valuable information. Capturing this information better will increase communication about the frequency with which the resident engages in unsafe actions that could potentially contribute to a fall. Tabs within the ECS that indicate "unsafe action", "getting up without assistance", and "wandering" were each color-coded to make them more obvious to staff as they are charting about behaviors.</p>		

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

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F 323	<p>Continued From page 27</p> <p>hypotension?</p> <p>*Was she in pain prior to the fall and was that why she was attempting to reposition herself.</p> <p>*Who the staff person was that was responsible for the resident at that time.</p> <p>Review of resident 3's entire medical record revealed she had not been on a restorative program.</p> <p>Review of resident 3's physician progress notes revealed from February 2013 through February 2014 the physician documented she had fallen in September 2013. There was no evidence they discussed any clinical reason for the falls.</p> <p>Review of resident 3's pharmacy reports from February 2013 through January 2014 revealed the pharmacist had not documented on any of her falls. An interview on 2/20/14 at 9:00 a.m. with the consulting pharmacist revealed she had not documented in her reports on the falls. She had not thought the medications she was on had caused the falls.</p> <p>Review of resident 3's therapy documentation revealed physical therapy (PT) and occupation therapy (OT) had completed screens on her in December 2013 following falls. They made no recommendations and stated "Resident demonstrates poor rehabilitation potential unable to follow one step commands."</p> <p>Interview on 2/20/14 with the consulting physical therapist revealed: *When a resident had dementia and did not have rehabilitation potential, the therapists would not work with them. *They had not worked with resident 3 according</p>	F 323	<p>F323 (continued)</p> <p>Staff members were told that it is frequently documented that "alarm was sounding" at the time of a resident fall, but it is not generally captured in the resident's medical record when there were multiple episodes prior to that fall in which the alarm or sensor was activated and appropriate interventions and guidance given to the resident to prevent a fall. The fall investigation will include (whenever the information is available/possible to determine) information such as when the resident was last toileted, repositioned, received medication that could have contributed to a fall, how long the resident had been in bed/in wheelchair, whether the call light was within reach, and whether there were additional assessments to determine whether the fall was influenced by a medical condition such as orthostatic hypotension, low blood glucose level, vertigo, pain</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 28 to their documentation on a positioning program.</p> <p>Review of resident 3's care plan revealed: *She had dementia. *On 12/17/13 and 1/25/14 they identified she had fallen. *Interventions included: -Assure pain management. -Instruct to call for help. -Sensor alarm. -Floor mat next to bed. *There were no interventions that addressed a specific toileting program or repositioning schedule.</p> <p>Interview on 2/19/14 at 11:00 a.m. with the director of nursing revealed: *The nursing notes were the assessments that had been completed after each fall resident 3 had. *The electronic medical record had an Unusual Reporting form that was to be completed after each fall. *These forms had not been completed by nurses after her falls. *She later acknowledged the care plan had addressed interventions to prevent an injury when the resident fell, but it had not addressed ways to prevent the falls.</p> <p>Review of the provider's 6/28/12 Fall Prevention and Management policy revealed: **Medical factors which may indicate fall risk include but are not limited to: agitation or delirium, infection, toxic/metabolic condition, cardiopulmonary (heart and lungs) changes, CNS [central nervous system/brain] changes, dehydration, or blood loss, sleep disturbances, orthostatic hypotension (blood pressure drops</p>	F 323	<p>F323 (continued) weakness, urinary tract infection, etc. as it pertains to the situation at hand and the actions (or presumed actions/symptoms possibly experienced) of the resident. Monitoring compliance with this corrective action will be the responsibility of the Director of Nursing or her designee. Findings will be reviewed at the weekly "Medicare Meeting". A summary of the findings from the weekly reviews will be reported to the Leadership/ QA committee on a monthly basis for 3 months. The Leadership committee will determine the frequency at which this monitoring should continue.</p> <p>2. During the Directed In-Service Training completed by the facility during the week of March 10, 2014 staff were directed to utilizing the safety belt on the whirlpool tub chair is to be done without exception for all residents whenever using the</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 29</p> <p>when resident stands), and polypharmacy (multiple medication use). **Other factors to consider are: age, history of falls, frequent toileting, impaired mobility, impaired vision, inappropriate use of assistive devices, inappropriate footwear, impaired cognition (mental), physical deficits." **Medication categories commonly associated with injuries from falls are: antidepressants, cardiac drugs, psychotropics, antihypertensive, and diuretics." **The fall is discussed with the Medicare Team weekly and the team discusses interventions to prevent further falls. Interventions may include but are not limited to referral for therapy screen/services, encouragement for the resident to ambulate with assistance". **Once a fall occurs: -Assess each fall taking into account all aspects mentioned above. -Involve the pharmacist as appropriate. -Involve primary physician. -Individualize the resident's care plan." Surveyor: 32355 2. Observation and interview on 2/19/14 at 8:40 a.m. of certified nursing assistant (CNA) D revealed: *She had been disinfecting the whirlpool tub. *The whirlpool tub chair had a safety belt (device the residents wore to ensure their safety during bathing) loosely wrapped around the back of the chair. *She had sprayed the chair and belt with disinfectant. *Would not have used the safety belt for all residents who received a whirlpool bath.*She would have only used the safety belt on residents that leaned forward or slid down the chair. Review of the provider's incident reports sent to the State Department of Health revealed:</p>	F 323	<p>F323 (continued) whirlpool tub to prevent an accident. This will be monitored randomly several times weekly by the Director of Nursing or her designee to include direct observation (on various days, at different times), make note of the fact that the belt is being used (is still attached to the chair/wet immediately after a bath/being disinfected), and/or staff interview. Any staff member failing to use the seatbelt on the whirlpool tub chair will be subject to disciplinary action (with written documentation of the conference maintained in the employee's file). Findings pertaining to compliance with this safety measure will be reported to the Leadership/ QA on a monthly basis for 3 months and quarterly thereafter for at least the first 6 months. The Leadership committee will determine the frequency at which this monitoring should continue.</p>		

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

PRINTED: 03/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2014
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F 323	<p>Continued From page 30</p> <p>*On 10/24/13 an unidentified resident had just finished receiving a whirlpool bath. *The resident had slid out of the whirlpool tub chair while being moved out of the tub. *She had not been secured in the chair with the safety belt.</p> <p>Interview on 2/20/14 at 10:15 a.m. with the director of nurses (DON) and infection control nurse revealed the safety belt should have been used on all residents who had received a whirlpool bath. Education had been provided with a notice posted in the whirlpool tub room after the above incident occurred.</p> <p>Review of the provider's January 2013 Cleaning and Disinfecting the Whirlpool Tub policy revealed: *Additional information had been attached to the document. This information had been dated 12/18/13. **All residents must be belted in the whirlpool chair." Surveyor: 32331 3. Observation on 2/18/14 at 3:10 p.m. in room 212 a fifteen and one-half ounce (oz) spray can of Claire disinfectant (kills microorganisms) on the side of the resident's bathroom sink.</p> <p>Observation on 2/18/14 at 6:20 p.m. in an unlocked whirlpool tub room on Hummingbird Lane on a shelf next to the door revealed a fifteen and one-half oz spray can of Claire disinfectant which revealed the following caution information on the can's label: *Keep out of reach of children. *Avoid contact with eyes, skin, or clothing. *Causes moderate eye irritation. *Harmful if absorbed through the skin.</p>	F 323	<p>F323 (continued) 3. During the Directed In-Service Training completed by the facility during the week of March 10, 2014 staff were told that the disinfecting spray that had been commonly used as an air freshener and readily available to staff may not be stored within easy access of residents. There had been a common practice of leaving a can in areas where it would be likely to be needed, but this practice was changed immediately. Disinfecting spray bottles will be stored in a locked cupboard in the shower/tub room on each wing and kept out of the reach of residents. If a potentially hazardous chemical (air freshener) is noted to be in a resident room and is something that has been purchased by a resident or a family member, teaching will occur and the item will be removed and secured</p>		

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F 323	<p>Continued From page 31</p> <p>*Hazardous to human and domestic pets.</p> <p>Observation and interview on 2/19/14 at 7:45 a.m. with housekeeping assistant F in room 212 revealed: *A spray bottle of Claire disinfectant on the side of the resident's sink. *She stated the disinfectant product was in most rooms, either on top of the paper towel dispenser or on the sink's counter in most resident bathrooms.</p> <p>Interview on 2/19/14 at 10:10 a.m. with licensed practical nurse B regarding the disinfectant in the resident rooms and in personal care areas. She revealed it had been used as an air freshener and was not used as a disinfectant.</p> <p>Surveyor: 32355 Interview on 2/19/14 at 11:30 p.m. with the DON revealed: *The staff had been using the disinfectant as an air freshener and not a disinfectant. *She had been unaware of all the cans of disinfectant located in the tub rooms and resident bathrooms. *The chemicals should not have been accessible to the residents.</p> <p>Review of the provider's 3/18/08 Material Safety Data Sheet for the Claire disinfectant spray revealed: *The product was harmful in contact with eyes. *The product was considered hazardous under OSHA (Occupational Safety and Health Administration). *Contact may irritate or burn eyes. *Prolonged or repeated contact could result in skin irritation and a rash.</p>	F 323	<p>F323 (continued)</p> <p>where it will be out of reach should another resident have a potential to wander (at the family's discretion this may be taken home). Families will be guided in the fact that if they choose to have an air freshener readily available, this should be a non-plug-in type that is safe around children and cannot be sprayed into the face/eyes. This will be monitored by direct observation on a random basis in all of the resident rooms and common tub rooms by the Director of Housekeeping Services or her designee every week x4. A report will be made to the Leadership/QA committee after monitoring for at least 1 month; if there is evidence of substantial compliance with storing chemicals safely throughout the residential unit, the committee can then make additional recommendations about the frequency of monitoring and reporting.</p>		

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F 323	Continued From page 32 *Intentional misuse by concentrating and inhaling the product could be harmful or fatal. *Prolonged inhalation may be harmful. *Ingestion may cause gastrointestinal (stomach and intestine) irritation, nausea, vomiting, and diarrhea. Review of the provider's undated Housekeeping/Chemical Use and Storage policy revealed hazardous cleaning solutions, chemicals, poisons, and substances should have been labeled, stored in a safe place, and kept in an enclosed section separate from other cleaning materials.	F 323	<i>* DON will report all falls to QA. The administrator and DON monitor and review all falls on a weekly basis. KR/SDDOH/MF</i>		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F329 Resident #5 was noted to be routinely receiving an over-the-counter preparation to induce sleep. It was noted that it would be more likely to have documentation of the frequency at which a resident experiences difficulty sleeping. This resident has not experienced difficulty sleeping with this medication being administered on a daily basis. The resident said that she has not been having trouble sleeping. She said that she would have no objection to a change in the frequency at which the medication is administered. Her physician has been asked about considering a medication reduction or	3/14/14	

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F 329	<p>Continued From page 33</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to identify the use of an unnecessary drug for one of one resident (5) on diphenhydramine (an antihistamine which decreases congestion and can be used for sleep) medication. Findings include.</p> <p>1. Review of resident 5's complete medical record revealed: *She had been admitted on 2/10/05. *She was eighty-three years old. *She had diagnoses that had included anxiety and depression. *A physician's order dated 8/14/12 "[Tylenol PM Extra Strength] Disphenhydramine-APAP (sleep) 500 MG [milligrams]-25 MG tablet dose ordered (1 tablet) by mouth daily HS (at bedtime) for pain / insomnia [unable to sleep] ."</p> <p>Review of resident 5's medication administration records from 2/1/14 through 2/17/14 revealed: *The diphenhydramine medication had been given each HS (at bedtime). *There were no non-medication interventions listed. *The side effects listed were "None Found."</p> <p>Review of resident 5's 1/20/14 care plan revealed: *There was no documentation for administration of the diphenhydramine medication or why it had</p>	F 329	<p>F323 (continued) changing this medication to be administered on a PRN basis. Orders were received on March 14, 2014 to change this medication to PRN. The consultant pharmacist has been asked to consider hypnotic medication, the duration of administration, and whether there have been indications for administration and/or contraindications while doing a comprehensive review of the medication regimen for each resident on a monthly basis. The Director of Nursing (DON) and Administrator will review recommendations regarding potential dose reductions and the implementation of other non-pharmacological approaches to address insomnia. This will be monitored on a monthly basis through a collaborative effort between the DON and the pharmacist to assure that hypnotic medication is appropriately administered at the lowest possible</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	<p>Continued From page 34 been given. *There were no non-medication interventions listed for the insomnia.</p> <p>Review of the resident's monthly Medication Regimen Review by the consultant pharmacist 1/29/13 through 1/23/14 revealed there were no recommendations for change or continued need for the diphenhydramine medication.</p> <p>Interview on 2/19/14 at 4:30 p.m. with the director of nursing (DON) and the administrator regarding resident 5's diphenhydramine medication revealed: *Resident had been sleeping well with no non-medication interventions for the insomnia conducted. *Non-medication approaches for insomnia would have been good to try to see if this helped her sleep without medication. *The biggest concern was her poor food intake.</p> <p>Interview on 2/20/14 at 9:00 a.m. with the consultant pharmacist with the DON and the administrator present regarding resident 5's continued usage of the diphenhydramine medication revealed: *She had reviewed the order monthly. *She had made no recommendations to change the order. *She agreed that it was an unnecessary drug and needed to have been reduced or removed. *She agreed it needed to have been further reviewed for continued usage.</p> <p>Todd P. Semla et al., Geriatric Dosage Handbook, 16th ed., American Pharmacists Association, Hudson, Ohio, 2011, p. 494, revealed the diphenhydramine medication.</p>	F 329	<p>F323 (continued) therapeutic dose and residents do not suffer from adverse reactions. This monitoring will include assuring that the resident's care plan includes non-pharmacological approaches to augment the medication regimen. A summary of findings will be reported at least quarterly to the Leadership/QA committee for at least 6 months; the committee will then make additional recommendations about the frequency of monitoring and reporting.</p> <p><i>* DON will report to QA. KR/SDDOH/MF</i></p>		

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F 329	Continued From page 35 *May be inappropriate for use in geriatric (elderly) residents. *May cause sedation (reduction in irritability or agitation), and should not have been used as a hypnotic (to induce sleep) in the elderly. *May cause excessive sedation and confusion. *Has potent anticholinergic effects (affects the nervous system). *Special geriatric considerations included: -Diphenhydramine contained high sedative and anticholinergic properties, so it may not be considered the antihistamine of choice for prolonged use in the elderly. -The use as a sleep aid was discouraged due to its anticholinergic effects. -Interpretive guidelines from the Centers for Medicare and Medicaid Services (CMS) discouraged the use of diphenhydramine as a sedative or anxiolytic (against anxiety) in long-term care facilities. Review of the provider's undated Pharmacy Review policy revealed the consulting pharmacist should have reported potential drug therapy irregularities and to have made recommendations for improving the drug therapy.	F 329		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441	F441 Observations made by surveyors during the process of disinfecting the whirlpool tub were reviewed with the C.N.A. (D) having primary responsibility for doing whirlpools 5 days/week. She was re-educated in the proper technique to disinfect the whirlpool tub. It has been clarified in that policy, that it	3/13/14

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

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FORM APPROVED
OMB NO. 0938-0391

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F 441	<p>Continued From page 36</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, and policy review, the provider failed to ensure sanitary conditions were maintained: *To prevent cross-contamination after disinfecting one of one whirlpool tub.</p> <p><i>[Redacted]</i></p>	F 441	<p>F441 (continued)</p> <p>is necessary for staff to wash hands after completing resident care and that it is recommended that gloves are worn during the disinfecting process. Once gloves are removed, the staff person who has disinfected the tub and other surfaces is required again to wash his/her hands prior to touching other surfaces. The process of disinfecting of the whirlpool tub will be monitored by the Director of Housekeeping Services or her designee every week x4. A report will be made to the Leadership/ QA committee after monitoring for at least 1 month; if there is evidence of substantial compliance with following the procedure for disinfecting the whirlpool, the committee can then make additional recommendations about the frequency of monitoring and reporting.</p> <p><i>* Director of housekeeping will report to QA. KR/CDDH/ME</i></p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 37</p> <p>Findings include:</p> <p>1. Observation on 2/19/14 at 8:40 a.m. of certified nursing assistant (CNA) D prior to, during, and after the disinfecting of the whirlpool tub revealed: *She had not washed or sanitized her hands prior to disinfecting the tub. *Without gloves on she touched the following: -The seat of the whirlpool tub two times. -The wire attached to the drain plug. -The controls to add the disinfectant solution. -A large handled brush used for scrubbing the whirlpool tub. *She had not worn gloves during the entire disinfecting process. *She had not washed or sanitized her hands after disinfecting the tub. *She retrieved a clipboard with papers attached to it to show the surveyor. *She opened a drawer on a storage unit and retrieved a razor.</p> <p>Interview on 2/19/14 at the time of the above observation with CNA D confirmed she should have worn gloves and washed her hands prior to and after the disinfecting process.</p> <p>Interview on 2/20/14 at 10:00 a.m. with the director of nurses (DON) and the infection control nurse confirmed improper technique had been used for the disinfecting of the whirlpool tub.</p> <p>Review of the provider's January 2013 Cleaning and Disinfecting the Whirlpool Tub policy revealed no procedure for wearing gloves or disinfecting of the hands.</p> <p>The facility had not been able to provide a policy or procedure on the proper storage for resident's</p>	F 441	<p>F441 (continued)</p> <p>The facility has developed a policy for storing resident's personal care products. This policy allows for the facility to store items such as shampoo, lotion, mouthwash, etc. inside the bathroom "medicine cabinet" (behind the mirror) or on the edge of the sink (according to the resident's preference if one has been expressed). If a resident prefers to store items in the closet or dresser, this is acceptable. Effective March 13, 2014 personal toiletry items will no longer be stored under a bathroom vanity cabinet. Although this change in policy was prompted by a perceived potential for damage to personal items if there would happen to be some plumbing issue, the facility has opted to continue to use these under the sink cabinet areas in each resident bathroom to store facility provided items such as a bedpan, urinal, and</p>		

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

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F 441	Continued From page 38 personal care products.	F 441	F441 (continued) wash basin (when not in use) because any of these items can be readily removed and replaced should there be a plumbing issue. Compliance with this plan will be monitored by the Director of Housekeeping Services or her designee every week x4. A report will be made to the Leadership/QA committee after monitoring for at least 1 month; if there is evidence of substantial compliance with following the procedure for storing personal care products, the committee can then make additional recommendations about the frequency of monitoring and reporting.		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435122	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2014
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 2/19/14. St. Williams Home for the Aged 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 2/20/14 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 K144 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		F
K 033 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and record review, the</p>	K 033		F

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

S. May Walker

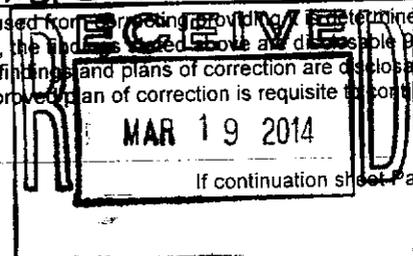
TITLE

Administrator

(X6) DATE

3/17/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings cited 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.



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

PRINTED: 03/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435122	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2014
NAME OF PROVIDER OR SUPPLIER ST WILLIAMS HOME FOR THE AGED			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SOUTH 9TH STREET MILBANK, SD 57252	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 033	Continued From page 1 provider failed to maintain a protected path of egress from the basement to the exterior of the building. One 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 9:30 a.m. on 2/19/14 revealed a basement stairway that discharged onto the main level corridor system of Hummingbird Lane. That condition did not provide a continuous protected exit passage to the exterior of the building. Review of the previous life safety code survey confirmed that condition had existed since the original construction. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K 033		
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation, interview, and document review, the provider failed to install a remote	K 144	K144 An electrician has been contacted about moving the enunciator panel so that it is in an area that is consistently monitored by staff. The anticipated date of this work is on or before April 10, 2014.	4/10/14

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K 144	Continued From page 2 alarm in a continuously occupied location to indicate when the generator system was in a trouble status. Findings include: 1. Observation at 10:30 a.m. on 2/19/14 revealed the facility's emergency power supply (EPS) consisted of a generator and a transfer switch. The location of the generator and transfer switch panel was not in an area continuously occupied. The enunciator panel was not installed at a location that was readily observable by staff. Interview with the maintenance supervisor at the time of observation revealed the enunciator had been installed in the unattached garage when the generator was installed in 2006. That remote enunciator should have been installed in a continuously occupied location to alert staff if there was trouble with the generator.	K 144		

ORIGINAL

PRINTED: 03/03/2014
FORM APPROVED

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10649	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/20/2014
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NAME OF PROVIDER OR SUPPLIER ST. WILLIAMS HOME FOR THE AGED	STREET ADDRESS, CITY, STATE, ZIP CODE 901 E VIRGIL AVE PO BOX 432 MILBANK, SD 57252
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 000	Initial Comments Surveyor: 32334 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 2/18/14 through 2/20/14. St. Williams Home for the Aged was found not in compliance with the following requirement: S166, S300, and S314.	S 000		
S 166	44:04:02:17(1-10) OCCUPANT PROTECTION The facility must take at least the following precautions: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents; (3) Provide a call system for each...resident bed and in all toilet rooms and bathing facilities routinely used by...residents. The call system must be capable of being easily activated by the...resident and must register at a station serving the unit; (4) Provide handrails firmly attached to the walls on both sides of all resident corridors in nursing facilities; (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors in nursing facilities. Other exterior doors must be locked or alarmed. The alarm must be audible at a designated nurses' station and may not automatically silence when the door is closed;	S 166	S166 Prior to the week of March 7, 2014 an audible alarm was installed on the door entering the staircase to the north of the resident dining room. An alarm sounds in the immediate area of the door and the nursing station (unless the proper sequence of numbers are depressed on the keypad proximal to the door to deactivate the alarm) The Maintenance Director (or his designee) will assure the alarm is functioning on a weekly basis x1 month. A report will be made to the Leadership/QA committee after monitoring for at least 1 month; if there is evidence of the alarm being functional on a consistent basis, the committee can then make additional recommendations about the frequency of monitoring and reporting.	3/7/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: S. May Walker TITLE: Administrator (X6) DATE: _____

SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 166	Continued From Page 1 (7) Portable space heaters and portable halogen lamps may not be used in a facility; (8) Household-type electric blankets or heating pads may not be used in a facility; (9) Any light fixture located over a...resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof lamp; and (10) Any clothes dryer must have a galvanized metal vent pipe for exhaust. This Rule is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to maintain the electrically activated audible alarm for unattended doors in an active condition for one of seven exit doors (north of dining). Findings include: 1. Observation at 11:15 a.m. on 2/19/14 revealed an unattended exit door north of the dining area. That door did not alarm when the door was opened. Interview with the maintenance supervisor at the time of the observation revealed the alarm had been deactivated for staff entrance and egress during the hours of 4 a.m. to 11 p.m. That door however was not being continuously monitored during the deactivated hours and should have been alarmed.	S 166		
S 300	44:04:07:14 Nutritional assessments A registered dietitian shall ensure a nutritional	S 300		

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S 300	<p>Continued From Page 2</p> <p>assessment is completed on each new resident upon admission; any resident having a significant change in diet, eating ability, or nutritional status; monthly for any resident receiving tube feedings; and on any resident with a disease or condition that puts the resident at significant nutritional risk. A monthly tube feeding assessment must include nutritional adequacy of calories, protein, and fluids. An annual assessment shall be completed for each resident.</p> <p>This Rule is not met as evidenced by: Surveyor: 12218 Based on record review, and interview, the provider failed to ensure the initial nutrition assessment for one of one recently admitted resident (11) had been completed within the fourteen days of admission. Findings include:</p> <p>1. Review of resident 11's medical record revealed: *She had been admitted on 1/23/14. *Her diagnoses included history of falls, adult failure to thrive, dementia, esophageal reflux osteoarthritis, and hypertension. *The initial nutritional assessment by the registered dietitian (RD) was completed on 2/13/14.</p> <p>Interview with the administrator on 2/20/14 at 11:15 a.m. revealed: *She knew the RD also consulted at the hospital as well as the nursing home. *The dietary manager was suppose to have alerted the RD whenever a new resident was admitted. *The initial nutritional assessment had not been completed within the 14 days of admission. It was completed 22 days after admission.</p>	S 300	<p>S300 The Dietary Manager had not notified the Dietician of resident 11's admission. Since that time, a log was started and maintained in the kitchen office to assure that the Dietician is aware of a resident admission or significant change in status (because she is able to refer to this log whether she is consulting at the nursing facility or the adjoining hospital). The Dietary Manager will be responsible for monitoring that the Dietician is notified of a resident's admission in order to assure a timely assessment on a monthly basis x3 months. She will report findings to the Leadership/ QA committee monthly x3 months; if there has been substantial compliance with this corrective action, the committee will determine whether continued monitoring is warranted.</p>	4/10/14

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S 314	Continued From Page 3	S 314		
S 314	<p>44:04:08:03.01 Drug Therapy Reviewed Monthly</p> <p>The pharmaceutical service must be under the supervision of a licensed pharmacist who is responsible to the administrator for developing, coordinating, and supervising medication control. The pharmacist must review the drug regimen of each nursing facility resident...at least monthly. The pharmacist must review, at a minimum, the...resident's diagnosis, the drug regimen, and any pertinent laboratory findings and dietary considerations. The pharmacist must report potential drug therapy irregularities and make recommendations for improving the drug therapy of the residents...to the attending physician and the administrator. The pharmacist must document the review by preparing a monthly report of the potential irregularities and recommendations. The administrator must retain the report in the nursing facility...</p> <p>This Rule is not met as evidenced by: Surveyor: 22452 Based on interview and 6/13/12 pharmacist agreement, the pharmacist failed to provide the administrator a monthly report of any potential drug irregularities and her recommendations. Findings include:</p> <p>1. Interview on 2/19/14 at 2:30 p.m. with the director of nursing (DON) and the administrator regarding pharmacy services revealed: *The consulting pharmacist reviewed each resident's drug regimen on a monthly basis and entered all her findings in each resident's electronic medical record. *An internal memo in the electronic medical</p>	S 314	<p>S314 The electronic charting system (ECS) will be updated on or before April 10, 2014 to include an option for the pharmacist to select a documentation screen facilitating documentation of a monthly facility report about the monthly review. This report will include any medication irregularities, recommendations for improving the drug therapy of the residents, any questions or concerns noted during the monthly medication review. The consultant pharmacist will also be invited to the monthly Leadership/QA committee meeting in order to assure that management is able to have a pharmaceutical perspective regarding the current status of residents, policies and procedures, and/or other issues pertaining to the monthly resident drug therapy review.</p>	4/10/14

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S 314	Continued From Page 4 record was forwarded to the DON. *The DON would then determine if the physician would need to be contacted prior to the next nursing home visit if irregularities or concerns had been noted. *They had never received a monthly report from the consulting pharmacist. Interview on 2/20/14 at 8:30 a.m. with the pharmacist regarding the above revealed: *She and the administrator and DON had talked about her completing a monthly report for the monthly quality assurance meeting. *She had not been able to do that because of time constraints and obligations at other nursing facilities where she consulted. Review of the 6/13/12 consultant pharmacist and provider agreement revealed the consultant pharmacist was required on a monthly basis to meet with the medical director and leadership members for approximately one hour to review the status of all residents.	S 314	S314 (continued) The consultant pharmacist will be asked to print a consultant report for the Administrator on a monthly basis. Monitoring attendance at the monthly Leadership/ QA committee meeting and recognition of receipt of this report and will be the responsibility of the Administrative Secretary. She will report her findings at the monthly meeting x3 months and quarterly thereafter; if after 6 months, there has been consistent compliance with this plan of correction, the committee will determine the frequency at which this monitoring/reporting should continue.	