

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

ORIGINAL

PRINTED: 12/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2014
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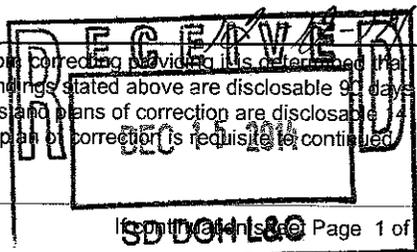
NAME OF PROVIDER OR SUPPLIER AVERA BORMANN MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 4TH STREET PARKSTON, SD 57366
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F 000	INITIAL COMMENTS Surveyor: 32355 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 11/17/14 through 11/19/14. Avera Bormann Manor was found not in compliance with the following requirements: F176, F221, F240, F280, F281, F314, F323, F329, F333, F371, F441, and F514.	F 000	Addendums noted with an asterisk per initial onsite review with facility DON and facility infection control nurse. JK/SDDOH/MF	
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: 32335 Based on observation, record review, and interview, the provider failed to ensure assessments to self-administer medications were completed quarterly for one of one randomly observed resident (13). Findings include: 1. Observation on 11/17/14 at 5:30 p.m. in the dining room of resident 13 revealed: *Registered nurse (RN) I took her medication from the medication cart and put it into a medicine cup. *She then walked over to her and set the medication cup down in front of her. *She walked away and informed this surveyor that the resident self-administered her medication.	F 176	The policy on self-administered meds has been reviewed by all professional nurses and med aides. A medication self-administration assessment will be completed on resident #13 along with her next MDS review. All other residents who self-administer medications will also have assessments completed no later than Jan. 8 th , 2015. To assure that all resident's assessments are updated at least on a quarterly basis, they will be completed when each resident's MDS assessments are due. The date the assessment was completed and the date the next one will be due will be added to a flow sheet. This flow sheet will be filled out at our weekly care-planning sessions. The results of this flow sheet will be given to the QA nurse each quarter who will then present it to the QA committee * UNTIL 1/11/15 JK/SDDOH/MF * BY THE DON OR designee. JK/SDDOH/MF	x1/02/15 JK/SDDOH/MF

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE President / C-EO	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 45 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 176	Continued From page 1 Review of resident 13's medical record revealed a self-administration assessment had been completed on 7/24/13 and not again until 10/1/14. Interview on 11/19/14 from 1:10 p.m. through 2:00 p.m. with the director of nursing regarding resident 13 revealed the self-administration assessments should have been done at least quarterly. She agreed they had not been done to that standard.	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: 32335 Based on observation, record review, interview, and policy review, the provider failed to ensure assessments for all restraints or potential restraints were completed at least quarterly for 4 of 11 sampled residents (1, 3, 4, and 6). Findings include: 1. Observation on 11/17/14 at 2:20 p.m. of resident 6 revealed: *He had a fabric tent over his bed. *The tent zipped close on both sides of his bed leaving the bottom of the bed open. Observation on 11/18/14 at 9:45 a.m. of resident 6 revealed he was in his room sitting in a recliner	F 221	1. A restraint assessment has been completed on resident #6. To assure no further restraint assessments will be missed, a flow sheet has been implemented for the interdisciplinary team to review each week. This will enable the team to make sure all restraint assessments are done with each MDS assessment. The flow sheet will show the date the last restraint was completed and when the next assessment is due. The information from the flow sheet will be given to the QA nurse on a monthly basis so she can report to the QA committee quarterly. 2. A restraint assessment has been completed on resident #1. The use of his ½ rails has also been added to his care plan. 3. An initial restraint assessment has been completed on resident #3 and ½ rails have also been added to his care plan. 4. An initial restraint assessment for resident #4 has been completed and the use of ½ rails has also been added to her care plan.	* 11/09/15 JK/SDD/HME	

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F 221	<p>Continued From page 2 with a full hand mitt over his right hand.</p> <p>Review of resident 6's 3/7/14 and 11/14/14 Minimum Data Set (MDS) assessments revealed: *He rarely or never was able to make himself understood. *He sometimes had the ability to understand others. *He required total assistance from staff to complete his activities of daily living. *In bed he had a "limb" and "other" restraint. *Out of bed he had a "trunk" and "limb" restraint.</p> <p>Review of resident 6's 11/6/14 care plan revealed: *Restraints had been identified as a problem area. *The restraints being used had included the following: -Hand mitt. -Posey net bed frame. -Seat belt.</p> <p>Review of resident 6's medical record revealed the last restraint assessment had been completed on 10/21/13.</p> <p>Interview and record review on 11/19/14 from 1:10 p.m. through 2:00 p.m. with the director of nursing (DON) revealed the restraint assessments had not been completed as required.</p> <p>Surveyor: 26180 2. Random observations of resident 1 from 11/17/14 through 11/19/14 revealed when he was in bed a one-half side rail was pulled up on the top half of his bed.</p> <p>Review of resident 1's entire medical record</p>	F 221	<p><i>JK/SDDCH/MF</i></p> <p>To assure residents #1, 3, and [redacted] will continue to have quarterly assessments and updated care plans for restraints/side rails, they have been added to the flow sheet mentioned in F221-1. To assure all other residents are assessed for restraints/side rails appropriately, all residents with any type of restraints or use of ½ rails have had a restraint assessment completed and have also been added to the flow sheet for care planning. Also, all staff have reviewed, signed, and dated our restraint policy and procedure.</p> <p>The DON will take the information on the use of ½ rails or any other restraint in our facility to the QA nurse on a monthly basis. She in turn will take it to the QA committee each quarter <i>until 12/1/15. JK/SDDCH/MF</i></p> <p><i>[redacted] JK/SDDCH/MF</i></p>		

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F 221	<p>Continued From page 3</p> <p>revealed a restraint assessment had been completed on 10/15/13. There had not been one done since.</p> <p>Review of resident 1's 10/23/14 care plan revealed it had not addressed the use of a side rail when he was laid down.</p> <p>Interview on 11/19/14 at 11:50 a.m. with the DON revealed: *She confirmed resident 1 had not had quarterly assessments of his side rail. *A side rail was considered a restraint. *They were to complete a side rail assessment every quarter to evaluate if the side rail was being used as a restraint or a positioning device. *A side rail would have been part of the resident's care plan.</p> <p>Surveyor: 32355</p> <p>3. Random observations of resident 3 from 11/17/14 through 11/19/14 revealed when he was in bed two-half side rails were pulled up on the top half of his bed.</p> <p>Review of resident 3's entire medical record revealed: *There had been no restraint assessments completed. *His 10/30/14 care plan had not addressed the use of both side rails when he was laying in bed.</p> <p>4. Random observations of resident 4 from 11/17/14 through 11/19/14 revealed when she was not in her bed, two-half side rails were pulled up on the top half of her bed.</p> <p>Review of resident 4's entire medical record</p>	F 221			

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F 221	Continued From page 4 revealed: *There had been no restraint assessments completed. *Her 10/28/14 care plan had not addressed the use of both side rails. 5. Interview on 11/19/14 at 11:50 a.m. with the DON revealed: *The side rails were considered a restraint. *She confirmed residents 3 and 4 had no restraint assessments completed. *She would have expected an initial restraint assessment to have been completed and than reassessed every quarter thereafter. *The care plans for residents 3 and 4 should have reflected the use of the side rails. Review of the provider's January 2013 Restraints/Protective Devices LTC policy reveal: *Purpose: -"To set procedural guidelines for the intervention and care of residents involving restraints, while focusing on the residents well being and preserving the residents dignity and rights." *Procedure: -"Nurse is to document on restraint initiated intervention on the EMR [electronic medical record]." -"The resident is reassessed quarterly and as needed. The renewal order for restraints is every 60 days and as needed." -The care plan was to be modified as orders and changes for the restraints occurred.	F 221			
F 240 SS=E	483.15 CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE A facility must care for its residents in a manner and in an environment that promotes	F 240			

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F 240	<p>Continued From page 6 revealed: *Staff had identified he could not get out of his room without assistance. *The following interventions were in place: - "Activity staff to assist him to any activity he wishes to attend. - Enjoys music, animals, news, watches TV in his room, likes to go outside, loves country music, and also uses his own laptop. - Ringo the dog or pet therapy. - 1:1 [one-to-one] visiting and 1:1 program done three times weekly. - Family visits often. - Enjoys visiting and joking around with the staff, take outside when possible. - Is able to see out into the hallway when he is in his room and enjoys watching staff, others go by." *No other interventions were in place for taking him out of his room.</p> <p>Review of resident 15's activity attendance documentation revealed: *He is "confined" to his room most of the time. **[Resident name] requires assistance and planning with nurses to plan for him to attend an activity out of his room or outside."</p> <p>c. Interview on 11/18/14 at 4:00 p.m. with the activities director regarding residents 6 and 15 revealed: *They had not been coming out of their room very often. *Activities staff conducted one-to-one activities in their rooms. *Nursing staff had relied on the activities staff to get the residents out of their rooms.</p> <p>Interview on 11/19/14 at 1:10 p.m. with the director of nursing revealed:</p>	F 240	<p>*The provider updated the one-to-one policy on 11/20/14 to reflect the changes made. JK/SDDH/1MF</p>	

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F 240	Continued From page 7 *She agreed residents 6 and 15 were not being brought out of their rooms to prevent isolation. *She stated it had been better up until the rooms had been remodeled and made bigger. *After that remodeling nursing staff were not bringing the residents out. *She expected the nursing staff to bring them out of their rooms just like any other resident in the facility. *She had no policy on dignity.	F 240			
F 280 SS=D	Review of the Long-Term Care Facilities Resident's Bill of Rights handbook provided to the residents at admission revealed "The facility must provide care and an environment that contributes to your quality of life." 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280			

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F 280	Continued From page 8 This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, record review, interview, and policy review, the provider failed to ensure 2 of 11 sampled residents' (3 and 5) care plans were reviewed and revised as changes in care needs occurred. Findings include: 1. Random observations of resident 5 from 11/17/14 through 11/19/14 revealed she: *Had advanced dementia (confusion and memory loss). *Was unable to voice her needs. *Sat for long periods of time in her Broda chair (special wheelchair). *Continually moved her wheelchair with her feet and moved up and down the halls. *Fidgeted alot. *Had a lap belt restraint on at all times when she was in the chair. *Sometimes took her shoes and socks off. *Was walked with assistance to the dining room table for meals. Review of resident 5's November 2014 medication administration record (MAR) revealed she received the following psychotropic (treatment for psychiatric/mental disorders) medications daily: *Seroquel (treatment for mental disorders altering a person's reality) for anxiety. *Zoloft for depression. *Exelon for dementia. Interview on 11/18/14 at 2:30 p.m. with certified	F 280 F280	1. The care plan for resident #5 has been updated to include the following: a. Any behaviors exhibited b. Her diagnosis of depression c. Non-medication interventions for staff to use to prevent restlessness and anxiety d. Potential UTI's 2. Resident #3's care plan has been updated to include the following: a. A body pillow to assist with positioning b. Rook boots c. An over the bed cradle d. A repositioning program e. A focus area that he is at high risk for falls f. Use of TABS alarm g. Non-medication interventions for pain <i>* and revised by 11/15. JK/SDDH/MF</i> To assure that other focus points are not omitted from any resident's careplan, the interdisciplinary team have all reviewed our policy on careplans and made changes where necessary. All resident's care plans will be reviewed [redacted] [redacted] Each resident will be added to our care planning check list. The information from the check list will be given to the QA nurse every month so she can present it to the QA committee each quarter. <i>* until 12/1/15. JK/SDDH/MF</i> <i>X [redacted] JK/SDDH/MF</i>	<i>* 11/19/15 JK/SDDH/MF</i>	

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F 280	<p>Continued From page 9</p> <p>nursing assistants (CNA) F and G and one unidentified CNA regarding resident 5 revealed she:</p> <ul style="list-style-type: none"> *Was usually very pleasant and loved to sing. *Became very frustrated when she needed to have a bowel movement or if she had an accident with her bowels, and they needed to clean her up. *Sometimes she tried to pick imagined things off the floor. <p>Review of resident 5's behavior documentation revealed from 4/23/14 through 11/19/14:</p> <ul style="list-style-type: none"> *There were behaviors documented six times. *Those behaviors were restless and fidgeting. *There was no indication her behaviors included combativeness or behaviors that presented a danger to herself or others. <p>Interview on 11/18/14 at 4:00 p.m. with the social services coordinator regarding resident 5 revealed:</p> <ul style="list-style-type: none"> *The resident became agitated when she had a urinary tract infection (UTI). *Although she was an advocate for the resident, she usually did not question anything the physician ordered to manage the behaviors. <p>Review of resident 5's 9/25/14 care plan revealed:</p> <ul style="list-style-type: none"> *She had a potential for falls related psychotropic medications. *The side effects of the psychotropic medications she was on. *It had not addressed: <ul style="list-style-type: none"> -The behaviors that she exhibited. -The depression. -What they did to prevent the restlessness and anxiety. -How they addressed potential UTIs. 	F 280			

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F 280	<p>Continued From page 10</p> <ul style="list-style-type: none"> -How they prevented accidents with her bowels. -Why she was on the psychotropic medications she was on. -A plan to implement gradual dose reductions of the psychotropic medications. <p>Interviews on 11/19/14 at 11:40 a.m. with the director of nursing (DON) regarding resident 5 revealed the care plan should have addressed the reason she was on the psychotropic medications.</p> <p>Surveyor: 32355</p> <p>2. Review of resident 3's complete medical record revealed:</p> <ul style="list-style-type: none"> *An admission date of 10/18/11. *Diagnoses of depression (sadness), peripheral vascular disease (decrease blood flow to the veins), diabetes mellitus (unstable blood sugar levels in the blood without medication), pain, and history of pressure ulcers (open areas in the skin) to his feet. *He had been dependent upon staff to assist him with all of his mobility needs (transfers and moving in bed) and activities of daily living (ADL). *He was at high risk for skin breakdown and falls. *He took morphine sulfate (narcotic pain medication) 15 milligrams twice a day for pain management. <p>Random observations from 11/17/14 through 11/19/14 of resident 3 revealed:</p> <ul style="list-style-type: none"> *While he was laying in his bed he had: <ul style="list-style-type: none"> -A large body pillow positioned behind his back. -A Tabs alarm (signaling device for staff) attached to his shirt. -Rook boots (relieve pressure) on both of his feet. *An over-the-bed cradle (lifts blankets off feet) 	F 280			

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F 280	<p>Continued From page 11 sitting on his recliner.</p> <p>Review of resident 3's 10/30/14 care plan revealed:</p> <p>*A focus area indicating he was at risk for skin breakdown. There had been no approach indicating he had required the use of:</p> <p>-A large body pillow, Rook boots, and an over-the-bed cradle.</p> <p>-A repositioning program for how often staff were to have assisted him with bed mobility and relieving any pressure points.</p> <p>*A focus area indicating he had been at high risk for falls. The Tabs alarm had not been listed as an approach to help prevent falls.</p> <p>*A focus area indicating he had pain in his legs and back. Staff were to have medicated him for pain as directed. No non-medication interventions had been provided.</p> <p>Interview on 11/19/14 at 2:20 p.m. with the DON regarding resident 3 revealed:</p> <p>*The Minimum Data Set coordinator would have been responsible for the updating and revising of the above areas of concern for the resident's care plan.</p> <p>*She would have expected the care plan to reflect the resident's current care needs and concerns.</p> <p>Review of the provider's March 1996 Care Plan policy revealed:</p> <p>***"The overall plan of care must be reviewed every 90 days, and updated when there is a significant change of condition and/or following hospitalization."</p> <p>*Each resident shall have an individualized overall plan of care which emphasizes the care and development of the whole person."</p>	F 280			

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

PRINTED: 12/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 281 F 281 SS=D	Continued From page 12 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, and record review, the provider failed to ensure: *Physician's orders were obtained for continued care needs on one of one sampled resident (3) who required the use of a Foley catheter (drains urine from the bladder). *Medications given to residents had been on the current physician's orders for two of nine randomly observed residents (13 and 14). Findings include: 1. Review of resident 3's complete medical record revealed he: *Had a diagnosis of bladder retention. *Had a Foley catheter to assist with the draining of the urine from his bladder. *Had physician's orders requiring the Foley catheter to be changed every month. *Was to have had the Foley catheter changed on 11/17/14. Observation on 11/17/14 at 4:10 p.m. of resident 3 revealed he had no Foley catheter in place. Interview on 11/17/14 at 5:10 p.m. with registered nurse (RN) L revealed: *She had attempted to change resident 3's Foley catheter that morning. *She had met resistance and was unable to	F 281 F 281 F281	1. A diagnosis of UTI was added to the order for Cipro and bladder scan for resident #3. An order to discontinue the foley catheter was obtained on 11/22/14. To avoid further errors such as this for resident #3 and any resident in the future, the deficiency F281 was reviewed by all nursing staff. An incident report has been made out for this error. 2. The medication creon and all other medications for resident #13 have been reviewed and corrected as needed. An incident report has been made out for this medication error. 3. The medication furosemide and all other medications for resident #14 have been reviewed	<i>*11/02/15 JK/SJCHM</i>	

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F 281	<p>Continued From page 13</p> <p>re-insert a new Foley catheter.</p> <p>*She had called the physician and received orders to obtain a urine sample for testing. They were concerned he had a urinary tract infection (UTI) due to his increase in confusion.</p> <p>*She was waiting on results from the urine sample and further direction from the physician.</p> <p>*He currently had no Foley catheter in place at that time.</p> <p>Review of resident 3's physician's orders dated 11/18/14 revealed "Cipro (antibiotic to treat infection) 250 milligrams orally twice a day for seven days. Bladder scan (mechanic device showing how much urine was in the bladder) as needed.</p> <p>The above physicians' orders had not provided:</p> <p>*A diagnosis for the antibiotic.</p> <p>*Direction for when or if the catheter was to be reinserted.</p> <p>*Direction to the nursing staff when using the bladder scan if they should report to the physician on any urine retention.</p> <p>Interview on 11/19/14 at 2:15 p.m. with the director of nursing (DON) revealed she would have expected to find:</p> <p>*Clarification from the physician on when or if the catheter should be reinserted.</p> <p>*Direction for the nursing staff on when to report to the physician should the bladder scan show any urine retention.</p> <p>*A proper diagnosis for the use of the antibiotic and bladder scan.</p> <p>Surveyor: 32335 2. Observation on 11/17/14 at 5:30 p.m. of</p>	F 281	<p>and corrected as needed. An incident report has been made out for this medication error.</p> <p>*nursing staff on 11/17/14. JK/SDD/H/MF To prevent medication errors such as this occurring in the future, a policy on following physician orders and transcribing the orders has been reviewed by all professionals. The number of med errors by the nursing staff will be [redacted] each month by the DON and given to the QA nurse who will present the number to the QA committee on a quarterly basis *through 11/1/15. JK/SDD/H/MF * or designee JK/SDD/H/MF * [redacted] JK/SDD/H/MF</p> <p>* A medication error audit has been developed by the DON on 11/19/14 to include residents 3, 13 and 14. These audits will be done weekly for 4 weeks, then monthly for 3 months, and then quarterly through 11/1/15 by the DON or designee. JK/SDD/H/MF</p> <p>*reviewed JK/SDD/H/MF</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 281	Continued From page 14 registered nurse (RN) I revealed she had prepared one tablet of Creon 24,000 unit (medication to help break down fats, protein, and starch) for resident 13. She had left the medication at the table for the resident to self-administer. Review of resident 13's 11/12/14 physician's orders revealed Creon 24,000 unit had not been on the orders. 3. Observation on 11/18/14 at 7:40 a.m. of RN J revealed she had prepared one tablet of furosemide (water pill) 40 milligram (mg) for resident 14 along with other medications. Review of resident 14's 10/7/14 physician's orders revealed furosemide had not been on the orders. 4. Interview and record review on 11/19/14 from 10:15 a.m. through 10:45 a.m. with RN K revealed she could not locate the above medications on the residents current physician's orders. Interview on 11/19/14 at 1:10 p.m. with the DON revealed the above medications given to residents 13 and 14 should have been on the current physician's orders. Policies on following physician's orders and transcribing orders were requested of the DON, but they were not provided to this surveyor by the time the team exited the facility.	F 281			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314			

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

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F 314	<p>Continued From page 15</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, and record review, the provider failed to ensure interventions were in place and implemented for one of two sampled residents (3) who was at risk for skin breakdown. Findings include:</p> <p>1. Observation on 11/18/14 from 1:15 p.m. through 4:45 p.m. of resident 3 revealed: *He had: -Been resting in his bed. -Been laying on his back. -Remained on his back during the entire observation time frame. *No staff were observed attempting to reposition him onto his side.</p> <p>Review of resident 3's complete medical record revealed: *An admission date of 10/18/11. *Diagnoses of peripheral vascular disease (problem with circulation in veins), diabetes mellitus (unstable sugar levels in the blood), and a history of pressure ulcers (open areas in the skin). *He could only be out of his bed four hours a day</p>	F 314	<p><i>* weekly basis for one month, monthly for 3 months and then quarterly through 12/11/15. These</i> <i>JK/SDD/HMF</i></p> <p><i>* by 12/17/14. A visual audit will be completed on all these residents by the charge nurses weekly for 4 weeks monthly for 3 months, then quarterly through 12/11/15. These audits will be initiated on 12/09/14.</i> <i>JK/SDD/HMF * 1/03/15 JK/SDD/HMF</i></p> <p>F314</p> <p>1. A repositioning program has been set up for resident #3 and added to his care plan. To assure a repositioning schedule is in place for all residents requiring one all staff have reviewed the policies on repositioning and prevention of skin breakdown. A repositioning flow sheet has been implemented for resident #3 and any other resident needing assistance with repositioning or is at high risk for skin breakdown. All repositioning flow sheets will be reviewed by DON on a [redacted] results given to the QA nurse who will then present them to the QA committee each quarter. <i>* through 12/11/15 JK/SDD/HMF</i></p> <p><i>* [redacted] JK/SDD/HMF</i></p>

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F 314	<p>Continued From page 16</p> <p>to promote the healing of the wound.</p> <p>*He was at risk for skin breakdown with a history of pressure ulcers to both of his heels.</p> <p>*He was dependent on the staff to meet all of his mobility needs (transfers and repositioning in bed).</p> <p>Review of resident 3's 8/15/14 significant change Minimum Data Set (MDS) assessment confirmed he was at risk for skin breakdown. He had a pressure relieving device for his bed and wheelchair. He had not been setup for a repositioning program.</p> <p>Review of resident 3's 10/30/14 care plan revealed:</p> <p>*A focus area indicating he was at risk for skin breakdown.</p> <p>*He was dependent upon staff to assist him with bed mobility and transfers.</p> <p>*He had a history of pressure ulcers to his heels.</p> <p>*No repositioning program implemented for the staff to follow.</p> <p>Interview on 11/19/14 at 9:25 a.m. with certified nursing assistant E regarding resident 3 revealed:</p> <p>*She confirmed the resident was dependent upon staff to assist him with bed mobility and transfers.</p> <p>*The staff were to have repositioned him every two hours. That was a standard of practice for all residents.</p> <p>Interview on 11/19/14 at 2:30 p.m. with the director of nursing regarding resident 3 revealed:</p> <p>*He was at risk of skin breakdown with a history of pressure ulcers.</p> <p>*She would have expected the MDS coordinator to implement a repositioning program for him to ensure no further skin breakdown occurred.</p>	F 314			

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

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F 314	Continued From page 17 *She would have expected to find a repositioning program on his care plan.	F 314			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES Policies and procedures for repositioning and prevention of pressure ulcers were requested of the DON. They were not provided to this surveyor by the survey exit time. The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, and instruction review, the provider failed to ensure four of four randomly observed EZ Way Stands (mechanical lift used for transferring residents) had safety tabs per manufacturer's guidelines. Findings include: 1. Random observations from 11/17/14 through 11/18/14 of four EZ Way Stand mechanical lifts revealed they had no safety tabs attached to the harness attachment area. Those tabs were to ensure the residents would not have fallen from the mechanical lift. Interview on 11/18/14 at 9:45 a.m. with the maintenance supervisor revealed: *He had not been aware all four of the EZ Way	F 323	The safety tabs will be installed on the 4 Ez Way stands by the Maintenance Department. The Maintenance Department will perform monthly inspections. These inspections will be per manufacturer safety and Maintenance checklist which includes safety tab inspection. These inspection reports will be given to the Director of Nursing and Quality Assurance on a monthly basis. (see attached checklist) * [REDACTED] JK/SDD/HMF	* 01/03/15 JK/SDD/HMF	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	Continued From page 18 Stands were missing their safety tabs. *He had just received a pack of safety tabs in the mail but had not replaced them at the time of this survey. *He did not have a preventative maintenance program in place to routinely check the EZ Way Stands for safety tabs and proper functioning. *The representative for the EZ Stand mechanical lifts did not come to the facility to check the lifts for proper functioning and safety purposes. *He would have relied on the staff to inform him of any concerns regarding the mechanical lifts. *He agreed the residents were at risk for injury with the safety tabs missing from the EZ Way Stands. Review of the provider's EZ Way Stand Operator's instructions revealed: **"It is important that certain basic checks be periodically made by maintenance staff to ensure on-going safety throughout the life of the device." **"The manufacturer suggests that the following components and operating points be scheduled for inspection at intervals no greater than one month." *Any detected deficiency must be rectified before the stand is put back into service." **"Safety tabs needs to be checked to make sure they are in place."	F 323			
F 329 SS=D	483.25(I) 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	F 329			

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F 329	<p>Continued From page 19</p> <p>adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, observation and interview, the provider failed to ensure one of five sampled residents (5) on a psychotropic medication (treatment of a psychiatric condition) had an appropriate reason for the use of that medication. Findings include:</p> <p>1. Random observations of resident 5 from 11/17/14 through 11/19/14 revealed she: *Had advanced dementia (confusion and memory loss). *Was unable to voice her needs. *Was continually moving her wheelchair with her feet, and fidgeting while moving around the facility.</p>	F 329	<p><i>x 12/17/14. An audit will be initiated on 12/19/14 to review five random residents on psychotropic medications for appropriate use to include behavior and mental status changes. These audits will be done weekly on 5 random residents for 4 weeks, monthly for 3 months and then quarterly through 12/1/15 by the DON or designee. JK/SDDH/ME</i></p> <p>F329</p> <p>1. A gradual dose reduction for resident #5 has been started on 12/11/14. The remaining residents who take antipsychotic medications will be reviewed at our next pharmacy meeting scheduled for [REDACTED]. The policy on psychotropic drug use has been revised, and reviewed by all professional nurses on staff. GDRs will be discussed and implemented at our monthly pharmacy meetings. These results will be taken to the QA nurse monthly so she can present them to the QA committee every quarter* through 12/1/15. JK/SDDH/ME</p> <p><i>x [REDACTED] JK/SDDH/ME</i></p>	*11/23/15 JK/SDDH/ME

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F 329	<p>Continued From page 20</p> <p>Review of resident 5's November 2014 medication administration record (MAR) revealed she received the following psychotropic medications daily:</p> <ul style="list-style-type: none"> *Seroquel (treatment for mental disorder altering a person's reality) for anxiety. *Zoloft for depression. *Exelon for dementia. <p>Review of resident 5's monthly pharmacy consult reports with recommendations revealed:</p> <ul style="list-style-type: none"> *8/28/13-"Need dx [diagnosis] on Exelon and Seroquel. The response was "Has dx of dementia and anxiety." *9/30/13- "Need for psychotic med Seroquel--not anxiety. Add "Dementing illness with associated behavioral symptoms." The diagnosis was then changed to that. *12/17/13- Had to decrease Exelon to 4.6 milligrams (mg) due to increased anxiety. *11/19/13 Recommend (arrow down/decrease) Seroquel from 25 mg daily to 12.5 mg daily. There was no change made by the physician. *No further recommendations until 8/27/14 and the above 11/19/13 recommendation was repeated. <p>Review of resident 5's 9/23/14 physician's progress note revealed:</p> <p>***[Resident's name] has a history of anxiety and depression. She developed some dementia over the years as well. She is still restless in the evenings and at night. I would not recommend any dose reduction at this time."</p> <p>-That response was nearly one month after the recommendation by the pharmacist.</p> <p>Interview on 11/18/14 at 2:30 p.m. with certified nursing assistants (CNA) F and G and one</p>	F 329		

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

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F 329	<p>Continued From page 21</p> <p>unidentified CNA regarding resident 5 revealed she:</p> <p>*Was usually very pleasant, and loved to sing.</p> <p>*Became very frustrated when she needed to have a bowel movement or if she had an accident with her bowels.</p> <p>*Sometimes she tried to pick things off the floor, that were not there.</p> <p>Review of resident 5's physician 9/30/13 through the present orders revealed she had received the Seroquel for anxiety since 9/30/13 with no dose reductions.</p> <p>Review of resident 5's 9/19/14 Minimum Data Set revealed she had exhibited no mood issues, behaviors, psychosis, or delirium in the assessment time frame.</p> <p>Review of resident 5's social services notes revealed there was no documentation regarding their behaviors.</p> <p>Review of resident 5's behaviors documentation revealed from 4/23/14 through 11/19/14 behaviors revealed:</p> <p>*There were behaviors documented six times.</p> <p>*Those behaviors were restless and fidgeting.</p> <p>*There was no indication her behaviors included combativeness, or behaviors that presented a danger to herself or others.</p> <p>Interview on 11/18/14 4:00 p.m. with the social services coordinator regarding resident 5 revealed:</p> <p>*The resident became agitated when she had a urinary tract infection.</p> <p>*Although she was an advocate for the resident, she usually did not question anything the</p>	F 329			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	Continued From page 22 physician ordered to manage the behaviors. Interview on 11/19/14 at 11:40 a.m. with the director of nursing regarding resident 5 revealed: *She agreed: -Anxiety was not an appropriate reason for the use of an antipsychotic medication like Seroquel. *The resident became agitated when she needed to have a bowel movement. *They would follow state guidelines regarding gradual dose reductions of psychotropic medications. *The physician reviewed the pharmacy recommendations at the monthly psychotropic medication meeting. -That had been one month after the recommendations. *They did not have policies that addressed: -The use of medications for behaviors. -Gradual dose reductions of psychotropic medications.	F 329			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, and interview, the provider failed to correctly follow a physician's order for a blood thinning medication during one of one medication observation (resident 14). Findings include: 1. Observation and interview on 11/18/14 at 7:40	F 333			

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

PRINTED: 12/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 333	Continued From page 23 a.m. of registered nurse (RN) J revealed she had prepared 3.5 milligrams (mg) of warfarin (medication to thin the blood) for resident 14 along with other medications. She informed this surveyor he was to receive 3 mg for two days and then alternate with 3.5 mg every third day. Review of resident 14's 10/7/14 physician's orders revealed the order was for "Warfarin 3.5 mg and alt [alternate] every other day with 3 mg." Review of resident 14's 8/5/14 physician's progress note revealed he was receiving "Coumadin [warfarin] 3.5 mg every other day alternate with 3 mg." Interview and record review on 11/19/14 from 10:15 a.m. through 10:45 a.m. with RN K revealed they had been alternating every third day not every other day. Interview on 11/19/14 at 1:10 p.m. with the director of nursing regarding resident 14 revealed: *The original order for warfarin had been confusing. *The nurses should have clarified the original order. *The physician's order for alternating every other day had not been followed.	F 333 F333	1. The order for Coumadin on resident #14 has been clarified and an incident report has been completed. To prevent medication errors such as this occurring in the future, a policy on following physician orders and transcribing the orders has been reviewed by all professionals. The number of med errors by the nursing staff will be tallied each month by the DON and given to the QA nurse who will present the number to the QA committee on a quarterly basis. * [REDACTED]	11/02/15 JK/SDDCH/MF	
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371			

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

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FORM APPROVED
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F 371	Continued From page 24 under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, and policy review, the provider failed to ensure appropriate handwashing, glove use, and handling of ready-to-eat food items had been done by two of two observed cooks (C and D) while preparing and serving two of two meals (supper and dinner). Findings include: 1. Observation on 11/18/14 from 5:20 p.m. through 6:00 p.m. of cook D while preparing and serving the supper meal revealed: *She had washed her hands and put on a pair of gloves. With those gloved hands she had performed the following multiple tasks while serving supper: -Removed tin foil from three serving wells. -Touched multiple residents' dietary cards. -Touched two sheets of paper multiple times that contained information on the residents' choices for supper. -Handled and opened two plastic packages containing hamburger buns multiple times to retrieve the buns with her hands. -Hamburgers were placed on those buns and served to the residents for eating. -She had not been observed washing her hands or changing her gloves between any of the above tasks. Observation on 11/18/14 from 11:35 a.m. through	F 371	F371-Plan of Correction On December 8 th , a dietary in-service was held. The following policies were revised and reviewed: hand washing, glove usage-bare hand contact with food. Also reviewed the 4-part CD, based on Serve Safe Protocol, entitled "Everything You Ever Wanted to Know about Food Safety, But Were Afraid to Ask", along with a 4- part food safety quiz that is reviewed, and completed by dietary staff annually [REDACTED]. All employees will be observed for proper handling of foods by the CDM/RD during meal service weekly, observation to be completed by 12/24/2014. After that time, one observation per month, per employee, will be conducted and reported through Quality Assurance monthly, [REDACTED]. * [REDACTED]	X 11/02/15 JK/SDDH/MF	

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

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F 371	<p>Continued From page 25</p> <p>12:00 noon of cook C while serving the dinner meal revealed:</p> <p>*She had opened a plastic bag containing a tray of sandwiches.</p> <p>*She then placed tongs inside of the plastic bag.</p> <p>*She then placed the tongs on top of the plastic bag after placing the first sandwich on a plate for the resident to eat.</p> <p>*She had been observed multiple times retrieving sandwiches from inside of the plastic bag using the tong. After each time she had used the tongs, she placed them on top of the plastic.</p> <p>Interview on 11/18/14 with at the time of the observation with cook C confirmed she had not served the sandwiches in a sanitary manner. The tongs should have been replaced inside of the plastic bag after each use. The outside of the plastic bag had not been considered a clean surface.</p> <p>Interview on 11/19/14 at 10:15 a.m. with the dietary manager revealed:</p> <p>*Cook D should have changed her gloves and washed her hands between each task.</p> <p>*She would have expected cook D to have performed one task with one set of gloves.</p> <p>*Cook C should not have left the tongs on top of the plastic bag.</p> <p>Review of the provider's October 2012 Glove Usage In Dietary policy revealed:</p> <p>***If used, single use gloves shall be used for only one task such as working with ready to eat food and discarded when damaged or soiled, or when interruptions occur in the operation."</p> <p>***Remember gloves are just like hands, they get soiled. Anytime a contaminated surface is touched, the gloves must be changed."</p>	F 371			

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

PRINTED: 12/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441			

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 27</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180</p> <p>Based on observation, interview, and policy review, the provider failed to ensure:</p> <p>*Two of three sampled residents' (1, 3) personal care observations were performed using proper glove use and hand hygiene.</p> <p>*A cleaning policy had been developed for four of four EZ way stand lifts (a mechanical aide to assist in standing residents). Findings include:</p> <p>1. Observation on 11/17/14 at 4:45 p.m. revealed certified nursing assistants (CNA) G and H went into resident 1's room to get him up for supper. With gloved hands they:</p> <p>*Used the EZ way stand to transfer him into the wheelchair and put him on the toilet in the bathroom.</p> <p>*CNA G removed the resident's incontinent brief (disposable undergarment) and disposed of it in the garbage.</p> <p>*With her soiled gloves she came out of the bathroom, into his room, and obtained a clean brief from his dresser.</p> <p>*They waited until he had finished in the bathroom and brought him out into his room.</p> <p>*They finished tidying up his bed and folded his blanket.</p> <p>*They had not removed their soiled gloves or washed their hands until they were leaving his room.</p> <p>Interview on 11/17/14 at the above time with CNA G revealed she:</p> <p>*Had removed his soiled incontinent brief and threw it away.</p> <p>*Had not removed her gloves at that time or washed her hands.</p>	F 441	<p><i>*by the education coordinator. JK/SDDH/MF</i></p> <p>F441</p> <ol style="list-style-type: none"> 1. CNAs G and H have reviewed this deficiency and have voiced understanding of their errors when caring for resident #1 <i>*on 11/17/14. JK/SDDH/MF</i> 2. CNA M has reviewed this deficiency and has voiced understanding of her errors <i>*on 11/17/14. JK/SDDH/MF</i> 3. To assist in preventing these errors from occurring in the future, all staff have reviewed our policy on hand washing. A mandatory in-service will be conducted on 12/17/14 on infection control and hand washing. All mechanical lift bases have been cleaned. To assure the lifts remain free of debris, a schedule has been set up for all w/chairs and mechanical lifts so they are cleaned [redacted] All staff will <i>* or check</i> review the new policy for this schedule. The DON <i>* JK/SDDH/MF</i> will do weekly checks to assure all standing lift bases are kept clean. These results will be passed onto the QA nurse who will then report them to the QA committee on a quarterly bases <i>* through 11/15. JK/SDDH/MF</i> <p><i>* [redacted] JK/SDDH/MF</i></p>	<p><i>* 11/02/15 JK/SDDH/MF</i></p>

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

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F 441	<p>Continued From page 28</p> <p>*Should have washed her hands before she went into his dresser and got a clean brief.</p> <p>Surveyor: 32355</p> <p>2. Observation on 11/18/14 at 8:05 a.m. of CNA M revealed:</p> <p>*She had entered resident 3's room to assist him with getting out of bed. With gloved hands she had:</p> <ul style="list-style-type: none"> *Pulled his pants and incontinent brief down. *Assisted him to his right side. *Touched his bottom, so this surveyor could observe the wound on his right buttock. *Pulled his pants and incontinent brief back up. *With her soiled gloves she: <ul style="list-style-type: none"> -Retrieved the EZ Way mechanical lift and his wheelchair. -Used the mechanical lift to transfer him into the wheelchair. -Adjusted his feet on the wheelchair footrests. -Retrieved his hearing aides and placed them in his ears. -Adjusted the bed covers on his bed and replaced the call light on top of the bed. *She had not removed those soiled gloves and sanitized her hands until she was leaving the room. <p>Interview on 11/19/14 at 2:40 p.m. with the director of nursing (DON) regarding the above observation confirmed CNA M should have removed her gloves and washed or sanitized her hands before handling the EZ Way mechanical lift and wheelchair.</p> <p>3. Review of the provider's October 2005 Handwashing/Hand Hygiene policy revealed: **Decontaminate hands after contact with a</p>	F 441	<p>*#4 Audits will be initiated on 12/1/2014 on nursing staff for delivering of appropriate personal care, glove use, and hand hygiene for residents 1 and 3, along with 3 other random residents. These audits will be done by the staff RN who are a part of the infection control committee. The audits will be done weekly for 4 weeks, then every two weeks for 3 months, and then monthly for 3 months. These results will be reviewed by the infection control nurse. The infection control nurse will further report these results to the QA nurse on a quarterly basis through 12/1/15</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	Continued From page 29 patient's intact skin." **"Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient/resident." 4. Random observations from 11/17/14 through 11/18/14 of four EZ Way Stand lifts revealed all four bases were dirty with black/brown colored debri. Interview on 11/18/14 at 8:45 a.m. with CNA M regarding the EZ Way Stand lifts revealed: *The night shift staff had been responsible for the cleaning of the mechanical lifts. *She would have cleaned the lifts when they were visibly dirty. Interview on 11/19/14 at 2:25 a.m. with the DON regarding the EZ Way Stand lifts revealed: *The night shift staff would have cleaned them when they had the time. *They had not been placed on any specific cleaning schedule. *The provider did not have a cleaning policy or procedure in place for the EZ Way Stand lifts.	F 441		
F 514 SS=C	483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and	F 514		

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F 514	<p>Continued From page 30</p> <p>services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, and interview, and job description review, the provider failed to ensure there was supportive documentation by social services and nursing staff to the assessments in the medical record for eleven of eleven sampled residents (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11). Findings include:</p> <p>1. Review of residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11's entire medical records revealed: *None of the residents medical records had any additional information documented that supported the quarterly, significant change, and annual Minimum Data Sets (MDS) assessments. *Social services had no quarterly documentation. *There was no narrative documentation by the nursing staff that elaborated on the information of the assessments.</p> <p>Interview on 11/18/14 at 4:00 p.m. with the social services coordinator confirmed she had not done any documentation to support the MDS. She only documented interventions as they occurred.</p> <p>Interview on 11/19/14 at 11:50 a.m. with the director of nursing confirmed since they had started the electronic medical records they had quit doing any additional documentation to support the MDS assessments. She was unaware if they had a policy that addressed what was considered a complete medical record.</p>	F 514	<p>* residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11. JK/SDDH/MF</p> <p>* completed for all new admissions, residents JK/SDDH/MF</p> <p>F514</p> <p>1. The SSC has added a social service assessment to [redacted] interventions. This assessment will be [redacted] with a significant change and quarterly. This assessment also includes an area for additional documentation each quarter or as needed.</p> <p>* The nursing staff will continue to complete interventions on each resident and will elaborate on these interventions as necessary in the nursing notes in the EMR.</p> <p>The interdisciplinary team will monitor this documentation at each care planning session to assure every resident's documentation is adequate. The DON will take the results of this monitoring to the QA nurse each month so she can take it to the QA committee on a quarterly basis* through 10/1/15. JK/SDDH/MF</p> <p>* [redacted] JK/SDDH/MF</p>	<p>* 11/03/15 JK/SDDH/MF</p>

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F 514	Continued From page 31 Review of the provider's social services coordinator's job description revealed: "Record keeping: Shall keep clear and accurate records. Charting must substantiate reports from the department as well as from the facility."	F 514	*#8. Education and review of the RAI manual 3.0 for documentation guidelines will be reviewed by the DON with all of the interdisciplinary care team by 11/11/15. JK/SDDH/MF		

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

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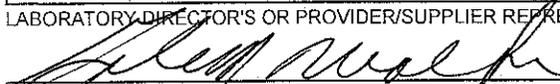
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FORM APPROVED
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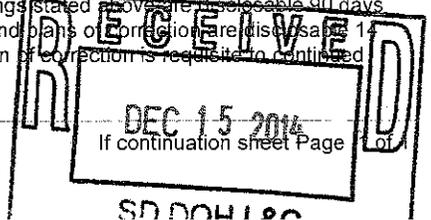
NAME OF PROVIDER OR SUPPLIER avera BORMANN MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 4TH STREET PARKSTON, SD 57366
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 11/18/14. Avera Bormann Manor was found 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 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>President / CEO</i>	(X6) DATE <i>12-12-14</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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 15 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued program participation.



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10660	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/19/2014
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NAME OF PROVIDER OR SUPPLIER AVERA BORMANN MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 4TH ST PARKSTON, SD 57366
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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: 32355
A license survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 11/17/14 through 11/19/14. Avera Bormann Manor was not found in compliance with the following requirement: S166.

S 000 Addendums noted with an asterisk per 01/05/15 telephone to facility administrator. JK/SDDOH/MF

S 166 44:04:02:17(1-10) OCCUPANT PROTECTION

The facility must take at least the following precautions:

- (1) Develop and implement a written and scheduled preventive maintenance program;
- (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents;
- (3) Provide a call system for each...resident bed and in all toilet rooms and bathing facilities routinely used by...residents. The call system must be capable of being easily activated by the...resident and must register at a station serving the unit;
- (4) Provide handrails firmly attached to the walls on both sides of all resident corridors in nursing facilities;
- (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks;
- (6) Install an electrically activated audible alarm on all unattended exit doors in nursing facilities. Other exterior doors must be locked or alarmed. The alarm must be audible at a designated nurses' station and may not automatically silence when the door is closed;
- (7) Portable space heaters and portable halogen

S 166



JK/SDDOH/MF

* see pages 2 and 3. JK/SDDOH/MF

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

[Handwritten Signature]

TITLE

President/CEO
PH5611

RECEIVED
DEC 15 2014
SD DOH L&C

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10660	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/19/2014
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NAME OF PROVIDER OR SUPPLIER avera bormann manor	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 4TH ST PARKSTON, SD 57366
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S 166	<p>Continued From page 1</p> <p>lamps may not be used in a facility; (8) Household-type electric blankets or heating pads may not be used in a facility; (9) Any light fixture located over a...resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof lamp; and (10) Any clothes dryer must have a galvanized metal vent pipe for exhaust.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32355 Based on observation, interview, and policy review, the provider failed to have three of seven exit doors (main entrance, west wing, and north wing) monitored by staff or alarmed. Findings include:</p> <p>1. Random observations from 11/17/14 through 11/19/14 of the main entrance door revealed while the surveyors: *Exited on 11/17/14 at 6:15 p.m. the door was unlocked, unattended, and unalarmed. *Entered on 11/18/14 at 7:30 a.m. the door was unlocked, unattended, and unalarmed. *Exited on 11/18/14 at 6:15 p.m. the door was unlocked, unattended, and unalarmed. *Entered on 11/19/14 at 7:30 a.m. the door was unlocked, unattended, and unalarmed.</p> <p>Interview on 11/18/14 at 3:45 p.m. and again on 11/19/14 at 8:00 a.m. with the administrator regarding the above observations revealed the main entrance door:</p>	S 166	<p>X S166 – We are in the process of drawing up plans for a delay egress hardware and alarms to be installed on all doors and facilities which include the north front door, west corridor door, south corridor door to the hospital, south corridor door to Bormann manor, east door to the courtyard, east door to the outside of the facility and west courtyard door and the west door to the outside. All 8 of the doors will be equipped with an alarm that sounds upon exit. This hardware and alarm will be installed by an outside contractor.</p> <p>The Maintenance Director will oversee the project to its completion. Upon completion, the Maintenance Director will report to the Director of Nurses and Quality Assurance. The operation of the new alarm system will be conducted on a monthly basis by the Maintenance Department and the results and log will be given to the Director of Nurses and Quality Assurance on a quarterly basis.</p> <p>Plans for the new alarm system have been drawn up by outside contractors. We will submit them to the State Department of Health for approval to</p>	<p>X 11/19/15 JK/SDD/HMF</p>
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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10660	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2014
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S 166	<p>Continued From page 2</p> <ul style="list-style-type: none"> *Had been locked after a certain time. No specific timeframe was provided. *Would have automatically locked and alarmed when any resident wearing a Wanderguard (wireless monitoring system for residents at risk of wandering) approached the door. *When unalarmed and unlocked allowed for easy entering and exiting by family members, visitors, and residents who did not wear a Wanderguard device. *The alert residents were to have signed a sheet upon leaving the building. That sheet was kept with the director of nursing. He could not guarantee that all the residents had done that. That had been the only process the provider had in place to monitor residents without Wanderguards. <p>2. Random observations from 11/17/14 through 11/19/14 of the west wing exit door revealed:</p> <ul style="list-style-type: none"> *The double doors entered directly into the hospital. *The doors were unlocked, unattended, and unalarmed. *Cognitively (confused) impaired residents resided on both north and south wings. Those wings were in close proximity of the west wing. <p>3. Random observations from 11/17/14 through 11/18/14 of the north wing exit door revealed:</p> <ul style="list-style-type: none"> *The double doors entered directly into the assisted living center. *The doors were unlocked, unattended, and unalarmed. <p>4. Interview on 11/18/14 at 3:50 p.m. with the administrator regarding the west wing and north wing exit doors revealed:</p> <ul style="list-style-type: none"> *He had been aware the doors were unlocked and unalarmed. 	S 166	<p>assure that we are meeting the State and Federal standards on egress.</p> <p>A temporary alarm will be placed on the door into the hospital until the permanent alarm has been installed. The nursing home main entrance door will remain fully activated at all times until new hardware is installed.</p> <p>All staff have been instructed that the door alarms shall remain on at all times for the safety of our residents.</p> <p style="text-align: right;">JK/SDDOH/MF</p>	
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South Dakota Department of Health

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S 166	<p>Continued From page 3</p> <p>*Residents were able to go to and from the hospital and assisted living center without any type of notification system for the staff.</p> <p>Review of the provider's April 2012 Security Alarm System: Locked Door policy revealed: *Policy: " It is the policy of Avera St. Benedict Health Center to offer as secure an environment as possible for our patients, residents at Bormann Manor. It is of utmost importance that each department strives to help keep our facility safe and secure at all times." *The security alarm for the front entrance at Avera Bormann Manor was to have been on between the hours of 11:00 p.m. and 4:00 a.m. *No procedure was in place on how to monitor: -The main entrance door when unlocked or unalarmed. -The west wing and north wing exit doors. -The safety of the residents who did not require the use of a Wandguard system.</p>	S 166		