

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

ORIGINAL

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS			STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106	
(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 000	INITIAL COMMENTS Surveyor: 18560 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/17/14 through 3/20/14 and from 3/24/14 through 3/26/14. Golden LivingCenter-Covington Heights was found not in compliance with the following requirements: F167, F170, F176, F223, F241, F242, F248, F250, F253, F280, F281, F309, F314, F323, F327, F329, F371, F425, F441, F490, and F514.	F 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. This applies to F167, F170, F176, F223, F241, F242, F248, F250, F253, F280, F281, F309, F314, F323, F327, F329, F371, F425, F441, F490, F514, K018, K027 and K044.	
F 167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation and interview, the provider failed to ensure most recent survey results were readily accessible to residents in four of four areas (administrator's office, nurses station, 100 wing, and 600 wing). Findings include: 1. Observations from 3/17/14 through 3/20/14 revealed:	F 167	F 167 RIGHT TO SURVEY RESULTS- READILY ACCESSIBLE 1. All survey results were lowered to provide access to all residents on 4-1-14. 2. All residents have the potential to be affected. 3. All staff will be educated by the Executive Director or designee on a Resident's right to examine the results of the most recent survey of the facility by 4-18-14. 4. The Executive Director or designee will audit all survey results for resident access weekly x 4 and monthly x 3 to ensure compliance. The Executive Director or designee will report results of these audits to the monthly Quality Assurance and Performance Improvement (QAPI) committee for further review and recommendations.	5. 4-22-14

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

TITLE

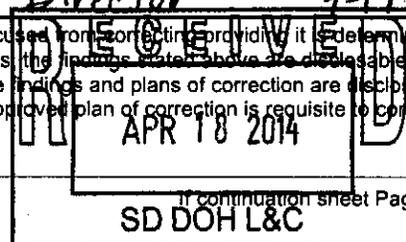
(X6) DATE

Diane Jorgay

Executive Director

4-17-14

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



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F 167	Continued From page 1 *The last survey results had been located inside a clear plastic holder attached to the walls outside of the administrator's office, nurses station, 100 wing, and 600 wing. *They were not accessible to residents in wheelchairs (w/c). *They had been mounted too high up on the walls from w/c height. Interview on 3/25/14 at 1:30 p.m. with the administrator confirmed the posted survey results had not been accessible to all residents.	F 167		
F 170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on interview and policy review, the provider failed to ensure mail was delivered to residents' rooms consistently Monday through Saturday for all residents who received mail. Findings include: 1. Interview on 3/18/14 at 2:15 p.m. with a random group of residents revealed mail was not regularly or consistently delivered on Saturdays. They would receive Saturdays mail on Monday. They wanted to receive their mail on Saturday when it arrived at the facility. Surveyor: 32331	F 170	F170 MAIL DELIVERY 1. Activity staff were educated regarding the resident's right to privacy in written communications, including the right to send and receive mail that is unopened within 24 hours of delivery on 4-14-14. 2. All residents have the potential to be affected. 3. All staff will be educated by the Executive Director or designee the resident's right to privacy in written communications, including the right to send and receive mail that is unopened within 24 hours of delivery by 4-18-14. 4. The Executive Director or designee will randomly audit 5 residents to ensure that the resident has received mail that is unopened within 24 hours of delivery weekly x 4 and monthly x 3 to ensure compliance. The Executive Director or designee will report results of these audits monthly to the Quality Assurance and Performance Improvement (QAPI) committee for further review and recommendations.	5. 4-22-14

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F 170	<p>Continued From page 2</p> <p>2. Interview on 3/20/14 at 11:10 a.m. with resident 11 revealed: *He had not received his daily newspaper. *He had not regularly or consistently received his mail on Saturdays.</p> <p>3. Interview on 3/24/14 at 2:10 p.m. with the activity director regarding resident mail delivery revealed: *The activity department delivered personal mail to residents. *If mail had not been received by the time activity staff left for the day, it would not have been delivered to residents until Monday.</p> <p>Interview on 3/24/14 at 4:05 p.m. with activity/business office staff person C revealed: *Mail had not been delivered to the provider on a consistent basis in the last five to six weeks. It had been delivered later from 4:30 p.m. to 5:00 p.m. *Activities would deliver the mail the next day when it arrived that late. *Only activities staff delivered personal mail to the residents.</p> <p>Interview on 3/24/14 at 4:10 p.m. with activity assistant D revealed: *If activities had not delivered the mail, she was unaware of any other staff who delivered it. *On Saturdays if the mail had not been delivered to the provider before a scheduled activity staff person had left for the day, the mail would have not been delivered until the following Monday.</p> <p>Interview on 3/24/14 at 4:35 p.m. with the activity director revealed she agreed the mail should have been delivered to residents on a daily basis.</p>	F 170		

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F 170	Continued From page 3 Review of the provider's 2009 Recreation Services Guide: Mail Service policy revealed mail delivery was provided within twenty-four hours of receipt of the mail including Saturday delivery.	F 170			
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: 22452 Based on record review, interview and policy review, the provider failed to ensure two of two sampled residents (23 and 24) who self-administered a medication had been assessed for their capability to self-administer medications. Findings include: 1. Interview on 3/20/14 at 11:00 a.m. with resident 23 revealed: *She had a Ventolin inhaler in her purse that she used as she needed. *She would usually tell the nurses when she had used the Ventolin inhaler. Review of resident 23's March medication administration record revealed: *Ventolin inhaler two puffs every six hours as needed. *There was no documentation the resident self-administered the Ventolin inhaler. Review of resident 23's medical record revealed:	F 176	F176 RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE 1. Resident #23 was assessed for self administration of drugs and deemed unsafe, medication was removed from room on 4-1-14 and nursing staff will administer drug. Resident #24's care plan was updated to include self-administration of drugs, physician order was obtained to self-administer cream, and the self-administration assessment was completed on 4-1-14. 2. All residents have the potential to be affected. 3. All Licensed Nursing Staff will be educated on the Self Administration of Drug Policy by the Director of Nursing Services or designee by 4-18-14. 4. The Director of Nursing Services or designee will randomly audit 5 residents to ensure that residents who self administer drugs have a physician order, updated care plan and self-administration assessment weekly x 4 and monthly x 3 or until all residents have been audited to ensure compliance. The Director of Nursing Services or designee will report results of these audits to the monthly Quality Assurance and Performance Improvement (QAPI) committee for further review and recommendations.	5. 4-22-14	

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F 176	<p>Continued From page 4</p> <p>*There was not a physician's order for her to self-administer the Ventolin inhaler.</p> <p>*There was not a self-administration assessment completed by the licensed nurse.</p> <p>*The self-administration of the Ventolin inhaler was not addressed on her care plan.</p> <p>2. Interview on 3/20/14 at 10:30 a.m. with resident 24 revealed:</p> <p>*She had a jar of Vanicream (cream for dry skin) in her nightstand that she used as she needed.</p> <p>*She thought the nurses knew she used the Vanicream, but they never asked her when she used it.</p> <p>Review of resident 24's medical record revealed:</p> <p>*There was not a physician's order for her to self-administer the Vanicream.</p> <p>*There was not a self-administration assessment completed by the licensed nurse.</p> <p>*The self-administration of the Vanicream was not addressed on her care plan.</p> <p>3. Interview on 3/20/14 at 1:30 p.m. with the director of nursing services regarding residents 23 and 24 revealed she:</p> <p>*Was not aware they self-administered any medications.</p> <p>*Confirmed a self-administration assessment had not been completed for them regarding their capability to self-administer the Ventolin inhaler and Vanicream respectively.</p> <p>Review of the provider's October 2007 Self-Administration Medication Administration by Resident policy revealed "Residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has</p>	F 176		

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F 176 F 223 SS=G	Continued From page 5 determined that the practice would be safe." 483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, record review, interview, and guideline review, the provider failed to stop a treatment upon request from one of two sampled residents (2). Findings include: 1. Observation on 3/17/14 from 7:15 p.m. to 7:30 p.m. of resident 2 revealed: *Two unidentified staff members had entered her room and shut the door. *Through the closed door this surveyor heard her screaming out repeatedly "stop," "you're hurting me," "you're breaking my legs," "call the police," and "take me to the hospital." Observation on 3/17/14 from 7:35 p.m. until 7:45 p.m. of resident 2 revealed: *She had been laying on her bed. *She screamed out "stop the pain, stop the pain, I need a pain pill, call the police you broke my legs," "I hurt," and "I am in so much pain." *She had been continuously clawing through her hair with her fingers during the entire observation.	F 176 F 223	F223 FREE FROM ABUSE/INVOLUNTARY SECLUSION 1. On 3-19-14, pain medications administered to resident #2 prior to dressing change at 9:15am were: Norco at 7:25am and Tylenol 650mg at 8:50am. Resident's MD was contacted via phone on 3/19/14 at 1:00pm regarding resident's behaviors of calling out and complaints of pain and resident's physician has spoken with resident's POA and suggested a hospice referral or an in house physician to assume her care. Investigation began immediately, the nurses identified were suspended pending the outcome of the investigation, event was reported to the Complaint Officer for the Department of Health and Local the Ombudsman on 3/20/14 at 1:00pm. The investigation concluded that there was not willful intent to inflict abuse on resident #2. On 3/19/14, therapy ordered a leg pad for the footrest on resident's wheelchair. Nursing staff will pre medicate resident 45 min-1 hour prior to completing treatment. The nurse will evaluate the resident's pain level prior to starting treatment. If resident is unable to tolerate procedure it will be postponed until resident agrees to continue. Nursing staff will be instructed to have resident rate pain on numeric scale of 1-10 before and after each treatment. Nursing staff will monitor resident during treatment and cares, providing a break in cares when resident dictates. Will refer resident to therapy for adaptive equipment to protect leg during positioning. On 3/20/14, a physician willing to treat resident #2 and see her onsite was identified and agreed to assume her care on 3/21/14. 2. All residents currently residing in the facility		

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F 223	Continued From page 6 Interview on 3/17/14 at 7:45 p.m. with licensed practical nurse (LPN) A regarding the above observations revealed resident 2: *Had an unstageable pressure ulcer (injuries to skin and underlying tissue) to her left heel. She had acquired the pressure ulcer while in the facility. *Hollered out frequently with complaints of pain. *Took Xanax (medication for anxiety) twice a day for anxiety and could have Norco (pain medication) as needed for pain. *Took the Norco in the mornings prior to dialysis on Tuesdays, Thursdays, and Saturdays per physician's orders. *Recently had been started on a pain patch. *Had not experienced any relief from anxiety or pain from any of the medications listed above. Observation and interview on 3/19/14 at 9:00 a.m. with resident 2 revealed she: *Had been laying in bed moaning and screaming out "call the police" and "they broke my legs." *Had stated she was having "hard" pain. *Had been rocking back and forth reaching for her legs. Observation on 3/19/14 at 9:05 a.m. of registered nurse (RN) B and LPN A performing a dressing change for resident 2 revealed: *RN B had assisted LPN A by supporting the resident's left foot. *LPN A removed the gauze dressing from her left foot. *Her wound had a foul and necrotic (dying tissue smell) odor. *The gauze dressing had a moderate amount of tan colored drainage. *She had screamed out during the entire process	F 223	were immediately assessed for pain by the professional nursing staff utilizing the pain scales available on the Clinical Health Status Form on 3-19-14. On 3-19-14, education was provided to nursing staff to stop treatment according to resident requests, please see F309. 3. Executive Director, Director of Nursing Services and Interdisciplinary Team (Nursing Unit Managers, Social Services Assistant, Director of Resident Assessment, Wound Nurse, Director of Admissions, Activity Director, Social Services Director, Registered Dietician, Assistant Executive Director) met on 3/19/14 at 1:30pm to review and revise as necessary the clinical guideline for pain. All members support current pain guidelines, no changes made. Immediate all staff meeting held on 3/19/14 at 2:15pm by Executive Director and Director of Nursing Services regarding the clinical guideline for pain, the importance of monitoring and reporting pain and timely notification of primary physician for any symptoms of uncontrolled pain. Nurse B and Nurse A providing dressing change to resident were re educated by Director of Nursing Services and the Executive Director on 3/19/14. Resident wing assignment sheets will now include an area for documenting if the resident expresses or appears to be in pain and a reminder to report to charge nurse. The Administrator, Director of Nursing Services and Social Services reviewed the facility's policy and procedure about abuse, to include what constitutes abuse and actions that may be or are perceived as abusive in nature on 4-10-14. The Director of Nursing Services or designee will re educate all staff on the facility's policy and procedure about abuse, to include what constitutes abuse and actions that may be or are perceived as abusive in nature by 4-18-14. 4. Director of Nursing Services or designee will randomly audit 5 residents' treatments weekly x 4 and monthly x 3 to ensure pain management and		

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F 223	<p>Continued From page 7 of removing the gauze dressing. *She had been screaming and moaning repeatedly for them to stop the dressing change. *She further screamed out: -"Help me, help me, call the police." -"Stop poking me with those needles." -"Stop it, it hurt." -"Oh my (swear word) give my knees a break." -"Get me to a doctor." -"Call the doctor." -"Hurry, hurry they broke my legs." *She had rocked back and forth reaching for her legs. *The nurses continued with the dressing change even with her pleas for them to stop. *They had continued with the dressing change even after a surveyor had asked if they were going to continue.</p> <p>Interview during the above observation with LPN A revealed she had: *Pre-medicated resident 2 at 7:15 a.m. with Norco. *Given the resident two Tylenol (pain medication) fifteen to twenty minutes prior to the dressing change to further help with pain management. *Stated they needed to continue with the dressing change with no explanation of why. *Stated the dressing change usually went better after breakfast but most of the time it had not mattered what time of the day it had been performed, because she was always in pain.</p> <p>Interview at the same time of the observation above with RN B revealed: *The wound's odor had been new from yesterdays dressing change. *They had needed to continue with the dressing change with no explanation of why.</p>	F 223	<p>respecting the wishes of the resident. Results of these audits will be presented to the monthly Quality Assurance and Performance Improvement (QAPI) committee by the Director of Nursing Services for further review and recommendation.</p>	5. 4-22-14

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F 223	<p>Continued From page 8</p> <p>*The yelling and screaming during her dressing change had been almost a daily occurrence.</p> <p>Review of resident 2's medical record revealed:</p> <p>*An admit date of 4/26/08.</p> <p>*Diagnoses of peripheral vascular disease (problem with circulation in veins), diabetes mellitus (inability to control sugar levels in the blood), psychosis (loss of contact with reality), depression (feelings of hopelessness), anxiety, pain in joint, pressure ulcer (wound) to the left heel, and glaucoma (poor eyesight).</p> <p>*She had acquired a stage II pressure ulcer (fluid filled blisters) to her left heel on 10/17/13. That stage II pressure ulcer had progressed to an unstageable pressure ulcer on 10/31/13.</p> <p>*The staff were to have cleansed the left heel with a Betadine solution twice a day and have covered it with a gauze dressing.</p> <p>*On 10/12/13 she had been sent to the emergency room (ER) for evaluation of her left foot for increase complaints of pain.</p> <p>*From the ER she had been given the following diagnoses of "bilateral leg pain, contusion of the left foot, hematoma of the left heel and an insufficiency/sub-acute fracture of the right foot. Staff were to continue pain management and "air cast" until orthopedic physician assesses on 10/22/13."</p> <p>*She could have Norco 1/2 to 1 tablet every six hours as needed (PRN) for pain.</p> <p>*On 11/6/13 the physician had ordered Norco one to two tablets prior to going to dialysis.</p> <p>*She had an order for acetaminophen (pain medication) every six hours PRN for pain.</p> <p>*On 2/27/14 the physician had ordered a Fentanyl patch (a patch worn on the skin to relieve pain).</p> <p>*She had been dependent on staff to assist her with all of her mobility (transfers, moving in bed,</p>	F 223		

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F 223	<p>Continued From page 9 and propelling her wheelchair) and activities of daily living needs per her annual 3/7/14 Minimum Data Set assessment .</p> <p>Review of resident 2's progress notes revealed on the following: *2/20/14 "Resident complains of pain during wound care, PRN pain medications given as ordered." No documentation had been found to indicate the pain medication had been effective. *2/23/14 "Changed dressing to the left heel, resident screamed "help" and tried to kick this nurse with her right foot. Completed dressing change, offered pain medication when resident complained of pain." *2/26/14 "Treatments completed this shift with discomfort noted to patient." *3/3/14 "Resident has treatment to left heel. Resident does not tolerate dressing change well. Hollers out to watch out for leg. Complains of breaking her leg when touched. Once dressing is changed resident calms down." *3/4/14 "Complains of pain to left heel during dressing change. PRN pain medications given as ordered." *3/6/14 "Changed dressing to left heel this am prior to dialysis. Resident screamed throughout, tried to explain if dressing was not changed as ordered wound could get much worse and more painful. Resident stated, You don't know what you're doing, get the nurse." *3/17/14 at 11:20 p.m. "Resident has been screaming in room from pain since 1700 (5:00 p.m.), pain medications given. Resident has yelled "call the police, they are hurting me," "call Sioux Valley, call my doctor, someone help me," and "stop him! he is shooting electricity in my legs again! Turn the electricity off!"</p>	F 223			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
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F 223	<p>Continued From page 10</p> <p>Review of resident 2's February 2014 PRN medication record revealed the PRN Norco had been administered thirteen times for pain at various times of the day. There was documentation for one of the doses that it had been ineffective. The other doses had been effective. The PRN Tylenol had not been administered. She could have had the PRN Norco a total of 112 times for the month of February per the physician's orders.</p> <p>Review of resident 2's March 2014 PRN medication record from 3/1/14 through 3/18/14 revealed documentation the PRN Norco had been administered seven times for pain in the evening. There was documentation for one of the doses that it had been ineffective. The other doses had been effective. The PRN Tylenol had not been administered. She could have had the PRN Norco a total of seventy-two times through March 18 per the physician's orders.</p> <p>Interview on 3/19/14 at 12:10 p.m. with the director of nursing services regarding resident 2 revealed:</p> <ul style="list-style-type: none"> *She agreed the staff had not been consistently pre-medicating the resident prior to the dressing changes. *She had not considered her yells of pain as being pain due to her behaviors of yelling out prior to the development of the left heel pressure ulcer. *She had no comment regarding the lapse of days on the medication administration record where the resident had not received any pain medications. *She would have expected the nurses to stop the dressing change, make sure the resident was safe, cover the wound, and update the physician 	F 223			

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

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F 223	Continued From page 11 on her status at that time. Review of the provider's January 2011 Verification of Investigation of Alleged Mistreatment, Abuse, Neglect, Injuries of Unknown Source, and Misappropriate of Resident Property Guidelines revealed: *"It is the policy of this center to take appropriate steps to prevent the occurrence of abuse." *Abuse was defined as "The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish." Review of the provider's undated Long-Term Care Facilities Resident's Bill of Rights revealed: *Residents have the right to refuse treatment. *Residents have the right to freedom from physical or mental abuse.	F 223			
F 241 SS=E	Refer to F309, Finding A1. 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. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, interview, record review, and policy review, the provider failed to ensure the dignity of residents was maintained for: *One of seventeen sampled residents (5) who had been wearing the same clothes for three	F 241			

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

PRINTED: 04/09/2014
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F 241	<p>Continued From page 12</p> <p>days and had uncombed hair at three of three observed meals.</p> <p>*Nine of nine randomly observed residents (4, 22, 25, 26, 27, 28, 29, 30, and 31) who were unshaven and were dependent on staff for shaving.</p> <p>Findings include:</p> <p>1. Random observations from 3/18/14 through 3/20/14 of resident 5 revealed he had been wearing the same light blue long sleeved button down shirt with white stripes and blue pants during that time.</p> <p>Observation on 3/18/14 at 12:15 p.m. and at 6:15 p.m. and on 3/20/14 at 8:20 a.m. of resident 5 in the dining room revealed his hair had not been combed, and he had not been shaved.</p> <p>Review of resident 5's 1/29/14 Minimum Data Set assessment revealed:</p> <p>*His memory was moderately impaired.</p> <p>*He was moderately depressed.</p> <p>*He needed supervision and the assistance of one person to help with dressing.</p> <p>Interview on 3/20/14 at 3:45 p.m. with the director of nursing services (DNS) regarding resident 5 revealed she:</p> <p>*Was not aware he had needed supervision and the assistance of one person to help with getting dressed.</p> <p>*Agreed staff should have noticed him wearing the same clothes for three days, and his hair had not been combed.</p> <p>Surveyor: 32355</p> <p>2. Random observations from 3/18/14 through</p>	F 241	<p>F241 DIGNITY</p> <p>1. Resident #5's clothing was changed and he was assisted with grooming/shaving and residents #4, 22, 25, 26, 27, 29, 30, and 31 were assisted with grooming/shaving upon discovery. Resident #28 stated that she always removed her facial hair with tweezers, when offered tweezers, she declined to do this on her own or with assistance. Resident states that if she requires assistance, she will ask staff for assistance. Resident #28's care plan was updated to reflect her wishes.</p> <p>2. All residents have the potential to be affected.</p> <p>3. The Administrator, Director of Nursing Services and Social Services reviewed the facility's policy and procedure about providing care with dignity and respect, honoring choice. The review included what constitutes dignity and respect and actions that may be or are perceived as lacking dignity and respect on 4-10-14. All Staff will be re educated regarding the facility's policy and procedure about providing care with dignity and respect, honoring choice. The review will include what constitutes dignity and respect and actions that may be or are perceived as lacking dignity and respect by 4-18-14.</p> <p>4. The Director of Nursing Services or designee will randomly audit 5 residents, to include resident #5 to ensure that they have clean clothing changed daily and are free of facial hair weekly x 4 and monthly x 3 to ensure compliance. The Director of Nursing Services or designee will report results of these audits to the monthly Quality Assurance and Performance Improvement (QAPI) committee for further review and recommendations.</p>	5. 4-22-14	

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

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F 241	<p>Continued From page 13</p> <p>3/20/14 of residents 4, 26, 27, and 31 revealed rough, black, and gray facial hair on their upper lips, chins, and cheeks. During that time frame their facial hair had not been removed or shaved.</p> <p>Interview on 3/20/14 at 11:40 a.m. with resident 27 revealed he had been expected to shave himself. No staff members would have reminded him to shave. He had preferred to shave daily. He would have required set-up and cueing from the staff.</p> <p>3. Random observations from 3/18/14 through 3/20/14 of residents 22, 25, 28, 29, and 30 revealed long, gray, and white facial hair on their upper lips and chins. During that time frame their facial hair had not been removed or shaved.</p> <p>4. Interview on 3/20/14 at 10:00 a.m. with certified nursing assistant S revealed the men should have been shaved daily in the morning. The women would have been shaved as needed.</p> <p>Interview on 3/20/14 at 3:30 p.m. with the DNS revealed: *She would have expected the men to be shaved daily. *Some of the men had been refusing to shave due to the cold weather. *The women were to have been shaved as needed. *She would have expected the staff to be observant of the residents and their shaving needs. *There was no charting available for when a resident had refused to be shaved.</p> <p>Review of the provider's 2006 Shaving the Resident policy revealed:</p>	F 241		

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F 241	Continued From page 14 *"The purpose is to remove facial hair and improve the resident's appearance and morale." *No indication on how often the residents should have been shaved.	F 241			
F 242 SS=D	Review of the provider's February 2010 Your Resident Rights Handbook revealed: "A nursing home must care for you in a manner and environment that promotes the maintenance and enhancement of your quality of life." 483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, interview, and Resident Right's handbook review, the provider failed to ensure one of one sampled resident's (18) requests regarding her care for shower requests was honored. Findings include: 1. Review of resident 18's medical record revealed a 1/8/14 admission date. Review of resident 18's 2/1/14 nursing progress notes revealed she stated "I prefer my shower in the morning."	F 242	F242 SELF-DETERMINATION – RIGHT TO MAKE CHOICES 1. Resident #18, no longer resides at the living center, no immediate action can be taken. 2. All residents have the potential to be affected. 3. The Administrator, Director of Nursing Services and Social Services reviewed the facility's policy and procedure about providing care with dignity and respect, honoring choice. The review included what constitutes dignity and respect and actions that may be or are perceived as lacking dignity and respect on 4-10-14. All staff will be re educated regarding the facility's policy and procedure about providing care with dignity and respect, honoring choice. The review will include what constitutes dignity and respect and actions that may be or are perceived as lacking dignity and respect by 4-18-14. The care conference checklist was updated to include questions on 4-10-14. the residents' right to make choices 4. The Director of Nursing Services or designee will randomly audit 5 residents to ensure that if they have specific preferences related to the provision of their cares that staff are honoring this weekly x 4 and monthly x 3 to ensure compliance. The Director of Nursing Services or designee will report results of these audits will be presented to the monthly Quality Assurance and Performance Improvement (QAPI) committee by the Director of Nursing Services for further review and recommendations.	5. 4-22-14	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 242	<p>Continued From page 15</p> <p>Review of resident 18's 1/8/14 through 3/18/14 activities of daily living (ADL) flow sheets revealed:</p> <p>*She had received total assistance with bathing on the following dates:</p> <p>-2/1/14 on shift 2 (6:30 a.m. to 2:30 p.m.).</p> <p>-2/12/14 on shift 2.</p> <p>-2/22/14 on shift 3 (2:30 p.m. to 10:30 p.m.).</p> <p>-3/9/14 on shift 3.</p> <p>-3/12/14 on shift 3.</p> <p>*The following Saturday evenings (her assigned bath times) there was no documentation if she had the showers or if she had refused the showers:</p> <p>-1/11/14.</p> <p>-2/22/14.</p> <p>-3/1/14.</p> <p>-3/8/14.</p> <p>-3/15/14.</p> <p>Interview on 3/25/14 at 4:00 p.m. with the director of nursing services regarding the above revealed:</p> <p>*The resident had been assigned to a Saturday evening bath when she had been admitted on 1/8/14.</p> <p>*Saturday evening was the bathing slot designated for her room.</p> <p>*They asked residents upon admission when they preferred their bath/shower but would not document that.</p> <p>*She knew the resident had refused some showers, but the staff had not documented those.</p> <p>*She thought if the resident had refused a shower, the staff would have attempted to give her a bed bath.</p> <p>Review of the provider's February 2010 Resident Rights handbook revealed:</p> <p>**You have the right to be treated with dignity and</p>	F 242			

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F 242	Continued From page 16 respect in full recognition of your individuality." **"As long as it fits your care plan, you have the right to make your own schedule."	F 242			
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, interview, record review, and policy review, the provider failed to provide activities based on resident's individual needs for 8 of 17 sampled residents (2, 3, 4, 5, 6, 14, 16, and 17). Findings include: 1. Interview on 3/20/14 from 5:30 p.m. through 6:00 p.m. with resident 16 revealed: *He had been on isolation precautions (not allowed to leave his room due to an infection) since 3/14/14. *He was blind. *He liked to visit with people. *Activities staff had not been to visit him at all while he had been isolated. *The social services coordinator "had popped her head in once" but had not come into his room. *He had told staff he would like to visit with a minister, but that had not happened. *He was bored and would have liked visitors. Review of resident 16's 2/24/14 care plan	F 248	F248 ACTIVITIES 1. Resident #3, 4, 5, 6, 14, 16 and 17's activity care plans were reviewed and updated as necessary to reflect current plan of care, participation records were reviewed and updated as necessary to reflect individual likes and recreation assessments were reviewed to identify one-to-one programming needs by 4-16-14. Resident's preferred church was contacted on 4-8-14 to provide one-to-one visits as requested by Resident #16 and visit was made on 4-13-14. Resident #2 no longer resides at living center, no immediate action can be taken. 2. All residents have the potential to be affected. 3. The Administrator, Director of Nursing Services and Activity Director reviewed the facility's policy and procedure about the provision of activities, including individual choice/preference and individual needs on 4-10-14. All staff will be educated on that the facility's policy and procedure about the provision of activities, including individual choice/preference and individual needs by 4-18-14. 4. The Activity Director or designee will randomly audit 5 residents' care plans, recreation assessments, one-to-programming logs and recreation participation records to ensure that activities are based on resident's individual needs until all resident's have been audited weekly x 4 and monthly x 3 to ensure compliance. 4. The Activity Director or designee will report results of these audits to the monthly Quality Assurance and Performance Improvement (QAPI) committee monthly for further review and recommendations.	5. 4-22-14	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 248	<p>Continued From page 17 revealed:</p> <ul style="list-style-type: none"> *It had not been updated to include him being on isolation. *An intervention that stated "Please refer my request to have a volunteer from one of the visiting churches for one-(to)one visits." - "This is per my preference as I enjoy having room visits of one-(to)one conversations." <p>Interview and record review on 3/25/14 at 11:20 a.m. with the activity director regarding resident 16 revealed:</p> <ul style="list-style-type: none"> *Activities staff had not been in to visit with him since he had been put on isolation precautions. *The activities charting completed from 3/14/14 through 3/21/14 had been inaccurate, as it had indicated he was coming out of his room. *She stated her assistant "would have to be retrained on documenting appropriately." *She had not set-up any one-to-one visits from outside groups. <p>2. Random observations from 3/17/14 through 3/20/14 and from 3/24/14 through 3/26/14 of resident 5 revealed he had been either resting on his bed in his room or had been in the dining room for meals. Resident 5 had not been observed attending any activities during those time periods.</p> <p>Observation and interview on 3/19/14 at 4:30 p.m. with resident 5 revealed:</p> <ul style="list-style-type: none"> *He had been laying in his bed resting but agreed to speak with this surveyor. *He agreed to walk down the hall to a visitors room. *He had been polite and answered questions. *He stated he liked to see his wife, go outside, water plants, and read magazines. 	F 248			

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

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F 248	<p>Continued From page 18</p> <p>*He slept a lot but would have attempted to go to activities if asked.</p> <p>Review of resident 5's medical record revealed: *He had a history of depression. *He was moderately depressed. *His cognition (mental ability to learn and remember) was moderately impaired and "benefits in a supervised and safe setting as the LTC [long term care] environment." *On 1/17/14 he had been admitted into behavioral health services for exhibiting inappropriate behaviors. *On 1/22/14 he had returned to the facility from behavioral health services.</p> <p>Review of resident 5's 1/29/14 care plan revealed he: *Required some assistance participating in activities of his choice. *Had not wanted to be invited to spiritual activities within the facility. *Liked to: -Reminisce about canoeing, drumming, hunting, and flying hot air balloons. -Visit with his wife, children, or friends on the phone. -Spend time outside. -Read magazines. -Play backgammon. -Watch the TV show Two and half men. -Spend time with his pet.</p> <p>Review of resident 5's Recreation Participation Record from 1/1/14 through 3/20/14 revealed he had refused or was sleeping for the following activities: movies, bingo, cards/games, spiritual, social, special event, exercise/sports, resident council, Trivia, crafts, and Wii. None of his</p>	F 248			

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

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F 248	<p>Continued From page 19</p> <p>individual likes mentioned in his 1/29/14 care plan had been transferred to the recreation participation records.</p> <p>Interview on 3/20/14 at 3:45 p.m. with the director of nursing services regarding resident 5 revealed they usually let him sleep during the day, because he was independent.</p> <p>Surveyor: 32355</p> <p>3. Random observations from 3/18/14 through 3/20/14 of resident 2 revealed:</p> <ul style="list-style-type: none"> *She had been out of her room for meals and dialysis only. *Between meals she had rested in her bed. *No TV or radio had been provided for auditorial (hearing) and mental stimulation. *She had exhibited an extreme fluctuation in behaviors by yelling out at various times of the day. *No one-on-one activity or visits had been observed from activities, nursing staff, or social services. *Staff had only been observed in her room during assistance with activities of daily living (ADL). <p>Review of resident 2's 3/10/14 care plan revealed:</p> <ul style="list-style-type: none"> *She had required assistance from staff in participating in activities of her choice. *Some of her favorite activities had included cooking, baking, listening to spiritual shows on TV, and spending time with friends and family. *She was to have been offered activities to do in her room upon request. <p>Review of resident 2's 3/7/14 recreation services assessment revealed a notation by the activity director stating resident 2 had no needs at that</p>	F 248			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106		
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F 248	<p>Continued From page 20</p> <p>time. She required assistance to and from activities.</p> <p>Review of resident 2's Recreation Participation Record from 2/1/14 through 3/18/14 revealed she had refused, was sleeping, or was out of the facility for dialysis. There was no documentation leisure activities had been offered.</p> <p>Review of the activity director's March 2014 calendar for one-to-one visits revealed: *Resident 2 had been scheduled for a one-to-one visit once a week in the morning on Fridays. *The activity staff initials were to have been placed behind her name upon completion of any one-to-one visits. *There had been no initials after her name through 3/24/14.</p> <p>Review of resident 2's 3/7/14 annual activity progress note revealed she had not enjoyed large group activities but did enjoy one-to-one visits.</p> <p>Interview on 3/20/14 at 2:10 p.m. with the activity director regarding resident 2 revealed: *She had visited one-to-one with the resident when the resident allowed it. *Most of her visits had been conversations. *She had no documentation to support any of those visits. *No special techniques had been attempted during periods of increase in agitation. *She had no documentation to support one-to-one visits had occurred .</p> <p>4. Random observations from 3/18/14 through 3/20/14 of resident 4 revealed: *He had been out of his room for meals only. *Between meals he had rested in his bed and had</p>	F 248		

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

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F 248	<p>Continued From page 21</p> <p>always been facing the wall.</p> <ul style="list-style-type: none"> *His radio had never been turned on. *His roommate's TV had been on at all times. *The divider curtain had been pulled at all times. *No one-to-one activity or visits had been observed from activities, nursing staff, or social services during the above observations. *Staff had only been observed in his room during assistance with his ADLs. <p>Review of resident 4's current care plan printed on 7/26/13 revealed:</p> <ul style="list-style-type: none"> *He had required assistance from staff to participate in activities. *His favorite activities had been hunting, fishing, watching TV especially westerns, the news, old country music, and sports. *Staff were to have visited with him regarding hunting and fishing. Pictures were to have been used during those conversations. *He was to have been invited to spiritual activities per his wife's request. *He was to have been involved in a variety of activities, even if all he could do was observe. <p>Review of resident 4's Recreation Participation Record from 2/1/14 through 3/24/14 revealed he had attended various activities on twenty-six days out of fifty-two.</p> <p>Review of resident 4's 1/9/14 quarterly activity note revealed:</p> <ul style="list-style-type: none"> **Staff continue to assist him to activities such as devotions and get fit." **Staff play music in his room (Johnny Cash, classic country music) and turn TV on for him as well." **Activity staff provide one-to-one interactions that include tool reminiscing, hunting and fishing 	F 248		

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

PRINTED: 04/09/2014
FORM APPROVED
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F 248	<p>Continued From page 22 magazines, and visiting about the weather, ect."</p> <p>Review of the activity director's March 2014 calendar for one-to-one visits for resident 4 revealed:</p> <ul style="list-style-type: none"> *He had been scheduled for a one-to-one visit two times a week on Mondays and Wednesdays. *The activity staff initials were to have been placed behind his name upon completion of any one-to-one visits. *There had only been initials behind his name on 3/19/14. <p>Review of resident 4's March 2014 individual programming log revealed he had been visited with by the activity director on 3/7/14 and 3/18/14.</p> <p>Interview on 3/24/14 at 2:10 p.m. with the activity director regarding resident 4 revealed:</p> <ul style="list-style-type: none"> *He was to have been visited with once a week. *She would have considered his ADL assistance by the staff and mealtime as a part of his activities. *She would have considered the visits from his wife as part of his daily activities. *She had not recognized the need for more one-to-one activities for resident 4. <p>5. Review of resident 17's medical record revealed he had diagnoses of human immunodeficiency virus (HIV) (a disease affecting the immune system) and C.diff (clostridium difficile) (diarrhea related to frequent antibiotic use and could be transmitted to other residents). He had recently been placed in isolation (unable to come out of his room) for the diagnosis of C.diff.</p> <p>Random observations from 3/18/14 through</p>	F 248		

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

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F 248	<p>Continued From page 23</p> <p>3/20/14 of resident 17 revealed he had:</p> <ul style="list-style-type: none"> *Been out of his room for smoke breaks and dialysis. *Eaten all meals in his room. *His TV turned on most of the time. *His divider and window curtains pulled at all times. *Rested on his bed at all times and faced the divider curtain. *No one-to-one activity nor visits had been observed from activities, nursing staff, or social services during the above observations. *Rarely allowed staff assistance with his ADL needs. <p>Review of resident 17's current care plan dated 2/27/14 revealed he preferred independent activities or spending time with his family. His life simple pleasure had been smoke breaks.</p> <p>Review of resident 17's 2/26/14 recreation services assessment revealed:</p> <ul style="list-style-type: none"> *He enjoyed: <ul style="list-style-type: none"> -Computer and video games but had not felt up to it. -Spending time outdoors and going for drives. -Reading of magazines on occasion. -Music of many kinds and watching TV. *He had been refusing reading material, music, and outings. **"He had no needs at this time." <p>Review of resident 17's Recreation Participation Record from 2/1/14 through 3/24/14 revealed he had either refused activities or had been sleeping.</p> <p>Review of the activity director's March 2014 calendar for one-to-one visits revealed he was not on the list to be visited with.</p>	F 248		

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

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F 248	<p>Continued From page 24</p> <p>Interview on 3/24/14 at 2:10 p.m. with the activity director regarding resident 17 revealed he would have attended only those activities of his choice. She had not placed him on a one-to-one visit schedule.</p> <p>Surveyor: 18560 6. Random observations from 3/17/14 through 3/20/14 and from 3/24/14 through 3/26/14 of resident 6 revealed she had been either resting on her bed in her room or had been in the dining room for meals. Resident 6 had not been observed attending any activities during those times.</p> <p>Review of resident 6's Recreation Participation Records revealed: *She needed reminders and encouragement to participate in activities. *She liked church services, music, doing exercises, outdoors, and news. *In January 2014 she had attended activities seven out of thirty-one days. *In February 2014 she had attended activities four out of twenty-eight days. *In March 2014 she had attended activities four out of twenty-one days.</p> <p>Interview on 3/25/14 at 8:25 a.m. with the activity director confirmed more activities could have been provided for resident 6.</p> <p>7. Random observations from 3/17/14 through 3/20/14 and from 3/24/14 through 3/26/14 of resident 3 revealed she had been observed once in the west lounge. Otherwise she had been either resting on her bed in her room or had been</p>	F 248		

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

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FORM APPROVED
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F 248	<p>Continued From page 25</p> <p>in the dining room for meals. Resident 3 had not been observed attending any activities during those times.</p> <p>Review of resident 3's Recreation Participation Records revealed: *She needed to be encouraged to participate in activities. *She liked to sit in the west lounge. *In January 2014 and February 2014 no activities were documented. *On 3/19/14 one individual programming of visiting had been documented. No other activities were documented from 3/1/14 through 3/21/14.</p> <p>Interview on 3/25/14 at 8:40 a.m. with the activity director confirmed more activities could have been provided for resident 3.</p> <p>Surveyor: 32331</p> <p>8. Observation of resident 14 revealed: *On 3/20/14 at 9:40 a.m. he was in the front lounge area in front of the TV sitting in a wheelchair with his eyes closed. *On 3/20/14 at 11:52 a.m. he was in the same location as the above sitting in a wheelchair with his eyes closed. *There was no observed staff interaction with him during those times.</p> <p>Review of resident 14's medical record revealed he had a diagnosis of a disease that causes progressive breakdown of the nerve cells in the brain and a diagnosis of depression.</p> <p>Review of resident 14's 2/18/14 care plan revealed: *He required assistance in participating in</p>	F 248		

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

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F 248	<p>Continued From page 26</p> <p>activities of his choice.</p> <ul style="list-style-type: none"> *He had needed extra time to communicate or follow cues. *Some of his favorite activities had included watching TV or listening to the radio, looking out his window, and spending time with family. *He had enjoyed special events, movies, and taking walks outdoors. *He was to have been offered independent or one-to-one activities that he enjoyed. <p>Review of resident 14's 2/12/14 Minimum Data Set assessment revealed he:</p> <ul style="list-style-type: none"> *Had the ability to hear adequately. *Had an unclear speech. *Was usually understood in his ability to express ideas and wants. *Usually had the ability to understand others. <p>Review of resident 14's 2/19/14 recreation services assessment revealed he:</p> <ul style="list-style-type: none"> *Had enjoyed word searches in the past. *Had enjoyed taking walks outdoors. *Enjoyed watching TV daily. *Enjoyed church music and other music. *Enjoyed looking out the window. *Liked pet therapy. *Enjoyed outings with staff and family. *Had attended devotions in the past. *Had visitors (sister and other family). *Liked spending time with family. *Had some limitations related to his diagnosis, but staff continued to assist him with activities he attended. <p>Review of resident 14's Recreation Participation Record from 2/1/14 through 3/24/14 revealed:</p> <ul style="list-style-type: none"> *He liked his view of the garden, spending time outdoors, and family visited regularly. 	F 248		

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

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F 248	<p>Continued From page 27</p> <p>*In the past he enjoyed going for walks outside, movies, church, and having a soft drink (Coke).</p> <p>*His recreation programs from 2/1/14 through 2/28/14 revealed: -Thirty-three times he had refused activities or he had been sleeping.</p> <p>*His recreation programs from 3/1/14 through 3/24/14 revealed: -Thirty times he had refused activities or he had been sleeping.</p> <p>*Independent leisure activities had included TV/radio and visiting/socializing each day with physical assistance and reminders needed to attend.</p> <p>Review of the provider's March 2014 calendar for one-to-one visits for resident 14 revealed he was scheduled for a one-to-one visit once per week in the p.m. by activity staff. Staff initials should have been placed behind his name. There were no initials after his name up through 3/24/14.</p> <p>Interview on 3/24/14 at 2:10 p.m. with the activity director regarding resident 14 revealed: *He was to have had a scheduled one-to-one activity once per week, but he was usually sleeping or he had refused. *He especially liked to go outside, and that had needed to be done more often. *She had not provided enough activities for him.</p> <p>9. Review of the provider's revised June 2009 Recreation Services Guide: Individual Programming policy revealed: *An individual program ensured all residents who were unable to have chosen not to participate in group programs would have consistent, goal-oriented, and individualized recreation opportunities.</p>	F 248			

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

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F 248	Continued From page 28 *Examples of individualized activities included: -Sensory stimulation or cognitive (mental process) therapy. -Social engagement. -Spiritual support and nurturing. -Creative, task-oriented activities. -Support of self-directed activities. *The structured individual interventions would have been developed based on each resident's history and assessed needs and preferences. *Each resident's individual program would have included interventions which met the resident's assessed social, emotional, physical, and cognitive functioning needs. *Activities would have been adapted in various ways to accommodate the resident's change in functioning due to physical or cognitive limitations. Review of the provider's 5/31/12 Activity Director job description revealed she had been: **"Responsible to ensure the development, organization, and coordination of living center and community resources to provide comprehensive activity services and programs that meet the needs and interests of each resident." **"Develop monthly recreation program calendars that reflect and meet the needs of facility resident."	F 248			
F 250 SS=E	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.	F 250			

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F 250	Continued From page 29 This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, record review, interview, and policy review, the provider failed to ensure medically related social services were provided for 7 of 17 sampled residents (2, 4, 5, 11, 15, 17, and 18). Findings include: 1. Review of resident 2's medical record revealed: *An admit date of 4/26/08. *Diagnoses of peripheral vascular disease (problem with circulation in veins), diabetes mellitus (inability to control sugar levels in the blood), psychosis (loss of contact with reality), depression (feelings of hopelessness), anxiety, pain in joint, pressure ulcer (wound) to the left heel, glaucoma (poor eyesight), and end stage renal disease (ESRD) (kidneys unable to filter wastes out of the blood stream). *Was out of the facility on Tuesdays, Thursdays, and Saturdays for dialysis (procedure to filter wastes from the blood). *She had acquired a stage II pressure ulcer (fluid filled blisters) on her left heel on 10/17/13. That stage II pressure ulcer (injuries to skin and underlying tissue) had progressed to an unstageable pressure ulcer on 10/31/13. *She had a history of behaviors. *She yelled out at various times of the day. *She had been on several different types of anti-psychotic medications (help with mood) in the past. *On 9/30/13 she had been started on alprazolam (medication to help with anxiety) 0.5 milligrams (mg) twice a day.	F 250	F 250 PROVISION OF MEDICALLY RELATED SOCIAL SERVICE 1. Resident #2 and #18 no longer reside in living center, no immediate corrective action can be taken. Resident #4 and #17's plan of care was reviewed and revised as necessary to ensure that medically-related social service interventions are in place. Resident #5 and #15 will have updated progress note reflecting any medically-related social services being provided on 4-17-14. Resident #11's discharge plan was updated and social services progress note dated 4-3-14, documents discharge plan status. 2. All residents have the potential to be affected. 3. The Administrator and Social Services reviewed the job descriptions recognizing the role/expectations of the Social Services Director and the Social Services Specialist on 4-10-14. All staff will be re educated on the role of the Social Services department on by 4-18-14. 4. The Social Services Director or designee will randomly audit 5 residents' social service documentation, care plan and discharge plan for appropriate medically-related social services weekly x 4 and monthly x 3 to ensure compliance until all residents have been audited. The Social Services Director or designee will report the results of these audits to the monthly Quality Assurance and Performance Improvement (QAPI) committee monthly for further review and recommendations.	5. 4-22-14	

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F 250	<p>Continued From page 30</p> <p>Observation on 3/17/14 from 7:15 p.m. to 7:30 p.m. revealed: *Two unidentified staff members had entered her room and shut the door. *Through the closed door this surveyor heard her screaming out repeatedly "stop," "you're hurting me," "you're breaking my legs," "call the police," and "take me to the hospital."</p> <p>Interview on 3/17/14 at 7:15 p.m. with resident 26 regarding resident 2 revealed: *She had been located in the room across from his. *She hollered out multiple times during the day and night. *Her hollering had interfered with his sleep. *He had not visited with anyone regarding her hollering. He stated "They won't do anything anyway."</p> <p>Observation on 3/17/14 from 7:35 p.m. through 7:45 p.m. of resident 2 revealed: *She had been laying on her bed. *She screamed out "stop the pain, stop the pain, I need a pain pill, call the police you broke my legs," "I hurt," and "I am in so much pain." *She had been continuously clawing through her hair with her fingers during the entire observation.</p> <p>Interview on 3/17/14 at 7:45 p.m. with licensed practical nurse (LPN) B regarding resident 2 revealed she hollered out at all times of the day. She had been aggressive and hit the staff during activities of daily living (ADL). There had been complaints from various residents regarding her yelling out. The alprazolam had not seemed to be helping her anxiety and hollering out.</p> <p>Interview on 3/18/14 at 9:40 a.m. with resident 21</p>	F 250		

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F 250	<p>Continued From page 31 regarding resident 2 revealed:</p> <ul style="list-style-type: none"> *Resident 21 had been her roommate for three years. *She confirmed resident 2 had hollered out at all times of the day. *She argued with everyone who had attempted to visit with her. *She would rest at night after they gave her "a sleeping pill." *Resident 21 had stated "I hate her." *Resident 21 had asked the social services (SS) specialist for a different room. He had stated "Not at this time and if the hollering bothers you more let me know." She had visited with him on a weekly basis about the hollering. <p>Interview on 3/20/14 at 1:05 p.m. with certified nursing assistant K regarding resident 2 revealed:</p> <ul style="list-style-type: none"> *She hollered out at random times during the day. *She would become aggressive during ADLs by hitting and scratching the staff. *Her hollering out had upset some of the other residents in the neighboring area. *She would have reported any behaviors to the charge nurse. *The resident always hollered out, and it was difficult to determine if she had pain or anxiety problems. <p>Random observations from 3/17/14 through 3/20/14 of resident 2 revealed:</p> <ul style="list-style-type: none"> *She had been up for breakfast or resting in her bed. *She had gone to dialysis on 3/18/14 and on 3/20/14. *Upon return from dialysis she had been hollering out from the time she entered the facility until the staff had laid her down to rest. *She hollered out at various times during the 	F 250		

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
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F 250	<p>Continued From page 32 above observation times.</p> <ul style="list-style-type: none"> *The only staff involvement that had occurred was during ADL assistance and medication pass. *No one-to-one visits from the social services department had been observed. *Her son had visited two times. During those visits she had been heard down the hall into the dining room yelling and cursing at him. That had been approximately 300 feet from her room. <p>Review of resident 2's 3/7/14 quarterly social services note revealed:</p> <ul style="list-style-type: none"> *Behaviors had improved. No types of behaviors had been listed. *No documentation to support if her behaviors had disturbed other residents. *No interventions had been attempted to help her with her anxiety issues. *No documentation to support she had been taking medication for anxiety and if it was helpful or not. *No documentation to support any one-on-one visits from the social services department had occurred. <p>Interview on 3/24/14 at 2:45 p.m. with the SS specialist regarding resident 2 revealed:</p> <ul style="list-style-type: none"> *She had been having mood changes for some time. *She had psychological reviews in the past but had not been compliant with return visits. *He had no documentation to support any one-on-one visits had occurred. He would have stopped in periodically to visit with her. *He would not have been involved with her pain management. That had been the nursing departments responsibility. *He had visited once with her roommate in regards to the outbursts. He had not realized that 	F 250			

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

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OMB NO. 0938-0391

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F 250	<p>Continued From page 33</p> <p>had continued to be a problem.</p> <p>*He had no further complaints from other residents in regards to her random outbursts.</p> <p>*He had not visited with any other residents to determine if her outbursts were disturbing and disruptive for them.</p> <p>2. Review of resident 4's medical record revealed:</p> <p>*A 11/9/12 admission date.</p> <p>*Admission diagnoses:</p> <ul style="list-style-type: none"> -Recent cerebral vascular accident (blood flow to part of the brain stopped). -Depression. -Dementia (memory loss) with behavioral disturbances. -Anxiety. -Poor eyesight. <p>*He had been dependent on staff to meet all of his mobility and ADLs.</p> <p>Random observations from 3/17/14 through 3/20/14 of resident 4 revealed he had:</p> <ul style="list-style-type: none"> *Been out of his room for meals only. *A spouse who came to assist him with his supper almost daily. *Rested in his bed in-between meals. *Faced the wall when resting in his bed. *His divider curtain between him and his roommate and window curtains pulled shut at all times. <p>The only staff involvement had occurred during ADLs and assisting him with his meals.</p> <p>Review of resident 4's 1/7/14 psychosocial quarterly progress note by the SS specialist revealed:</p> <ul style="list-style-type: none"> *He had memory problems and had difficulty understanding others. 	F 250			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 250	<p>Continued From page 34</p> <p>*He spent most of his time in his wheelchair or resting in his bed.</p> <p>Interview on 3/24/14 at 2:45 p.m. with the SS specialist regarding resident 4 revealed:</p> <p>*He had been highly involved with resident 4.</p> <p>*He had nothing to support that social services had attempted to find items to assist with his mental stimulation.</p> <p>*He visited with him at the same time he visited with his roommate.</p> <p>*He had no further comments to offer for resident 4 and his over-all well being and increased need for mental, visual, auditorial (hearing), and social stimulation.</p> <p>3. Review of resident 17's medical record revealed:</p> <p>*A 5/23/13 admission date.</p> <p>*Admission diagnoses:</p> <ul style="list-style-type: none"> -End stage renal disease with dialysis three times a week. -Clostridium difficile (C.diff) (bacteria related to frequent antibiotic use and could be transmitted to other residents). -Depression. <p>*He had recently been placed in isolation (unable to come out of his room) for the diagnosis of C.diff.</p> <p>*He had required limited assistance from the staff for ADLs.</p> <p>*He had occasionally refused care from the staff.</p> <p>*He ambulated independently.</p> <p>*He was alert, oriented, and able to make his needs known.</p> <p>Random and multiple observations from 3/17/14 through 3/20/14 of resident 17 revealed:</p> <p>*His room had been dark, and the divider curtain</p>	F 250			

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

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FORM APPROVED
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F 250	<p>Continued From page 35</p> <p>and window curtains had been pulled at all times. *He had only been out of his room for smoke breaks and dialysis visits. *He was required to wear a gown and gloves when going outside to smoke and for dialysis. *He had been resting on his bed facing the divider curtain in-between smoke breaks. *His TV had been his only form of stimulation in his room. *No personal effects or pictures had been hanging on his walls. *No chair had been provided for him to allow him a change of position from his bed. *No staff had been observed entering or exiting his room including the nursing staff during observation times.</p> <p>Interview on 3/24/14 at 2:45 p.m. with the SS specialist regarding resident 17 revealed: *He had been hard to offer support for as he frequently refused activities and care. *He had been encouraged by the SS when he had refused ADL assistance or bathing from the nursing staff. *His smoke breaks had been considered a part of his social activity with the staff by the SS department. *He had refused any type of counseling in the past. He had no further comments to offer for the resident and his over-all well being and increased need for mental, visual, auditorial, and social stimulation.</p> <p>4. Interview on 3/25/14 at 8:25 a.m. with the director of nursing services (DNS) regarding the above observations and interviews revealed she would have expected the social services department to have been involved with the above</p>	F 250		

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

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FORM APPROVED
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F 250	<p>Continued From page 36 residents and their over-all well being.</p> <p>Interview on 3/26/14 at 9:40 a.m. with the social services director regarding the above observations confirmed social services should have been an advocate for all residents in the facility.</p> <p>Surveyor: 22452 5. Review of resident 18's medical record revealed: *A 1/8/14 admission date. *Admission diagnoses: -Senile dementia (memory loss) with delirium (acute confusional episode). -Depressive disorder. -Dehydration (inadequate fluid intake). -Diarrhea (loose bowel movements). -Rheumatoid arthritis. -Atrial flutter (abnormal heartbeat). *She had been hospitalized: -1/15/14 through 1/31/14 for abdominal pain and dehydration. -2/5/14 through 2/8/14 for gastroenteritis (nausea and vomiting) and dehydration. -2/15/14 through 2/20/14 for syncopal (unresponsive episode), diarrhea, poor oral intake, and possible administration of blood pressure medications that had not been prescribed for her. *She returned from the hospital on 2/20/14 to receive comfort care with hospice services.</p> <p>Review of resident 18's 1/12/14 nurses' progress notes revealed "Asking to see social worker on Monday. Asking questions related to charges from wheelchair express for doctor appointments and whose responsibility it is to pay for it."</p>	F 250			

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

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F 250	<p>Continued From page 37</p> <p>Review of resident 18's 1/8/14 through 3/18/14 social service progress notes revealed no documentation regarding the above request.</p> <p>Review of resident 18's 3/4/14 hospice notes revealed: ***Patient does not want to stay in nursing home and wants to leave." ***States to daughter you help me or I will leave myself." ***Patient cries easily today and states this is no life." ***Patient states she does not get along with some of the staff. They do not listen to her and make her do things she doesn't want to do." ***One thing patient would like is to not have to go down to meals. Nurse states if there is an occasional time she doesn't feel good enough to go to dining room, she will be allowed to stay in room." ***Today is patient's birthday. She states this is some way to spend your birthday." ***Patient wants to go home and hire help in the home. Daughter states this is not feasible due to cost." ***Daughter states she has looked at other nursing homes but waiting list is 1-2 years. Daughter tells patient all nursing homes will be the same and at least here she has a nice single room."</p> <p>Interview on 3/26/14 at 8:58 a.m. with the SS specialist regarding resident 18 revealed: *If he was not in the building when a resident requested to see social services they would either call him or leave him a note. He had not remembered being told she had wanted to see him on 1/14/14. *The resident had a difficult stay as she had been</p>	F 250		

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

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F 250	<p>Continued From page 38</p> <p>quite ill.</p> <p>*She had returned from her hospitalization on 2/20/14 on comfort care with hospice services.</p> <p>*The daughter and resident had agreed to hospice services when the resident was in the hospital and had signed the appropriate paperwork.</p> <p>*Once the resident returned to the facility the daughter denied knowing the resident was on hospice.</p> <p>*The resident was on and off hospice services from 2/20/14 through her death on 3/18/14.</p> <p>*He had talked to the resident and daughter several times regarding hospice care and end of life issues but had not documented any of the conversations.</p> <p>Surveyor: 32335</p> <p>6. Random observations from 3/17/14 through 3/20/14 and from 3/24/14 through 3/26/14 of resident 5 revealed he had been either resting on his bed in his room or had been in the dining room for meals.</p> <p>Random observations from 3/18/14 through 3/20/14 of resident 5 revealed he had been wearing the same light blue, long sleeved, button down shirt with white stripes and blue pants.</p> <p>Observation on 3/18/14 at 12:15 p.m. and at 6:15 p.m. and on 3/20/14 at 8:20 a.m. of resident 5 in the dining room revealed his hair had not been combed, and he had not been shaved.</p> <p>Observation and interview on 3/19/14 at 4:30 p.m. with resident 5 revealed he:</p> <p>*Had been wearing the same light blue, long sleeved, button down shirt with white stripes and blue pants.</p>	F 250			

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

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F 250	<p>Continued From page 39</p> <ul style="list-style-type: none"> *Had not been shaved, and his hair had not been combed. *Had been laying on his bed resting but agreed to speak with this surveyor. *Agreed to walk down the hall to a visitors room. *Had been polite and answered questions. *Had spoken to this surveyor for fifteen minutes. *Stated he liked to see his wife, go outside, water plants, and read magazines. *Liked to visit. <p>Review of resident 5's medical record revealed:</p> <ul style="list-style-type: none"> *Diagnoses included cirrhosis of the liver, depression, anxiety, delirium, altered mental status, unspecified psychosis, edema, and pain. *He was moderately depressed as of 1/29/14. *His cognition was moderately impaired. *On 1/17/14 he had been admitted into behavioral health services for exhibiting inappropriate behaviors and mental health concerns. *On 1/22/14 he had returned to the facility. *On 1/29/14 there had been a case note entered from social services regarding a significant change in condition. *There had been no other social services documentation since 1/29/14. *Quality of care meetings had been completed on 12/2/13 and 3/6/14. None had been completed in between. *An interdisciplinary team note dated 7/25/13 stated he was displeased he had to be removed from hospice services, since he liked the "social contact" from extra nursing staff. *There was no documentation regarding follow-up to the above comment. *His 1/23/14 care plan stated "I want to feel like I am a part of things, continuing to socialize with others." *Interventions included: 	F 250			

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

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FORM APPROVED
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F 250	<p>Continued From page 40</p> <p>-Offering him opportunities to interact with others. -Identifying former preferences. -"Take the time to discuss my feelings when I'm feeling sad." *There was no documentation to indicate any of those interventions had been attempted.</p> <p>Interview on 3/20/14 at 4:00 p.m. with the DNS and the social services director revealed there had been no documentation from 1/29/14 through 3/6/14 that indicated social services had provided interventions to resident 5 since his return from behavioral health services on 1/22/14. Quality of care meetings should have been done monthly but had not been done for resident 5.</p> <p>Surveyor: 18560 7. Interview on 3/25/14 at 8:30 a.m. with resident 11 revealed he would like to move to another nursing home to be closer to his family. He stated he had discussed that a few times with the SS specialist but had made phone calls to the other nursing home himself.</p> <p>Review of resident 11's medical record revealed: *He had been admitted on 10/7/13. *A discharge plan form dated 10/15/13 noted "discharge anticipated within the next ninety days." *A care conference checklist dated 10/15/13 noted discharge plan had been reviewed for current plan, resources, or referrals needed for other nursing home. *A care conference checklist dated 1/14/14 noted discharge plan had been reviewed for current plan, resources, or referrals needed for other nursing home. *A psychosocial progress note dated 1/16/14</p>	F 250			

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

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F 250	<p>Continued From page 41</p> <p>noted he continued to talk about going back to his home area. Resident 11 had called the other nursing home to check on room availability.</p> <p>*A physician's progress note dated 3/18/14 noted he would like to go back to his home area.</p> <p>*No documentation on his care plan related to discharge planning to the nursing home in his home area.</p> <p>*No other documentation the SS specialist had assisted him with any discharge plans.</p> <p>Interview on 3/25/14 at 11:10 a.m. with the SS specialist confirmed he:</p> <p>*Knew resident 11 wanted to discharge to another nursing home to be closer to family.</p> <p>*Had not contacted the other nursing home.</p> <p>*Had not documented what planning, resources, referrals, or assistance he had provided to resident 11.</p> <p>8. Review of resident 15's medical record revealed:</p> <p>*He had been admitted on 1/25/13.</p> <p>*A social service note dated 1/16/14 resident 15 stated "he would like someone to talk to about possible depressed states."</p> <p>*A physician's order dated 1/17/14 for psychological services evaluation for depression.</p> <p>*A diagnostic assessment by the contracted behavior therapist dated 1/28/14 recommended individual therapy, referral for medication evaluation, and psychological evaluation to assist in diagnosis and treatment planning.</p> <p>*The contracted behavior therapist progress note dated 2/10/14 regarding the visit with resident 15.</p> <p>*A note by the SS specialist dated 2/10/14 repeated verbatim the above contracted behavior therapist progress note.</p> <p>*The contracted behavior therapist progress note</p>	F 250			

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

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F 250	<p>Continued From page 42</p> <p>dated 2/19/14 regarding the visit with resident 15. *A note by the SS specialist dated 2/19/14 repeated verbatim the above progress note. *A contracted behavior therapist progress note dated 2/24/14 regarding the visit with resident 15. *Contracted behavior therapist progress notes dated 3/10/14 and 3/17/14 stated resident declined session. *No further SS specialist notes had been documented.</p> <p>Interview on 3/25/14 at 2:40 p.m. with the SS specialist revealed: *He had been directly copying the contracted behavior therapist notes into his social service notes. *He thought the notes needed to be documented in the electronic medical record. *The notes looked like they were his notes, but they were not. *He had not documented any other social service interventions related to resident 15.</p> <p>Review of the provider's 8/30/11 Social Service Director Job Description Policy revealed the general purpose of the social service director was to "Identify and provide for each resident's social, emotional, and psychological needs, and the continuing development of the resident's full potential during his/her stay at the facility."</p> <p>Review of the provider's 8/30/11 Social Service Specialist Job Description Policy revealed: *The general purpose of the social service specialist was to "Assist the social service director in identifying and providing for each resident' social, emotional, and psychological needs, and the continuing development of the resident's full potential during his/her stay at the</p>	F 250			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
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F 250	Continued From page 43 facility and to assist in the planning for his/her discharge." *They should attend to various personal needs of the residents.	F 250			
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, and policy review, the provider failed to ensure surfaces were cleanable, doors did not have gaps, and resident care items were stored properly throughout the facility. Findings include: 1. Observation on 3/18/14 at 10:10 a.m. in the therapy room revealed resident use items had been stored under one of two sinks. Those items had been: -Multiple hand towels. -Multiple incontinent products. -Sheepskin (protective cloth). -One bottle of spray foam body cleanser. Interview on 3/20/14 at 4:45 p.m. with the director of rehabilitation revealed she had not been aware resident use items should not have been stored underneath of the sink. She was not sure if the items had been for resident use. 2. Random observations from 3/17/14 through 3/20/14 revealed:	F 253	F 253 HOUSEKEEPING & MAINTENANCE SERVICES 1. Resident use items stored under the sink in the therapy room were removed on 3-21-14 All doors were audited for missing pieces of wood on 4-11-14, InPro Corporation was contacted on 4-15-14 to assess all doors for needed repairs and is scheduled to come on the soonest available date, which is 4-24-14. Contractor, City Glass, came to the facility on 4-16-14 to provide a quote, facility awaiting quote and date for repair of the gaps in the two community and resident use doors. The scraped walls in rooms 401 and 407 were repaired on 4-16-14. Mechanical lift (400) identified with a scraped surface was repainted on 4-14-14. The duct tape was removed from the Resident stand-aide in the therapy room on 3-20-14. 400 shower room storage room heat vent was repaired on 3/27/14 The bedside table and floor mat in room 202A were replaced on 4-1-14. 2. The Executive Director or designee will provide all staff education, including housekeeping, therapy and maintenance staff, regarding providing housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior by 4-18-14. 3. The Maintenance Director or designee will randomly audit 5 areas for storage under the sink, doors for missing pieces of wood and gaps, walls for scrapes and cleanliness of lifts weekly x 4 and monthly x 3 to ensure compliance. 4. The Maintenance Director or designee will report audit results to the monthly Quality Assurance and Performance Improvement (QAPI) committee for further review and recommendations.	5. 4-22-14	

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
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F 253	<p>Continued From page 44</p> <p>*Multiple brown wooden doors including resident room doors throughout the facility had missing pieces of wood. The missing pieces of wood left a rough and uncleanable surface (photo 10).</p> <p>*Two of four observed community and resident use bathroom doors (100 wing) had not closed properly. Upon closing of the doors there had been a half inch gap. Those gaps had allowed visual capabilities into the bathrooms while in-use.</p> <p>*Two of twelve observed residents' rooms (401 and 407) walls were scraped and exposed the gypsum. The scraped walls had left the surfaces rough and an uncleanable surface (photo 11).</p> <p>*One of five observed transfer aides (equipment to assist residents with transfers) (400 wing) was scraped and exposed a metal surface. The scraped areas had created an uncleanable surface (photo 12).</p> <p>*One of one observed resident stand-aide in the therapy room had duct tape placed on the chest support area. That tape had created an uncleanable surface.</p> <p>Interview on 3/25/14 from 1:10 p.m. through 1:30 p.m. during an environmental walk-through with the maintenance director, administrator, and housekeeping director revealed the only item listed on a preventative maintenance program had been the wooden doors. The maintenance director was responsible for the upkeep of the transfer and stand-aides. He had been unaware of the uncleanable surfaces created on both of those pieces of equipment. They had not been aware of all the other areas of concern but confirmed the findings.</p> <p>Review of the provider's 8/30/11 Maintenance Supervisor Job Description policy revealed:</p>	F 253			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 253	Continued From page 45 **Ensure the building(s), equipment and utilities are maintained in good working order and facility grounds are properly maintained in accordance with facility policies and state and Federal Regulations." **Perform minor repairs and supervise the day-to-day repairs, improvement and preventative maintenance of the building." **Ensure equipment and work areas are clean, safe and orderly; and strict adherence to procedures regarding cleaners or hazardous material or objects; ensure Universal Precautions and infection control, isolation, fire, safety and sanitation practices and procedures are followed; and promptly address any hazardous conditions and equipment."	F 253			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280			

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F 280	Continued From page 46 This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, interview, and policy review, the provider failed to review and revise 3 of 18 sampled residents' (2, 4, and 18) care plans to reflect their current health conditions. Findings include: 1. Review of resident 18's medical record revealed: *A 1/8/14 admission date. *Admission diagnoses: -Senile dementia (memory loss) with delirium (acute confusional episode). -Depressive disorder. -Dehydration (inadequate fluid intake). -Diarrhea (loose bowel movements). -Rheumatoid arthritis. -Atrial flutter (abnormal heartbeat). *She had been hospitalized: -1/15/14 through 1/31/14 for abdominal pain and dehydration. -2/5/14 through 2/8/14 for gastroenteritis (nausea and vomiting) and dehydration. -2/15/14 through 2/20/14 for syncopal (unresponsive episode), diarrhea, poor oral intake, and possible administration of blood pressure medications that had not been prescribed for her. *She had frequent episodes of sternal (breastbone) and back pain and received routine and as needed pain medication. Review of resident 18's 3/7/14 care plan revealed no documentation regarding:	F 280	F 280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE CARE PLAN 1. Resident #2 and #18, no longer reside in the living center, no immediate correction can be taken. Resident #4's care plan was updated to reflect non pharmacological interventions for pain, types of diversion for behaviors, soothing interventions for anxiety and situations for staff to avoid to prevent anxiety on 3-21-14. 2. All residents have the potential to be affected. 3. Immediate all staff meeting held on 3/19/14 at 2:15pm by Executive Director and Director of Nursing Services regarding the clinical guideline for pain, the importance of monitoring and reporting pain and timely notification of primary physician for any symptoms of uncontrolled pain. The Director of Nursing Services or designee will provide all staff education regarding updating the care plan for all residents by 4-18-14. The Director of Nursing Services or designee will audit 5 resident care plans for accuracy weekly x 4 and monthly x 3 to ensure compliance. 4. The Director of Nursing Services or designee will report audit results to the monthly Quality Assurance and Performance Improvement (QAPI) committee for further review and recommendations.	5. 4-22-14	

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 280	<p>Continued From page 47</p> <ul style="list-style-type: none"> *Non-pharmacological approaches for pain control. *Diarrhea. Constipation was documented as a focus problem. *Dehydration. There was documentation regarding "Potential for alteration in hydration related to triggering for constipation." *Weight loss, nausea, or vomiting. <p>Surveyor: 32355</p> <p>2. Review of resident 2's medical record revealed:</p> <ul style="list-style-type: none"> *An admit date of 4/26/08. *She had acquired a stage II pressure ulcer (fluid filled blisters) on her left heel on 10/17/13. That stage II pressure ulcer (injuries to skin and underlying tissues) had progressed to an unstageable pressure ulcer on 10/31/13. *She had a history of behaviors. *She yelled out at various times of the day. *She had been on several different types of anti-psychotic medications (help with mood) in the past. *On 9/30/13 she had been started on alprazolam (medication for anxiety) 0.5 milligrams (mg) twice a day. <p>Review of resident 2's 3/10/14 care plan revealed no documentation regarding the following focus areas of:</p> <ul style="list-style-type: none"> *Pain. No non-pharmacological approaches for pain control. *Behaviors. Staff were to have: <ul style="list-style-type: none"> -Avoided situations that had been upsetting to her. No situations had been listed. -Offered her a diversion. No types of diversions had been listed. 	F 280		

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 280	<p>Continued From page 48</p> <p>-Attempted interventions prior to any behavioral activity. No types of interventions had been listed. *Depression. Staff were to have contacted her physician if her symptoms of depression had not improved. No types of symptoms had been listed.</p> <p>3. Review of resident 4's medical record revealed: *A 11/9/12 admission date. *Admission diagnoses: -Dementia (memory loss) with behavioral disturbances. -Anxiety. -Pain.</p> <p>Review of resident 4's current care plan with a print date of 7/26/13 revealed no interventions on the following focus areas for: *Pain. No non-pharmacological approaches for pain control. *Behaviors. Staff were to have "offer me something I like as a diversion. Consult with my spouse as to things of which may be pleasing to me." No types of diversions had been listed. *Anxiety. Staff were to have "Offer things that are soothing to me. My wife is able to speak on my behalf as to what is please to me." No soothing interventions had been listed. *Anxiety. Staff were to have "Avoid things that make me more anxious." No items had been listed for staff to avoid.</p> <p>4. Interview on 3/25/14 at 2:30 p.m. with registered nurse (RN) W revealed: *She had started the initial care plans for the residents. *She would have updated the care plans during annual and significant change reviews. *The unit coordinators had been responsible for</p>	F 280		

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 280	Continued From page 49 any further updating of the care plans. Interview on 3/25/14 at 2:45 p.m. with RN L (unit coordinator of halls 400, 500, and 600) revealed: *The unit coordinators had been responsible for the updating the care plans. *The care plans should have listed any special interventions required by the residents. Interview on 3/25/14 at 8:15 a.m. with the director of nursing services confirmed the unit coordinators had been responsible for the reviewing and revising of the residents' care plans. Review of the provider's May 2001 Care Plan policy revealed: **An interdisciplinary approach to identification of problems and developing solutions provides individualization and coordination of resident care." ***The interdisciplinary care plan is reviewed, revised and update quarterly and more frequently if warranted by a change in resident's condition."	F 280			
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Surveyor: 22452 Based on observation, record review, interview, and policy review, the provider failed to ensure:	F 281			

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

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F 281	<p>Continued From page 50</p> <p>*Insulin administration was appropriately documented for two of four sampled residents (7 and 24) who received sliding scale (insulin given depending on blood sugar results) insulin and the amount of carbohydrates consumed at meals/snacks.</p> <p>*Professional standards were followed for capping an insulin syringe after administration by one of seven licensed nurses (G) for one of one sampled resident (22).</p> <p>*Manufacturer's recommendations were followed for rinsing of the mouth after the administration of an inhaler for one of one sampled resident (32) by one of seven licensed nurses (A).</p> <p>*Physician's orders were followed for the administration of a medication for one of one sampled residents (18).</p> <p>*The documentation of an antianxiety medication reconciled (agreed with) with the amount that had been dispensed from the pharmacy for one of one sampled resident (26).</p> <p>*Professional standards were followed for the medication card matching the physician's order and medication administration record (MAR) for one of one sampled resident (1).</p> <p>Findings include:</p> <p>1. Review of resident 7's medical record revealed:</p> <p>*A diagnosis of diabetes.</p> <p>*A 5/13/13 physician's order for Novolog (a fast-acting insulin used to control high blood sugar in people with diabetes) solution given subcutaneously (below the skin) before meals and at bedtime.</p> <p>*The amount to have been given was based on blood sugar levels on a sliding scale as follows: -60 milligrams/deciliter (mg/dl) to 140 mg/dl: None</p>	F 281	<p>F281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>1. Residents #7 and #24's medication administration records were updated to reflect units of insulin administered based on sliding scale or carbs consumed on 3-21-14. Resident #1 no longer resides here, no corrective can be taken. Director of Nursing Services reviewed all residents current sliding scale insulin orders to ensure that each order includes a space for documenting units of insulin given, according to sliding scale. Director of Nursing Services reviewed all residents currently receiving sliding scale insulin based on carbohydrates consumed to ensure each order has a space to document carbohydrates consumed and units of insulin given per physician's order. The facility was unable to reconcile lorazepam for resident #26. Facility concludes that more than 1 medication card was accessed at point of administration resulting in inability to accurately reconcile the medication. See F425, regarding audit of all medication carts to ensure medication card and medication administration record match. Nurse G was educated on proper syringe handling on 4-3-14 and Nurse A was educated on proper administration of steroid based inhalers on 4-14-14.</p> <p>Resident #18 no longer resides at the living center, no immediate correction can be taken.</p> <p>2. All residents have the potential to be affected.</p> <p>3. The Director of Nursing Services or designee will educate all Licensed nursing staff regarding insulin orders and documentation including documentation of units of insulin administered based on sliding scale or</p>		

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F 281	<p>Continued From page 51</p> <p>-141 mg/dl to 200 mg/dl: 2 units. -201 mg/dl to 250 mg/dl: 4 units. -251 mg/dl to 300 mg/dl: 6 units. -301 mg/dl to 350 mg/dl: 8 units. -351 mg/dl to 400 mg/dl: 10 units. -Over 400 mg/dl: call physician. *Blood sugar levels on the MAR from 2/1/14 through 3/17/14 revealed: -Eighty-four times blood sugar levels were over 140 mg/dl which would have required additional insulin per the sliding scale. -The blood sugar levels over 140 mg/dl ranged from 141 mg/dl to 326 mg/dl. -None of the above levels over 140 mg/dl had documented units of insulin given based on the sliding scale amount ordered.</p> <p>2. Review of resident 24's medical record revealed: *A diagnosis of diabetes. *A 6/4/13 physician's order for Novolog insulin 1 to 6 units subcutaneously given three times a day before meals. *The amount to have been given was based on blood sugar levels on a sliding scale as follows: -200 mg/dl to 260 mg/dl :1 unit. -261 mg/dl to 320 mg/dl: 2 units. -321 mg/dl to 380 mg/dl: 3 units. -381 mg/dl to 440 mg/dl :4 units. -441 mg/dl to 500 mg/dl: 5 units -501 mg/dl to 600 mg/dl: 6 units. -Notify physician if blood sugars above 500 mg/dl. *Blood sugar levels on the MAR from 2/1/14 through 3/19/14 revealed: -Seventy-eight times blood sugar levels were over 200 mg/dl which would have required additional insulin per the sliding scale. -The blood sugar levels over 200 mg/dl ranged from 201 mg/dl through 495 mg/dl.</p>	F 281	<p>documentation of carbs consumed, proper use of insulin syringes, correct administration of steroid based inhalers, following physician orders and documentation of a resident change of condition with appropriate vital signs and MD/family notification by 4-18-14.</p> <p>4. The Director of Nursing Services or designee will audit 5 residents to review insulin orders and documentation, observation of nurse for proper syringe handling, progress notes reviewed for change of condition and medication administration record, physician order and medication card match weekly x 4 and monthly x 3. The Director of Nursing Services or designee will report results of audits monthly x 3 to the monthly Quality Assurance and Assessment Committee for further review and recommendations.</p>	5. 4-22-14	

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

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F 281	<p>Continued From page 52</p> <p>-None of the above levels over 200 mg/dl had documented units of insulin given based on the sliding scale amount ordered.</p> <p>3. Interview on 3/24/14 at 5:10 p.m. with the director of nursing services (DNS) regarding residents 7 and 24's sliding scale insulin amounts revealed the MAR needed to have included the amounts of insulin documented that had been given to the residents based on their blood sugar levels.</p> <p>Review of the provider's 2007 Medication Administration Subcutaneous (under the skin) policy revealed to have administered subcutaneous insulin as ordered and in a safe and effective manner.</p> <p>4. Review of resident 24's medical record revealed: *A 12/26/13 physician's order prn (whenever necessary) for "45 grams carbohydrates per meal/snack at HS (at bedtime). 15 grams of carbohydrates if blood sugar is less than 100 and then have HS snack of 30 grams of carbohydrates. No snacks between meals." *A 2/03/14 physician's order for Novolog insulin 1 unit subcutaneously after meals for every 17 carbohydrate grams. *A 3/13/14 physician's order to "Change Novolog to 1 to 16 carb (carbohydrate) ratio with meals and snacks, keep same sliding scale." *Documentation on the MAR from 2/4/14 through 3/20/14 revealed: -No amounts listed for the carbohydrates consumed by the resident. -No amounts listed for the units of insulin given to the resident based on the amounts of carbohydrates.</p>	F 281			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS			STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106		
(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 281	<p>Continued From page 53</p> <p>*The 12/23/13 care plan revealed: -Resident often had low blood sugars. -Meal consumption was to have been monitored daily.</p> <p>Review of resident 24's food and snack intake records from 1/24/14 through 3/25/14 revealed resident consumed an average of: *Eighty-six percent (%) at breakfast. *Ninety-two % at noon. *Ninety-six % at dinner. *Eighty-nine % at bedtime snack. *There was no documentation regarding the amount of carbohydrates offered and consumed at the meals and snacks.</p> <p>Interview on 3/24/14 at 2:45 p.m. with the registered dietitian (RD) revealed she had provided the carbohydrate counting cheat sheet and the sources of carbohydrate information to nursing. It had been up to nursing staff to have determined the amounts of carbohydrates at the meals based on the informational sheets provided by the RD.</p> <p>Interview on 3/24/14 at 3:45 p.m. with resident 24 revealed: *She had diabetes and was on a special diet. *Usually received a snack at bedtime such as ice cream, cookies, banana, or apple.</p> <p>Interview on 3/24/14 at 4:00 p.m. with registered nurse (RN) F regarding resident 24's diet revealed: *The resident was to have been given insulin based on how much carbohydrate she had consumed at meals and snacks and on her blood sugar levels. *She used a Carb Count Cheat Sheet for figuring</p>	F 281			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS	STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106
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F 281	<p>Continued From page 54</p> <p>how much carbohydrate was in food items. *The cheat sheet contained information on foods with carbohydrates ranging from twelve to twenty grams per serving.</p> <p>Interview on 3/24/14 at 5:10 p.m. with the DNS regarding resident 24 revealed the nursing staff: *Monitored the amount of carbohydrates the resident consumed at each meal but had not documented the amount anywhere. *Had not documented the amount of sliding scale Novolog insulin they had administered depending on what her carbohydrate consumption at each meal was. *Confirmed the current system needed to have been set-up differently, as there were risks for error and inconsistency.</p> <p>Interview on 3/25/14 at 2:00 p.m. with the RD revealed the provider did not have a policy on carbohydrate counting for insulin diets.</p> <p>Review of the provider's 2011 Physician's Orders policy revealed a physician's order must have been obtained for diet restrictions, consistency modifications, and therapeutic diets such as a diabetic diet.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Edition, St. Louis Mo., 2005, page 843, revealed "After the nurse administers the medication, the MAR is completed to verify that the medication was given as ordered. Accurate documentation serves as a way for health care providers to communicate with each other."</p> <p>5. Observation on 3/18/14 at 5:05 p.m. of RN G revealed she:</p>	F 281		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 281	<p>Continued From page 55</p> <p>*Administered insulin to resident 22.</p> <p>*Placed the orange cap back on the insulin needle after she had administered the insulin instead of sliding the safety shield attached to the syringe over the needle.</p> <p>Interview at that time with RN G regarding recapping of the insulin syringe revealed she was unaware she should not have done that.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Edition, St. Louis Mo., 2005, page 891, revealed: *Needle stick accidents occur when needles are recapped. *Syringes are designed with a sheath or guard that covers the needle after it is withdrawn from the skin. The needle is immediately covered, eliminating the chance for a needle-stick injury. **"Do not recap any needle."</p> <p>6. Observation on 3/18/14 at 5:25 p.m. of licensed practical nurse (LPN) A revealed she: *Administered an Advair inhaler (medication for asthma and chronic obstructive pulmonary disease) to resident 32. *Had not offered the resident any water to rinse her mouth out after she had inhaled the Advair.</p> <p>Interview at that time with LPN A revealed she was unaware the mouth needed to be rinsed with water after the administration of the Advair medication.</p> <p>Review of the manufacturer's insert regarding the Advair inhaler revealed: **"After each dose, rinse your mouth with water and spit the water out. Do not swallow." **"Not rinsing with water increases the risk for oral</p>	F 281			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106		
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F 281	<p>Continued From page 56 candidiasis (yeast infection)."</p> <p>7. Review of resident 18's 3/17/14 and 3/18/14 nurses' progress notes revealed: *3/17/14 at 5:00 p.m., "Resident is starting to decline. She refuses to eat and does not talk with family/staff. Resident is on hospice. Fingers are puffy and full of liquid. Skin color is dusky (grey). Called doctor and hospice to let know condition. Doctor ordered intravenous Lasix (medication for fluid retention). Resident had about 25 milliliters of output (urine)." *3/17/14 at 11:17 p.m., "Doctor ordered furosemide (Lasix) 40 milligrams (mg) intramuscularly. We are still waiting for the medication to be delivered and will give once it arrives." *3/18/14 at 1:17 a.m., "Certified nursing assistant entered room at 12:30 a.m. and found resident pale and unresponsive. Writer assessed resident with no lung/heart sounds for one full minute. Unable to obtain blood pressure or pulse. Resident was a do not resuscitate."</p> <p>Interview on 3/25/14 at 4:30 p.m. with the DNS regarding resident 18 revealed: *She was unsure if the nurse had called or faxed the pharmacy the need for the furosemide injection, or if she had told the pharmacy to send it as soon as possible. *There were usually two vials (containers) of furosemide in their emergency kit. They had used one of the vials for the intravenous dose administered at 5:00 p.m. *She was unsure if the nurse had looked in the emergency kit for the other vial, or if that vial had been used for someone else and had not yet been replaced by the pharmacist. *She had not followed-up with the pharmacy why</p>	F 281		

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
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F 281	<p>Continued From page 57</p> <p>the furosemide had not been delivered in a more timely manner, and as far as she knew the nurse on duty 3/17/14 had not either.</p> <p>8. Review of resident 26's March 2014 MAR revealed lorazepam (anti-anxiety medication) 1.0 mg at bedtime (HS).</p> <p>Observation of resident 26's lorazepam medication cards in the medication cart revealed: *There were three lorazepam medication cards in the locked drawer labeled as needed (PRN). The medication cards contained eighty-nine pills. *There was an HS lorazepam medication card that had been dispensed by the pharmacy with thirty pills of lorazepam. *The date 2/10/14 was documented by where the first lorazepam pill (number thirty) had been punched out of the medication card and administered. *There were two pills of lorazepam left in the HS medication card. *There was not another HS lorazepam medication card where the doses documented as administered from 3/10/14 to 3/19/14 had been taken from. *There was a discrepancy between the amount of lorazepam dispensed by the pharmacy and the amount that had been documented.</p> <p>Interview on 3/20/14 at 2:30 p.m. with RN L regarding resident 26 revealed: *She confirmed there were two pills left in the HS lorazepam medication cart. *According to the 2/10/14 date the medication card was started there should have been no pills left. Another HS lorazepam medication card should have been started on 3/12/14. *She thought maybe the 2/10/14 date the</p>	F 281			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS			STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106		
(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 281	<p>Continued From page 58</p> <p>lorazepam medication card had been started had been dated incorrectly.</p> <p>*She was unsure where the lorazepam pills that had been documented as administered from 3/10/14 through 3/19/14 had come from.</p> <p>*There might have been another empty HS lorazepam medication card that had been thrown away.</p> <p>*They had reconciled the PRN lorazepam every shift but had not reconciled the lorazepam when it was given routinely.</p> <p>*The resident received a PRN dose of lorazepam three times a week before dialysis.</p> <p>**That would not explain why the count and documentation of the HS lorazepam dose was off."</p> <p>9. Observation on 3/18/14 at 5:45 p.m. revealed RN G administered atorvastatin (cholesterol lowering medication) 20 mg to resident 1.</p> <p>Review of resident 1's March 2014 MAR revealed Simvastatin (cholesterol medication) 40 mg daily.</p> <p>Review of resident 1's 2/25/14 physician's orders revealed Simvastatin 40 mg daily.</p> <p>Interview on 3/18/14 at 5:46 p.m. with RN G revealed she had been informed atorvastatin was the generic for Simvastatin, and it was okay to administer it.</p> <p>Interview on 3/25/14 at 9:00 a.m. with the consultant pharmacist regarding resident 1 revealed:</p> <p>*The resident's physician had signed a therapeutic interchange authorization form upon admission that allowed the pharmacy to interchange medications as necessary.</p>	F 281			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
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F 281	<p>Continued From page 59</p> <p>*The 2/25/14 therapeutic interchange authorization form stated that atorvastatin 20 mg could be substituted for Simvastatin 40 mg daily.</p> <p>*Atorvastatin was generic Lipitor (cholesterol lowering medication) and was a different drug than Simvastatin.</p> <p>*The nursing staff had been informed by the pharmacy per facsimile on 3/3/14 they would be dispensing atorvastatin now instead of Simvastatin.</p> <p>*It was the nurses responsibility to update the physician's orders and MAR at that time, and that had not been done.</p> <p>*The physician's order, MAR, and medication card should have all matched.</p> <p>Interview on 3/25/14 at 10:30 a.m. with the DNS regarding resident 1 stated she had never seen an interchange authorization facsimile from the pharmacy that allowed the pharmacy to interchange medications for residents.</p> <p>Review of the provider's October 2007 Medication Administration General Guidelines policy revealed:</p> <p>**Prior to administration, the medication and dosage on the resident's MAR is compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the prescriber's orders are checked for the correct dosage schedule."</p> <p>**"Medications are administered as prescribed in accordance with manufacturers' specifications and good nursing principles."</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Edition, St.</p>	F 281		

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 281	Continued From page 60 Louis Mo., 2005, page 841, revealed "When administering medications, the nurse compares the label of the medication container with the medication form."	F 281			
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 18560 A. Based on observation, interview, and record review, the provider failed to ensure effective pain management for one of one sampled resident (2) with excruciating pain during a dressing change. That failure created a situation of immediate jeopardy that had the potential for causing harm to all residents with pain. NOTICE: Notice of immediate jeopardy was given verbally to the administrator and the director of nursing services (DNS) on 3/19/14 at 1:20 p.m. The administrator was asked for an immediate plan of correction to ensure resident 2's pain was effectively managed for future dressing changes and for other residents with pain. PLAN: On 3/19/14 at 8:10 p.m. the administrator	F 309	F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 1. Please refer to F309 Statement of Deficiency for immediate actions taken to ensure Resident #2's pain was managed. Resident #18 no longer reside in the living center, no immediate correction can be taken. Resident #9's physician was informed of resident's request for an increase of Sumatriptan Succinate, migraine medication and physician declined due to potential interactions with other medications she was taking on 3-17-14. On 3-18-14 at approximately 1500, RN contacted physician regarding pain management. Resident was administered Sumatriptan Succinate at 1624 on 3-18-14 according to physician orders. Resident reassessed at 1803 and resident reported significant decrease in pain. Resident #9's care plan updated to include resident specific intervention of caffeine intake. Regarding resident #16, Peritoneal Dialysis training was provided for Staff I, and J on 4-2-14, Staff H has been assigned to a separate area of the facility. 2. All residents have the potential to be affected. 3. The Director of Nursing Services or designee will re educate all Licensed nursing staff regarding providing the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care to include pain management and follow up, acute changes in condition and peritoneal dialysis training. by 4-18-14. 4. The Director of Nursing Services or designee will audit 5 residents' assessment for pain management prior to, during and following treatment, staff provided resident "time out", if requested during treatment, for management of chronic pain, audit EMARs for resident photos,		

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

PRINTED: 04/09/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS			STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106		
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F 309	Continued From page 61 provided the surveyors with the written plan of correction (POC). The written POC dated 3/19/14 at 8:10 p.m. was accepted by the surveyors at 8:20 p.m. That immediate POC included: *Nursing staff will pre-medicate resident 2 forty-five minutes to one hour prior to completing treatment. *The nurse will evaluate resident 2's pain level prior to starting treatment. *If resident 2 was unable to tolerate the procedure it would be postponed until she agreed to continue. *Nursing staff will be instructed to have resident 2 rate her pain on a numeric scale of 1-10 before and after each treatment. *Nursing staff will monitor resident 2 during treatment and cares, providing a break in cares when she dictates. *Resident 2 will be referred to therapy for adaptive equipment to protect her leg during positioning. *Resident 2's family will be assisted to contact and obtain a physician willing to treat her pain and see her onsite. *All residents currently residing in the facility were immediately assessed for pain by the professional nursing staff utilizing the pain scales available on the Clinical Health Status Form. *The executive director, DNS, and the interdisciplinary team (nursing unit manager, social services assistant, director of resident assessment, wound nurse, director of admissions, activity director, social services director, registered dietitian, assistant executive director) met on 3/19/14 at 1:30 p.m. to review and revise as necessary the clinical guideline for pain. All members supported the current pain guidelines, no changes were made. *Immediately an all staff meeting was held on	F 309	audit documentation of a resident's condition change and follow up documentation and if a peritoneal dialysis patient resides in living center, a trained nurse will be in the facility to provide services weekly x 4 and monthly x 3. The Director of Nursing Services or designee will report results of audits monthly x 3 to the monthly Quality Assurance and Assessment Committee for further review and recommendations.	5. 4-22-14	

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 309	<p>Continued From page 62</p> <p>3/19/14 at 2:15 p.m. by the executive director and the DNS regarding the clinical guideline for pain, the importance of monitoring and reporting pain, and timely notification of primary physician for any symptoms of uncontrolled pain.</p> <p>*Nurses providing dressing changes to resident 2 were re-educated by the DNS and the executive director on 3/19/14.</p> <p>*Resident wing assignment sheets will now include an area for documenting if the resident expresses or appears to be in pain and a reminder to report to charge nurse.</p> <p>During the survey on 3/19/14 at 8:20 p.m. the surveyors confirmed removal of the immediate jeopardy situation.</p> <p>Findings include:</p> <p>Surveyor: 32355</p> <p>1. Observation on 3/17/14 from 7:15 p.m. to 7:30 p.m. of resident 2 revealed:</p> <p>*Two unidentified staff members had entered her room and shut the door.</p> <p>*Through the closed door this surveyor heard her screaming out repeatedly "stop, stop it," "you're hurting me," "you're breaking my legs," "call the police," "I need a pain pill," and "take me to the hospital."</p> <p>Observation on 3/17/14 from 7:35 p.m. through 7:45 p.m. of resident 2 revealed:</p> <p>*She had been laying in her bed rocking her body back and forth.</p> <p>*She screamed out "stop the pain, stop the pain, I need a pain pill, call the police you broke my legs," "I hurt," and "I am in so much pain."</p> <p>*She had been continuously clawing through her hair with her fingers and clenching her teeth together during that time period.</p>	F 309			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
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F 309	<p>Continued From page 63</p> <p>*Her eyes were wide open and focused straight ahead.</p> <p>*She had yelled at this surveyor "get me a pain pill."</p> <p>Interview on 3/17/14 at 7:45 p.m. with licensed practical nurse (LPN) A regarding the above observations revealed resident 2:</p> <p>*Had an unstageable pressure ulcer (wound) to her left heel. She had acquired the pressure ulcer while in the provider's care.</p> <p>*Hollered out frequently with complaints of pain.</p> <p>*Took Xanax (medication for anxiety) twice a day for anxiety and could have Norco (pain medication) as needed for pain.</p> <p>*Only took the Norco on a routine basis in the mornings prior to her dialysis appointments on Tuesdays, Thursdays, and Saturdays.</p> <p>*Had been started on a pain patch in February.</p> <p>*Had not experienced any relief from anxiety or pain from any of the medications listed above.</p> <p>Observation and interview on 3/19/14 at 9:00 a.m. of resident 2 revealed she:</p> <p>*Had been laying in bed screaming and moaning "call the police" and "they broke my legs."</p> <p>*Had stated she was having "hard" pain.</p> <p>*Had been rocking back and forth reaching for her legs.</p> <p>Observation on 3/19/14 at 9:05 a.m. of registered (RN) B and LPN A performing a dressing change for resident 2 revealed:</p> <p>*RN B had assisted LPN A by supporting the resident's left foot.</p> <p>*LPN A had proceeded to remove the gauze dressing to her left foot.</p> <p>*The wound had a foul and necrotic (dying) odor (smell) upon the removal of the gauze dressing.</p>	F 309			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS			STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106		
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F 309	<p>Continued From page 64</p> <p>*The gauze dressing had a moderate amount of tan colored drainage on it.</p> <p>*She had screamed out during the entire process of removing the gauze dressing.</p> <p>*She had been screaming and moaning repeatedly for them to stop the dressing change.</p> <p>*She further screamed out: -"Help me, help me, call the police." -"Stop poking me with those needles." -"Stop it it hurt." -"Oh my (swear word) give my knees a break." -"Get me to a doctor." -"Call the doctor." -"Hurry, hurry they broke my legs."</p> <p>*She had rocked back and forth reaching for her legs.</p> <p>*The nurses continued with the dressing change even with her pleas for them to stop.</p> <p>*They had continued with the dressing change even after a surveyor had asked if they were going to continue.</p> <p>Interview during the above observation with LPN A revealed she had: *Pre-medicated resident 2 at 7:15 a.m. with Norco. *Given her Tylenol fifteen to twenty minutes prior to the dressing change to further help with pain management. *Stated they needed to continue with the dressing change without an explanation as of why. *Stated the dressing change usually went better after breakfast, but most of the time it had not mattered what time of the day it was performed.</p> <p>Interview at the same time of the observation above with RN B revealed: *The odor had been new from yesterdays dressing change.</p>	F 309			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
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F 309	<p>Continued From page 65</p> <p>*They had needed to continue with the dressing change.</p> <p>*The yelling and screaming during her dressing change had been almost a daily occurrence.</p> <p>*She would have asked the charge nurse to pre-medicate prior to a dressing change. The charge nurses had not always followed through with her request.</p> <p>Review of resident 2's medical record revealed:</p> <p>*An admit date of 4/26/08.</p> <p>*Diagnoses of peripheral vascular disease (problem with circulation in veins), diabetes mellitus (inability to control sugar levels in the blood), psychosis (loss of contact with reality), depression (feelings of hopelessness), anxiety, pain in joint, pressure ulcer (wound) to the left heel, and glaucoma (poor eyesight).</p> <p>*She was out of the facility on Tuesdays, Thursdays, and Saturdays for dialysis (procedure to filter wastes from the blood).</p> <p>*On 10/12/13 she had been sent to the emergency room (ER) for evaluation of her left foot for increase complaints of pain.</p> <p>*From the ER she had been given the diagnoses of "bilateral leg pain, contusion of the left foot, hematoma of the left heel and an insufficiency/sub-acute fracture of the right foot. Staff were to continue pain management and 'air cast' until orthopedic physician assesses on 10/22/13."</p> <p>*She could have Norco 5/325 milligrams (mg) 1/2 to 1 tablet every six hours as needed (PRN) for pain.</p> <p>*On 11/6/13 the physician had ordered Norco 5/325 mg one to two tablets prior to going to dialysis.</p> <p>*She had an order for acetaminophen (pain medication) 650 mg every six hours PRN for pain.</p>	F 309			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 309	<p>Continued From page 66</p> <p>*On 2/27/14 the physician had ordered a Fentanyl patch (patch worn on the skin to relieve pain) 12.5 micrograms/hour.</p> <p>*She had acquired a stage II pressure ulcer (fluid filled blisters) on her left heel on 10/17/13. That stage II pressure ulcer had progressed to an unstageable (unable to determine how deep the tissue damage) pressure ulcer on 10/31/13.</p> <p>*The staff were to have cleansed the left heel with a Betadine solution twice a day and covered it with a gauze dressing.</p> <p>*No supporting documentation had been found to support that any non-pharmacological (other than medications) interventions had been attempted.</p> <p>Review of resident 2's progress notes revealed on the following:</p> <p>*2/20/14 "Resident complains of pain during wound care, PRN pain medications given as ordered."</p> <p>*2/23/14 "Changed dressing to the left heel, resident screamed "help" and tried to kick this nurse with her right foot. Completed dressing change, offered pain medication when resident complained of pain."</p> <p>*2/26/14 "Treatments completed this shift with discomfort noted to patient."</p> <p>*3/3/14 "Resident has treatment to left heel. Resident does not tolerate dressing change well. Hollers out to watch out for leg. Complains of breaking her leg when touched. Once dressing is changed resident calms down."</p> <p>*3/4/14 "Complains of pain to left heel during dressing change. PRN pain medications given as ordered."</p> <p>*3/6/14 "Changed dressing to left heel this am prior to dialysis. Resident screamed throughout, tried to explain if dressing was not changed as ordered wound could get much worse and more</p>	F 309			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2014
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F 309	<p>Continued From page 67</p> <p>painful. Resident stated 'You don't know what you're doing, get the nurse.'</p> <p>*3/17/14 at 23:20 (11:20 p.m.) "Resident has been screaming in room from pain since 1700 (5:00 p.m.), pain medications given. Resident has yelled 'call the police, they are hurting me,' 'call Sioux Valley, call my doctor, someone help me,' and 'stop him! he is shooting electricity in my legs again! Turn the electricity off!' Call light in reach, will tell day registered nurse (RN) to talk to medical doctor (MD) about possible increase neuropathy pain."</p> <p>*3/18/14 at 11:42 p.m. "Resident screaming 'they're killing me' Resident had a shower this evening. She does not do well with this. Writer asked resident if she would like a pain pill. 'Yes that would be good.' complaining of left leg/heel hurting. Writer rates pain a 9 on a scale of 1-10, hollering, facial grimacing, tears." Norco had been provided and effective.</p> <p>*3/19/14 at 2:53 a.m. "Resident continues to report an increase in pain with dressing change to left heel as well as any repositioning, treatment applied to heel after shower, resident was screaming out how bad her pain was."</p> <p>Review of resident 2's 3/3/14 pain assessment revealed she had:</p> <p>*Negative vocalizations with a score of 2. That indicated she repeatedly called out, had loud moaning or groaning, and had crying episodes.</p> <p>*Facial expressions with a score of 2 indicating facial grimacing.</p> <p>*Body language with a score of 2. That indicated she had become rigid, clenched her fists, pulled up her knees, pulling/pushing staff away, and was striking out.</p> <p>*Consolability with a score of 2. Staff had been unable to console, distract, or reassure her.</p>	F 309		

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
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F 309	<p>Continued From page 68</p> <p>*Her total score for pain on a scale from 1-10 with 10 being the worst pain had been an 8.</p> <p>Review of resident 2's 3/7/14 annual Minimum Data Set assessment revealed:</p> <p>*She had been on scheduled pain medications and had received PRN pain medications during the assessment period.</p> <p>*She had not received any non-pharmacological pain interventions.</p> <p>*Her interview indicated she frequently had pain.</p> <p>*Stated her left foot hurt frequently.</p> <p>*Rated her pain a 4 on a scale of 1-10 with 10 being the most painful.</p> <p>*Stated the pain medications helped when taken.</p> <p>Review of resident 2's February 2014 PRN medication record revealed the PRN Norco had been administered thirteen times for pain at various times of the day. There was documentation for one of the doses that had been ineffective. The other doses had been charted as effective. The PRN Tylenol had not been administered. She could have had the PRN Norco 112 times for the month of February per the physician's orders.</p> <p>Review of resident 2's March 2014 PRN medication record from 3/1/14 through 3/18/14 revealed documentation the PRN Norco had been administered seven times for pain in the evening. There was documentation for one of the doses that had been ineffective. The other doses had charted as effective. The PRN Tylenol had not been administered. She could have had the PRN Norco seventy-two times from 3/1/14 through 3/18/14.</p> <p>Review of resident 2's physician's orders dated</p>	F 309		

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 309	<p>Continued From page 69</p> <p>2/16/14 revealed: *A fax had been sent to the physician in regards to increase in pain issues. *Concerns had been "Res. (resident) frequently complains of pain in the knees, legs and left heel. Many times refuses to take anything po (orally). Today resident moaning, pounding on wall, facial grimacing. Would she benefit from transdermal pain med?" *Physician's comments/orders had been "Use pain meds on her list as needed for now (High risk for change in mental status and other side effects - falls)."</p> <p>Review of resident 2's physician's orders dated 3/18/14 revealed: *A fax had been sent to her physician at 4:10 p.m. in regards to her increase in pain and behaviors. *Concerns had been "Patient has had an increase in behaviors/agitation. Dialysis has started her on Seroquel (mood medication) to be given at dialysis only due to uncooperative behaviors. Screams and hollers out very intensely at dialysis and at facility. Is on Fentanyl (pain patch) 12 mcg and Norco 5/325 mg po every six hours PRN - No relief noted. Please advise." *No return fax from the physician regarding the above concern had been received.</p> <p>No documentation had been found to support nursing staff had attempted to further contact the physician from the 3/18/14 fax request.</p> <p>Interview on 3/19/14 at 11:30 a.m. with the medical director revealed he would have expected pain medications to be given as ordered including the PRN medications. The physician should have been notified if those pain medications had not been effective.</p>	F 309			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 309	<p>Continued From page 70</p> <p>Interview on 3/19/14 at 12:10 p.m. with the DNS revealed: *She would have expected the staff to pre-medicate resident 2 prior to dressing changes. *Resident 2 should have received a pain pill no less than two times a day. *She would have expected the nurses to give pain medications as the resident needed them. *Resident 2 had a history of behaviors and yelling out. *Resident 2 always had pain and nothing appeared to help. *She had not always considered the resident's yelling out as a sign of pain but more of a behavioral issue. *She had no comment to offer as to whether the nurse should have called the physician on 3/18/14 for further orders versus faxing. *The provider would have contacted the medical director when the primary physician had not been doing their job. *She had not been sure if the medical director had been contacted in regards to resident 2's pain.</p> <p>Interview on 3/20/14 at 4:50 p.m. with resident 2's primary physician revealed the staff were to give the Norco as ordered every 6 hours PRN until she had visited with the son.</p> <p>Interview on 3/20/14 at 6:10 p.m. with resident 2's son revealed he had: *Expected the staff to protect her leg during her dressing change. *Expected the staff to take a time out or break during her dressing change. *Been comfortable with the staff medicating her</p>	F 309			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 309	<p>Continued From page 71 for pain. *Believed she had been having physical pain versus behaviors.</p> <p>Review of the provider's revised 2013 Pain Management guidelines revealed: *Purpose "To provide guidelines for consistent assessment, management, and documentation of pain in order to provide maximum comfort and enhanced quality of life." *Guidelines: -"Ensuring involvement of resident in pain management." -"Assessing pain and evaluating response to pain management interventions using a pain management scale based on resident self-report or objective assessment for cognitively impaired." -"Recognizing that pain medications may be given around-the-clock." -"Intervening to treat pain before the pain becomes severe." -"Using non-drug interventions to assist in pain management."</p> <p>Review of the provider's undated Long-Term Care Facilities Resident's Bill of Rights pamphlet revealed "You are entitled to quality of life. A facility must provide care and an environment that contributes to your quality of care."</p> <p>Surveyor: 22452 B. Based on observation, record review, and interview, the provider failed to ensure pain was managed for one of one sampled resident (9) who had acute pain. Findings include:</p> <p>1. Interview on 3/17/14 at 7:00 p.m. with resident 9 revealed she had:</p>	F 309		

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 309	<p>Continued From page 72</p> <ul style="list-style-type: none"> *Been admitted to the facility on 3/13/14. *Fallen on 3/14/14. *A migraine (headache) for three days. *Been given sumatriptan succinate (medication for the migraine) but not the same dosage she had taken in the past to relieve the migraine. *Told the staff she needed to take two pills when the migraine started instead of the one pill they had given her. <p>Observation on 3/18/14 at 10:00 a.m. of resident 9 revealed:</p> <ul style="list-style-type: none"> *She was lying in bed with the lights out. *The curtains were closed, and the room was dark. <p>Interview on 3/18/14 at 10:30 a.m. with resident 9 revealed she:</p> <ul style="list-style-type: none"> *Was nauseated and had been unable to eat anything since 3/15/14 but yogurt. *Still had the migraine and rated her pain "9 pushing to a 10" (on a pain scale with 0 being no pain and 10 severe pain). *Stated the migraine felt like a knife was twisted in her head. *Stated the acetaminophen the staff had given her had not helped the migraine, but "It was better than nothing." *Had found some Coke, and in the past the caffeine had helped her migraines. *Had taken another sumatriptan succinate on 3/17/14 at 3:00 p.m. for the migraine. The sumatriptan succinate could only be taken one tablet every twenty-four hours. <p>Interview on 3/18/14 at 2:00 p.m. with RN I regarding resident 9 revealed:</p> <ul style="list-style-type: none"> *He had given her acetaminophen at 11:00 a.m. that morning for her complaints of a migraine. 	F 309		

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 309	<p>Continued From page 73</p> <p>*She had rated her pain as a 9 and stated the acetaminophen was ineffective to relieve her migraine.</p> <p>*The physician had been informed on 3/17/14 she wanted the sumatriptan succinate increased.</p> <p>*The physician had declined due to potential interactions with another medication she was taking.</p> <p>*He had not recalled the physician since then to inform him of her persistent severe migraine pain, but he would before he went off duty today.</p> <p>Interview on 3/19/14 at 9:00 a.m. with resident 9 revealed:</p> <p>*Her migraine was much better.</p> <p>*She felt the caffeine in the Coke helped like it always had in the past.</p> <p>*She wished the staff would have offered her some caffeine on 3/15/14 when the migraine initially started since the physician would not increase her sumatriptan succinate.</p> <p>C. Based on record review and interview, the provider failed to ensure one of one sampled resident (18) who had an acute change in condition was accurately assessed, monitored, and documented on. Findings include:</p> <p>1. Review of resident 18's 2/14/14 nurses' progress notes revealed:</p> <p>*12:23 at p.m., "Resident was given another resident's morning medications by mistake. Resident did not have a picture on her emar (electronic medication administration record) and was sitting next to another resident who had on the same blouse. Resident exhibits no signs of adverse reaction or negative effects, doctor was notified and he ordered a hold on blood pressure medications for this shift. Vitals (blood pressure,</p>	F 309		

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 309	<p>Continued From page 74</p> <p>pulse, and respirations) are stable. Will continue to monitor."</p> <p>*2:25 p.m., "Vital signs 138/78 (normal blood pressure 120/60), pulse 65 (normal pulse 60-80) and respirations 18 (normal respirations 16-20). Resident refused to eat breakfast or lunch this shift. Received as needed (PRN) Mylanta for upset stomach. Doctor here this afternoon and saw resident and new orders received. Daughter here and aware. Blood pressures have been stable this shift."</p> <p>*4:52 p.m., "Mylanta given for resident's complaints of heartburn."</p> <p>*5:30 p.m., "Glucagon (medication for low blood sugar) given for blood sugar of 39 milligram (mg)/deciliter (dl) (normal blood sugar before meals 70 mg/dl to 130 mg/dl and after meals less than 180 mg/dl).</p> <p>*6:08 p.m., "PRN Glucagon effective as blood sugar 139 mg/dl. Mylanta PRN was given and resident stated she thinks it helped a little."</p> <p>*There was no further documentation from 6:08 p.m. to 11:59 p.m.</p> <p>Review of resident 18's 2/15/14 nurses' progress notes revealed:</p> <p>*3:48 a.m., "Acetaminophen given for resident complaints of back pain of 7 on a scale of 10."</p> <p>*7:09 a.m., "Glucagon administered for a blood sugar of 24 mg/dl."</p> <p>*7:19 a.m., "Glucagon administration was effective as blood sugar is up to 63 mg/dl."</p> <p>*7:58 a.m., "Mylanta given and was ineffective. Resident said her stomach still hurts."</p> <p>*9:30 a.m., "Called daughter. Phone was off and message was left with details regarding what had happened. Informed that she was sent to emergency room and gave phone number to emergency room in the message. Encourage her</p>	F 309			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106		
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F 309	<p>Continued From page 75 to call with any questions." *10:32 a.m., "Resident vomited two times. About one minute later she had what appeared to be a small seizure and her eyes rolled back in her head. I shook her and did a sternal rub with no response. At that time I yelled for help and got the crash cart. Another nurse called 911. I initiated cardiac pulmonary resuscitation (CPR) and used the Ambu-bag (hand-held device that provides ventilation [breathing] to patients who are not breathing or not breathing adequately). After about 2 to 3 minutes her pulse came back and she started breathing again. Blood pressure 288/44. Emergency medical technician (EMT) arrived and transported her to hospital. Resident has a history of hypokalemia (low potassium), hypertension (high blood pressure), hypotension (low blood pressure), atrial fibrillation (irregular heart rate), and bradycardia (slow pulse).</p> <p>Review of resident 18's blood sugar monitoring log revealed no documentation her blood sugar was checked from 2/14/14 at 6:08 p.m. until 2/15/14 at 7:09 a.m.</p> <p>Review of resident 18's vital sign monitoring log revealed no documentation her blood pressure had been checked from 2/14/14 at 11:22 a.m. until her unresponsive episode on 2/15/14.</p> <p>Review of resident 18's 2/14/14 medication administration record (MAR) revealed she had received the following medications at 8:00 a.m. not ordered by her physician: *Glipizide and Meformin (blood sugar lowering medications). *Lisinopril 20.5 milligrams (mg). *Lopidogel (blood thinning medication). *Citalopram (antidepressant medication).</p>	F 309		

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106		
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F 309	<p>Continued From page 76</p> <p>*Colace (stool softner).</p> <p>Review of resident 18's 2/14/14, 8:00 a.m. MAR revealed she had received her following scheduled medications:</p> <p>*Sitagliptin (blood sugar lowering medication).</p> <p>*Furosemide (medication for fluid retention).</p> <p>*The physician ordered to hold her scheduled Lisinopril 2.5 mg.</p> <p>*Coumadin (blood thinning medication) at 9:00 p.m. on 2/13/14.</p> <p>*Sertraline (antidepressant medication).</p> <p>Review of resident 18's 2/15/14 hospital history and physical revealed:</p> <p>***"Patient had a hypoglycemic episode this morning with blood sugar reportedly at 29 mg/dl. Staff did follow protocol and treat the hypoglycemia, although I have no documentation."</p> <p>***"The patient did become unresponsive and was thought to have a syncope (fainting) episode being lowered to the ground."</p> <p>***"Unsure of the exact time frame that the patient was unresponsive. However, the staff became alarmed and did chest compressions, although reportedly there is no indication that the patient had no pulse or was not breathing on her own."</p> <p>***"Resident did receive 8 times her scheduled dose of lisinopril on 2/14/14."</p> <p>***"Syncope episode. Question if related to recent diarrhea and volume depletion. This along with poor intake and possible administration of blood pressure medications that were not prescribed."</p> <p>***"Diabetes type 2 with hypoglycemic episode this morning. This is likely secondary to poor oral intake as well as medication error."</p> <p>Interview on 3/25/14 at 3:45 p.m. with the DNS</p>	F 309		

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS			STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106		
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F 309	<p>Continued From page 77</p> <p>regarding resident 18 revealed:</p> <p>*She confirmed a new nurse had administered the above medications at 8:00 a.m. on 2/14/14.</p> <p>*The resident had become unresponsive and coded (without heartbeat or breathing) on 2/15/14. The hospital had told her the additional medications she had received on 2/14/14 had nothing to do with her coding. The nurses on duty had revived the resident, and she had been transported to the hospital.</p> <p>*The resident's blood sugar had been checked on 2/14/14 at 6:08 p.m. and had improved after the administration of the Glucagon.</p> <p>*The nurse had not rechecked her blood sugar during the night, as she was not having any symptoms of low blood sugar.</p> <p>*She felt the nurses used their professional judgement.</p> <p>*She had spoken to the nurse on 2/15/14 regarding her documentation not being done according to the actual times that events had occurred.</p> <p>*She assumed the resident had become unresponsive and coded between 8:30 a.m. to 8:45 a.m. on 2/15/14.</p> <p>*The nurse on duty 2/15/14 had not documented the resident had eaten any breakfast and should have. The certified nursing assistants documented on the food tracker she had consumed 50 percent (%) of her breakfast meal.</p> <p>*The resident was transported back from the hospital on 2/20/14 to receive comfort care.</p> <p>Surveyor: 32335</p> <p>D. Based on record review, interview, and policy review, the provider failed to provide specialized training to three of four staff (H, I, and J) who performed dialysis (procedure to filter wastes from the blood) for one of one resident (16) on</p>	F 309			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 309	<p>Continued From page 78</p> <p>peritoneal (tissue that lines the abdomen) dialysis. Findings include:</p> <p>1. Interview on 3/24/14 at 2:00 p.m. with the DNS revealed RN H, J, and V had performed the peritoneal dialysis on resident 16 since he had been admitted on 1/27/14. The contracted dialysis center had provided a training to all her staff on 12/30/13 prior to resident 16 moving into the facility.</p> <p>Interview on 3/25/14 at 8:30 a.m. with RN I revealed he had assisted in turning off the dialysis that morning for resident 16. He had not attended the peritoneal dialysis training on 12/30/13. He had training over a year ago from a different provider.</p> <p>After three requests the training sign-in sheet was provided to this surveyor on 3/25/14. Review of the 12/30/13 peritoneal dialysis training sign-in sheet revealed only RN V had attended the training.</p> <p>Interview on 3/25/14 at 10:20 a.m. with an RN from the contracted dialysis center regarding resident 16 and the peritoneal dialysis training revealed they had provided a training on 12/30/13 to the provider's staff. They had kept a "signed validation" for each staff member that had gone through the training. The provider was given a copy of the list. The "validation" or training included an overview of dialysis expectations, tips on when to call, and hands-on experience. Their expectation was that every staff member who had performed dialysis for resident 16 would have received the training they had provided. That was so staff would follow their expectations, and the dialysis center would know the staff had been</p>	F 309		

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 309	Continued From page 79 trained according to their procedures. If the provider had new staff that started they would have expected to be contacted and would have provided another training. At a minimum they would have provided annual training. Interview on 3/25/14 at 2:00 p.m. and at 3:20 p.m. with the DNS revealed RN H had been working the night resident 16 had been admitted. Staff from the contracted dialysis center had come in and showed her how to perform the dialysis. The DNS contacted the dialysis center, and they stated that would not have been considered validation training. RN I had not attended the 12/30/13 training but had training through another dialysis center. The DNS was unable to locate a certificate or the date on when he would have completed it. RN J had not been in attendance at the training, and the DNS was unable to verify any training had been provided to her on performing peritoneal dialysis.	F 309			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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	F 314			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
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F 314	<p>Continued From page 80 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, record review, and policy review, the provider failed to ensure one of three sampled residents (2) remained free from provider-acquired pressure ulcers (injuries to skin and underlying tissues). Findings include:</p> <p>1. Review of resident 2's medical record revealed: *An admit date of 4/26/08. *Diagnoses of peripheral vascular disease (problem with circulation in veins), diabetes mellitus (inability to control sugar levels in the blood), psychosis (loss of contact with reality), depression (feelings of hopelessness), anxiety, pain in joint, pressure ulcer to the left heel, and glaucoma (poor eyesight). *She was out of the facility on Tuesdays, Thursdays, and Saturdays for dialysis (procedure to filter wastes from the blood). *On 10/12/13 she had been sent to the emergency room (ER) for evaluation of her left foot for increase complaints of pain. *From the ER she had been given the following diagnoses of "bilateral leg pain, contusion of the left foot, hematoma of the left heel and an insufficiency/sub-acute fracture of the right foot. Staff were to continue pain management and 'air cast' until orthopedic physician assesses on 10/22/13." *She had acquired a stage II pressure ulcer (fluid filled blisters) on her left heel on 10/17/13. That stage II pressure ulcer progressed to an</p>	F 314	<p>F314 TREATMENT AND SERVICES TO PREVENT/HEAL PRESSURE SORES</p> <p>1. Upon discovery, staff provided an air mattress to Resident #2. Skin assessments will be completed on all current residents to identify any skin concerns by 4-19-14. 2. All residents have the potential to be affected. 3. The Director of Nursing Services and Interdisciplinary Team reviewed the provider's policy and procedure about pressure ulcers to include skin assessment, screening, developing a care plan, implementing interventions, monitoring treatment and prevention on 4-10-14. All staff will be educated on the facility's pressure ulcer policy and procedure to include skin assessment, repositioning, screening, developing a care plan, implementing interventions, monitoring treatment and prevention as well as a review of all provider acquired pressure ulcers by 4-18-14. 4. The Director of Nursing Services or designee will randomly audit 5 residents to ensure appropriate interventions are in place to promote healing and prevent new sores from developing, full skin assessment completed within 24 hours of admission and weekly thereafter, and care plan addresses current interventions weekly x 4 and monthly x 3. The Director of Nursing Services or designee will report results of audits to the monthly Quality Assurance and Assessment Committee for further review and recommendations.</p>	5. 4-22-14	

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 314	<p>Continued From page 81</p> <p>unstageable (unable to determine the depth of the tissue injury) pressure ulcer on 10/31/13. *She had been followed by a wound clinic provider. *She had acquired an open area to her coccyx (bony area of the buttocks) on 3/17/14. The area had measured 2 centimeters (cm) by 0.3 cm. *She had been dependent upon staff to assist her with her all of her mobility (transfers and moving in bed) and activities of daily living (ADL) needs.</p> <p>Random observations on 3/18/14 from 2:30 p.m. through 5:30 p.m. of resident 2 revealed: *She had returned from dialysis after dinner and was laid down to rest. *From 2:30 p.m. through 5:30 p.m. she was lying on her bed on her back. *She had been wearing pressure relieving boots to both feet. *No special devices had been visualized on her bed to assist with pressure relieving measures, floating of her heels, or repositioning. *No staff members had been observed attempting to reposition her during that time frame.</p> <p>Random observations on 3/19/14 from 2:30 p.m. through 6:00 p.m. of resident 2 revealed she had been resting in bed and lying on her back. She had been wearing pressure relieving boots to both feet. No staff members had been observed attempting to reposition her during that time frame. She continued to have no special devices in her bed to assist with pressure relieving measures, floating of her heels, or repositioning.</p> <p>Review of resident 2's medication and treatment administration records for October 2013 revealed no documentation the staff had removed her air</p>	F 314			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
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F 314	<p>Continued From page 82 cast to check for skin breakdown.</p> <p>Review of resident 2's nursing progress notes from 10/12/13 through 10/31/13 revealed no documentation: *To indicate her air cast boot had been removed for skin assessments. *To support the staff had repositioned her every two hours or floated her heels.</p> <p>Review of resident 2's progress notes from 10/25/13 through 3/29/14 by registered nurse (RN) B revealed: *She was to wear Prevalon heel boots (pressure relieving) at all times. *She had been unable to make independent positional changes on her own. *She had been dependent on staff to assist her with mobility changes. *She was to have been assisted with repositioning every two hours and PRN (whenever necessary).</p> <p>Interview on 3/19/14 at 12:00 noon with RN B revealed: *She was the provider's wound nurse. *She had been responsible for the assessing and weekly charting on all wounds. *All mattresses in the facility had been pressure relieving. *She had confirmed resident 2's left heel pressure ulcer and open area to the coccyx had been acquired in the facility. *Resident 2 was ordered a walking boot in October 2013. *The left heel pressure ulcer had originated from that boot. *She was not sure if the boot had been worn at all times.</p>	F 314		

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS			STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106		
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F 314	<p>Continued From page 83</p> <p>Review of resident 2's 3/7/14 annual Minimum Data Set assessment revealed she had been at risk for pressure ulcers and had required assistance with bed mobility.</p> <p>Review of resident 2's 3/10/14 care plan revealed: *A pressure ulcer at risk focus area. *No interventions to support she should have been repositioned every two hours or had her heels floated while in bed.</p> <p>Interview on 3/20/14 at 2:10 p.m. with licensed practical nurse U revealed: *She had worked twelve hour shifts. *She would have checked the residents for repositioning four times during her shift. She would not have been able to check on them more frequently. *She could not guarantee the staff had been repositioning the residents every two hours. *The staff had not documented repositioning.</p> <p>Interview on 3/25/14 at 2:45 p.m. with RN L revealed: *All residents were to have been repositioned every two hours. *The staff would not have repositioned those residents who had the capability to reposition themselves. *The provider had a report document for staff use only. That staff document would have indicated how often the resident should have been repositioned. *That information had not been found on the care plan. She agreed that information should have been put into the care plan. *There had been no document for review to</p>	F 314			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 314	<p>Continued From page 84</p> <p>ensure the staff had been repositioning the residents every two hours.</p> <p>Interview on 3/25/14 at 8:15 a.m. with the director of nursing services (DNS) confirmed: *Residents were to have been repositioned every two hours. *There had been no documents to support the staff had repositioned the residents every two hours. *The provider had a working document the staff had been provided with everyday for charting purposes. *Those documents had not been saved and were shredded. *She would have expected heels to be floated. *She would have expected to see heels floated and repositioned as an intervention on the care plan.</p> <p>Review of the provider's 8/30/11 Wound Nurse job description revealed: *She should "Communicate to the DNS/administrator/charge nurse/certified nursing assistant on new skin conditions and changes in skin conditions for the inclusion in the resident's plan of care." *"Consult with other professionals as directed by the DNS when indicated to determine appropriate treatment and plan of care."</p> <p>Review of the provider's revised 2013 Skin Integrity Guideline policy revealed: *Purpose: "To decrease pressure ulcer formation by identifying those residents who are at risk and developing interventions." *Objective: -"Decrease the prevalence and incidence of residents that develop pressure ulcers."</p>	F 314			

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F 314	Continued From page 85 -"Provide guideline for optimal care to promote healing to residents with all identified alterations in skin integrity." *General guidelines: "The interdisciplinary plan of care will address problems, goals, and interventions directed toward prevention of pressure ulcers and/or skin integrity concerns identified." **"The interventions will be documented in the immediate plan of care or comprehensive care plan." **"Pressure redistribution mattresses are in place." **"If there is decline in skin integrity pressure redistribution surfaces will be reviewed for appropriateness." **"Initiate positioning schedule to meet individual resident needs and minimize concentrated pressure to skin." **"Positioning devices such as pillows or foam wedges are recommended to keep bony prominences from direct contact with one another." **"Determine care plans consistently implemented, evaluated, and revised based on the needs of the resident."	F 314			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 86</p> <p>by: Surveyor: 32355</p> <p>Based on observation, interview, and policy review, the provider failed to ensure:</p> <ul style="list-style-type: none"> *One of twelve observed resident rooms (401) telephone jack was covered. *Two of five observed clean utility rooms (100 and 400 wing) light fixtures had covers over the bulbs. *One of two observed arm supports attached to the toilet (room 407) was kept in good condition/repair. *One of two observed arm supports attached to the toilet (room 413) was securely attached to the toilet. *Chemicals were stored appropriately in multiple areas of the facility (bathing rooms, residents' rooms, therapy room, and hallways). *The beauty shop seat cover on the chair was kept in good condition/repair. *One of four observed resident's siderail covers (room 409) was kept in good condition/repair. *Molding on multiple resident-use doors had been attached and secured. <p>Findings include:</p> <p>1. Observation on 3/17/14 at 6:30 p.m. of resident room 401 revealed a phone jack located behind the resident's bed. The phone jack had no plate cover attached to it. That had left an area of exposed wires/cords.</p> <p>2a. Observation on 3/17/14 at 7:00 p.m. of the clean utility room on the 400 wing revealed no light fixture cover over the bulbs. The light bulbs had not been shatterproof. The room contained multiple resident-use items. Those items were:</p> <ul style="list-style-type: none"> *Bed pans. *An over-the-bed table containing gowns, disposable incontinent briefs, and towels. 	F 323	<p>F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/ DEVICES</p> <p>1. A plate was placed on the phone jack in room 401 4-17-14. Covers were placed on the light bulbs in the 100 and 400 utility rooms on 3-27-14. The arm support was replaced on the toilet in room 407 on 3-27-14. The arm support was secured to the toilet in room 413 on 3-27-14. Chemicals from the bathing rooms, resident rooms, therapy room and hallways were removed and placed in proper storage on 4-11-14. A new beauty shop chair was ordered on 4-1-14. The side rail covers in room 409A were replaced on 4-9-14. InPro Corporation was contacted on 4-15-14 to assess all doors for needed repairs and is scheduled to come on the soonest available date, which is 4-24-14.</p> <p>2. All residents have the potential to be affected.</p> <p>3. Administrator, Director of Nursing and interdisciplinary team reviewed the provider's policy and procedure about recognizing the addressing accident/hazards on 4-11-14. The Director of Nursing Services or designee will re educate all staff regarding the policy and procedure about recognizing and addressing accidents/hazards, chemicals storage by 4-18-14.</p> <p>4. The Director of Nursing Services or designee will randomly audit 5 halls for chemicals stored appropriately, arm supports on toilets are secured and in good condition, cover on beauty shop chair in good condition, side rail covers are free from crack and tears, 5 rooms or utility rooms to ensure light bulbs are properly covered, plates on phone jacks are in place and door molding is in good repair weekly x 4 and monthly x 3 to ensure compliance. The Director of Nursing Services or designee will report results of audits to the monthly Quality Assurance and Assessment Committee (QAPI) for further review and recommendations.</p>	5. 4-22-14	

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
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F 323	<p>Continued From page 87</p> <p>*Multiple open boxes containing depend products, rolls of toilet paper, and biohazardous bags.</p> <p>*Plastic graduates (containers) used for measuring urine output or water (photos 1 and 9).</p> <p>b. Observation on 3/20/14 at 8:40 a.m. of the clean utility room on the 100 wing revealed no light fixture cover over the bulbs. The light bulbs had not been shatterproof. The room contained multiple resident use items. Those items were towels, gowns, wheelchair cushions, and disposable incontinent briefs.</p> <p>3a. Observation on 3/17/14 at 7:15 p.m. of resident room 407's bathroom revealed arm supports attached to the toilet. One of the arm supports had been broken creating a large hole with cracked and split areas. Those areas were located in places where residents could have received skin tears or cut their arms and hands (photo 2).</p> <p>b. Observation on 3/20/14 at 3:00 p.m. of resident room 413's bathroom revealed arm supports attached to the toilet. Those arm supports had been loose and were easily moved apart by this surveyor. Resident 27 had resided in that room and was independent with toileting. Those loose arm supports had created a risk of falls for him.</p> <p>4. Random observations from 3/17/14 through 3/20/14 revealed multiple areas in the facility where chemicals were not stored or secured properly and had created the potential for harm. Those areas and chemicals had been: *A plastic tub of Clorox germicidal wipes was stored directly next to an open container of disposable incontinent briefs in an unlocked</p>	F 323			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 88</p> <p>cupboard in the 200 wing bathing room (photo 3). The label had indicated to keep them out of the reach of children.</p> <p>*Plastic tubs of Micro-kill wipes were stored on the 100, 300, and 400 hallway wing handrails. Those wipes had been located next to resident rooms 103, 301, and 404.</p> <p>*A plastic tub of Micro-kill wipes was stored in resident room 414. Those wipes had been stored in the sink area of the room. They were stored directly next to lotions, hair products, deodorant, toothpaste, and toothbrushes.</p> <p>*A spray bottle of Cen Kleen disinfectant cleaner was stored on a shelf in the resident bathing rooms of the 400 and 500 wings. The bathing room doors had been left open. There had been several unidentified residents observed passing by those rooms. One unidentified resident had been observed entering the 400 wing bathing room to use the bathroom.</p> <p>*Two bottles of A 456II disinfectant cleaner and one tub of Micro-kill wipes were stored in an unlocked cupboard in the 500 wing resident bathing room. The door had been left open. There had been several unidentified residents observed passing that room.</p> <p>5a. Observation on 3/18/14 at 10:10 a.m. of the therapy room revealed: *A kitchen area with several cupboards and one above the sink area. *The cupboard above the sink had been unlocked and contained one spray bottle of Quaternary disinfectant cleaner. *The Quaternary disinfectant cleaner had been stored by several drinking glasses and measuring cups (photo 4).</p> <p>b. A plastic tub of Micro-kill wipes had been sitting</p>	F 323			

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 323	<p>Continued From page 89</p> <p>on the counter by several baking pans in the kitchen area.</p> <p>*The Micro-kill wipes label revealed they were to be kept out of the reach of children (photo 5).</p> <p>c. Interview on 3/18/14 at the time of the above observations with occupational therapist E revealed:</p> <p>*The kitchen area had been used by the residents for education before returning to their home.</p> <p>*The Quaternary disinfectant cleaner and Micro-kill wipes had been used for disinfecting purposes.</p> <p>*She had not realized the disinfectant products should not have been located by resident-use items.</p> <p>Interview on 3/20/14 at 4:47 p.m. with the director of rehabilitation revealed all chemicals should not have been stored with cooking items. Those chemicals should have been placed in a secured/locked area.</p> <p>Review of the provider's 12/26/12 Department Cleaning and Maintenance Schedule for the rehabilitation department revealed:</p> <p>***The rehab (rehabilitation) department equipment will be maintained in an orderly, clean, and safe condition at all times."</p> <p>***Equipment will be checked, sanitized, and maintained according to its specific properties and manufacturer's recommendations."</p> <p>***Equipment will be cleaned on a monthly basis unless required more frequently."</p> <p>*The Hydrocollator will be emptied and cleaned every two weeks.</p> <p>*The rehabilitation department is to coordinate with housekeeping for cleaning of the kitchen appliances.</p>	F 323		

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 90</p> <p>The provider had been unable to provide a policy and procedure for the proper storage and securing of chemicals.</p> <p>6. Observation on 3/20/14 at 8:32 a.m. of the beauty shop chair revealed several holes, and cracked and split areas on the seating area. Those areas were located in places where residents could have received skin tears or cuts to their lower extremities and bottom (photo 8).</p> <p>7. Observation on 3/17/14 at 7:20 p.m. of resident room 409 revealed both beds had siderail protector cushions attached to them. One of the cushions attached to bed a revealed several cracked and split areas. Those areas had left an uncleanable surface and the potential for cuts and skin tears to the resident's lower extremities (photo 13).</p> <p>8. Random observations from 3/17/14 through 3/20/14 revealed multiple doors into the residents' rooms had attached molding to the bottom of them. The molding had been detached or was missing in several areas. Those detached areas were sharp and jagged (photo 14).</p> <p>9. Interview on 3/25/14 from 1:10 p.m. through 1:40 p.m. during an environmental walk through with the maintenance director, administrator, and housekeeping director revealed they had not been aware of all the above areas of concern. They confirmed the above areas had been unsafe practices.</p> <p>Review of the provider's 8/30/11 Maintenance Supervisor Job Description policy revealed: ***Ensure the building(s), equipment and utilities</p>	F 323		

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 323	Continued From page 91 are maintained in good working order and facility grounds are properly maintained in accordance with facility policies and state and Federal Regulations." **"Perform minor repairs and supervise the day-to-day repairs, improvement and preventative maintenance of the building." **"Ensure equipment and work areas are clean, safe and orderly; and strict adherence to procedures regarding cleaners or hazardous material or objects; ensure Universal Precautions and infection control, isolation, fire, safety and sanitation practices and procedures are followed; and promptly address any hazardous conditions and equipment."	F 323			
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review and interview, the provider failed to monitor and document fluid intake for one of one sampled resident (18) who was dehydrated (had inadequate fluid intake). Findings include: 1. Review of resident 18's 1/8/14 through 3/18/14 medical record revealed: *A 1/8/14 admission date. *Admission diagnoses: -Senile dementia (memory loss) with delirium (acute confusional episode).	F 327			

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F 327	<p>Continued From page 92</p> <ul style="list-style-type: none"> -Depressive disorder. -Dehydration (inadequate fluid intake). -Diarrhea (loose bowel movements). -Mild cognitive (memory) impairment. <p>*She was hospitalized:</p> <ul style="list-style-type: none"> -1/15/14 through 1/31/14 for abdominal pain and dehydration. -2/5/14 through 2/8/14 for gastroenteritis (nausea and vomiting) and dehydration. -2/15/14 through 2/20/14 for syncopal (unresponsive episode), diarrhea, poor oral intake, and possible administration of blood pressure medications that had not been prescribed for her. <p>Interview on 3/25/14 at 4:00 p.m. with the director of nursing services (DNS) regarding resident 18 revealed:</p> <ul style="list-style-type: none"> *She confirmed the resident had recurrent dehydration and diarrhea. *They would not keep track of fluid intake unless it was a specific physician's order. The nurses would not initiate fluid monitoring without a physician's order. *They had not felt it was necessary to check with the physician to obtain an order to monitor intake related to her recurrent dehydration. *They monitored what she ate and drank but had not documented any of her fluid intake. <p>Surveyor: 32331</p> <p>Interview on 3/26/14 at 8:20 a.m. with the certified dietary manager revealed nursing was responsible for fluid intake monitoring of all residents who received fluids.</p> <p>Interview on 3/26/14 at 8:25 a.m. with certified nursing assistant K revealed:</p> <ul style="list-style-type: none"> *The Care Tracker was used to document meal and snack intakes. 	F 327	<p>F327 SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <ol style="list-style-type: none"> 1. Resident #18 no longer resides at the Living Center no immediate action can be taken. Facility will monitor all residents at risk for dehydration weekly during the Nutrition/Wound risk meeting. 2. All residents have the potential to be affected. 3. The Director of Nursing Services or designee will educate all staff regarding providing each resident with sufficient fluid intake to maintain proper hydration and health and documentation as necessary by 4-18-14. 4. The Director of Nursing Services or designee will audit 5 residents medical record with a diagnosis of dehydration for Intake & Output for at least one week, unless otherwise ordered by the physician and corresponding documentation of Intake & Output weekly x 4 and monthly x 3. The Director of Nursing Services or designee will report results of audits to the monthly Quality Assurance and Assessment Committee (QAPI) for further review and recommendations. 	5. 4-22-14

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

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F 327	<p>Continued From page 93</p> <p>*Coding meals was done in percentages of twenty-five percent (%) intervals or 0%, 25%, 50%, 75%, 100% for the whole meal.</p> <p>*That coding had included the fluids taken in during the meals.</p> <p>*She had coded the fluids as part of the total % of the meal (foods plus fluids) in the Care Tracker.</p> <p>*She stated the licensed nurses were the only ones that could document an I and O (intake and output monitoring for residents with specific physician's orders for measurement) of fluids and other specific fluid amounts for residents.</p> <p>Interview on 3/26/14 at 8:45 a.m. with registered nurse B regarding how the provider recorded fluids consumed by residents revealed:</p> <p>*The Care Tracker was used to document meal and snack intakes.</p> <p>*Coding meals was done in percentages of twenty-five % intervals or 0%, 25%, 50%, 75%, 100% for the whole meal.</p> <p>*That coding had not included the fluids taken in during the meals.</p> <p>*She had not coded the fluids as part of the total % of the meal in the Care Tracker.</p> <p>*She coded the specific fluid amounts in cc (cubic centimeters) if there had been an order for an I or O, a fluid restriction, or a tube feeding.</p> <p>*She would not have coded the fluid intakes in cc unless there was a specific order for fluid monitoring.</p> <p>Interview on 3/26/14 at 10:15 a.m. with the DNS and the registered dietitian regarding how the provider recorded fluids consumed by residents revealed:</p> <p>*If there was not a physician's order the specific amount of fluids would not have been monitored.</p> <p>*The Care Tracker was used to document meal</p>	F 327			

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

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F 327	<p>Continued From page 94</p> <p>and snack intakes which included nutritious fluid intakes.</p> <p>*For residents with a diagnosis of dehydration, specific fluid amounts were not being monitored.</p> <p>*They both agreed adding hydration monitoring to the nutrition risk committee for those residents at hydration risk would be a good idea, especially for those with a diagnosis of dehydration.</p> <p>Review of the provider's 2011 Hydration Program (Dining Services) policy revealed the dining services department provided fluids needed by the nursing department to support an ongoing hydration program that included:</p> <p>*Water, tea, and flavored beverages for hydration.</p> <p>*Water with medication pass supplies.</p> <p>*Ice water on room trays or table settings at each meal unless contraindicated by physician order.</p> <p>*Additional floor stock beverages.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, p. 887, revealed:</p> <p>*Dehydration occurred when there was a fluid imbalance and fluid intake had not been increased.</p> <p>*Clinical dehydration occurred when residents were not able to replace their fluid output with enough fluid intake.</p>	F 327		
F 329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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</p>	F 329		

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

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F 329	<p>Continued From page 95</p> <p>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.</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: 32355 Based on observation, record review, interview, and policy review, the provider failed to ensure psychotropic (mood-altering medication) medication use for one of seven residents (2) had been monitored for effectiveness. Findings include:</p> <p>1. Observation on 3/17/14 from 7:15 p.m. to 7:30 p.m. of resident 2 revealed: *Two unidentified staff members had entered her room and shut the door. *Through the closed door this surveyor heard her screaming out repeatedly for them to "stop, stop it," "you're hurting me," "call the police," "I need a pain pill," and "take me to the hospital."</p>	F 329	<p>F329 DRUGS REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <ol style="list-style-type: none"> 1. Resident #2 no longer resides at the Living Center no immediate correction could be taken. 2. All residents utilizing psychotropic medications have the potential to be affected. 3. The Director of Nursing Services will educate all Licensed nursing staff and social services staff regarding residents who receive a psychotropic medication will be identified and monitored for effectiveness through the facility Quality of Care meeting process by 4-18-14. 4. The Director of Nursing Services or designee will randomly audit 5 residents receiving psychotropic medications for appropriate documentation regarding effectiveness, corresponding diagnosis, all PRN medications have specified indications for use, care plan addresses possible side effects and addresses target behaviors to monitor for when receiving psychotropic medications and the care plan addresses the use of non pharmacological interventions weekly x 4 and monthly x 3. The Director of Nursing Services or designee will report results of audits to the monthly Quality Assurance and Assessment Committee (QAPI) for further review and recommendations. 	5. 4-22-14	

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F 329	<p>Continued From page 96</p> <p>Observation on 3/17/14 from 7:35 p.m. through 7:45 p.m. of resident 2 revealed: *She had been laying in her bed rocking her body back and forth. *She screamed out "stop the pain, stop the pain, I need a pain pill, call the police you broke my legs," "I hurt," and "I am in so much pain." *She had been continuously clawing through her hair with her fingers and clenching her teeth together during the entire observation . *Her eyes were wide open and focused straight ahead. *She yelled at this surveyor to "get me a pain pill."</p> <p>Interview on 3/17/14 at 7:45 p.m. with licensed practical nurse (LPN) A regarding the above observations revealed resident 2: *Had an unstageable pressure ulcer (wound) to her left heel. She had acquired the pressure ulcer while in the provider's care. *Hollered out frequently with complaints of pain. *Had a history of inappropriate behaviors with assistance in activities of daily living (ADL) and hollered out frequently. *Took Xanax (medication for anxiety) twice a day for anxiety and could have Norco (pain medication) as needed for pain. *Had been started on a pain patch in February. *Had not been experiencing relief from any of the medications listed above for her anxiety or pain.</p> <p>Observation on 3/20/14 from 9:10 a.m. through 9:35 a.m. regarding resident 2 revealed: *She had refused to get out of bed and go to dialysis. *She had refused care from the staff. *The provider had called her son to visit with her in regards to going to dialysis.</p>	F 329		

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
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F 329	<p>Continued From page 97</p> <p>*This surveyor had been sitting in the dining room of the 400 and 500 wings and could hear her yelling from her room on the 400 wing approximately 300 feet away.</p> <p>*She had been yelling and cussing at her son to "get the (swear word) out of here," "you don't understand (swear word)," "Oh my (swear word), oh my (swear word)," and "Leave me alone."</p> <p>*When she had left facility at 9:35 a.m. she was heard cussing and swearing at her son all the way down the corridor.</p> <p>Review of resident 2's medical record revealed: *An admit date of 4/26/08. *Diagnoses of peripheral vascular disease (problem with circulation in veins), diabetes mellitus (inability to control sugar levels in the blood), psychosis (loss of contact with reality), depression (feelings of hopelessness), anxiety, pain in joint, pressure ulcer (wound) to the left heel, and glaucoma (poor eyesight). *She was out of the facility on Tuesdays, Thursdays, and Saturdays for dialysis (procedure to filter wastes from the blood). *On 9/30/13 the physician had ordered Xanax 0.5 milligrams (mg) to be given in the morning and 1.0 mg to be given at bedtime. *She had a history of refusing her medications. *She had a long standing history of inappropriate verbal and physical behaviors. *She had been dependent upon staff to assist her with all of her ADLs.</p> <p>Review of resident 2's behavioral charting log from 2/21/14 through 3/17/14 revealed she had: *Frequently screamed at the staff. *Threatened the staff. *Scratched the staff. *Made disruptive and excessive noises. The</p>	F 329		

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 329	<p>Continued From page 98</p> <p>charge nurse had been informed of those behaviors several times.</p> <p>Review of resident 2's Quality of Care Meeting notes on 11/4/12, 1/17/14, and 2/17/14 revealed she had:</p> <ul style="list-style-type: none"> *Felt bad about herself *Been short tempered with inappropriate verbal behaviors. *Physical behaviors with rejection of cares. *A diagnosis of anxiety and had been taking alprazolam (Xanax) (medication for anxiety). *No documentation to indicate the alprazolam had been effective for her behaviors. <p>Review of resident 2's nursing progress notes from 10/1/13 through 3/17/14 confirmed she still continued to frequently have the above mentioned behaviors. No documentation had been found the alprazolam had been effective for her behaviors.</p> <p>Review of resident 2's nursing progress notes on 3/18/14 at 6:03 p.m. revealed "Nurse from dialysis called this AM to talk with this writer about patients behaviors at dialysis today. She indicates that she was given Ativan (anxiety medication) prior to her run and was given another dose prior to the end of her run due to increased agitation. She indicates that patient was cussing and swearing, patient got upset and pulled dialysis needles out of her arm."</p> <p>Review of resident 2's annual Minimum Data Set assessment dated 3/7/14 revealed the resident continued to exhibit inappropriate verbal and physical behaviors.</p> <p>Review of resident 2's pharmacy consultant</p>	F 329		

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 329	Continued From page 99 recommendation reports dated 8/3/13 through 3/20/14 revealed the use or effectiveness of the alprazolam on her behaviors had not been mentioned. The physician had refused a pharmacy recommendation to review her Xanax on 11/7/13. No changes had been made by the physician for a dose reduction or medication change. Interview on 3/19/14 at 12:00 noon with registered nurse B revealed resident 2 had a history of yelling out with inappropriate behaviors. Interview on 3/19/14 at 12:10 p.m. with the director of nursing services revealed: *Resident 2 had a long term history of cursing and yelling out. *The physician had been aware of her behaviors. *The alprazolam had not been effective all of the time. Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, p. 958, revealed the use of benzodiazepines (Xanax medication has been classified as a benzodiazepine, a category of medicines that help relive nervousness, tension, and other symptoms by slowing the central nervous system) in older adults has been potentially dangerous because of the tendency of the drug to remain active in the body for a longer time.	F 329			
F 371 SS=E	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	F 371			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
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F 371	<p>Continued From page 100 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, record review, and policy review, the provider failed to ensure sanitary conditions were maintained for: *Proper thawing of meats in a refrigerator in the kitchen. *Refrigeration units in six of six units in the kitchen, one of one unit in the therapy department, one of one unit in the rehabilitation unit, and one of one unit in the east dining room. *The sanitizing wiping cloths in the kitchen. *The floors in the dry goods storage room. Findings include:</p> <p>1. Observation on 3/17/14 from 6:15 p.m. through 6:45 p.m. in the kitchen revealed: *In the True three-door refrigerator there was a raw beef roast thawing on a large aluminum baking sheet with two packages of cooked ham puree laying on top of the roast. -There was visible blood on the baking sheet from the thawing raw beef roast. *The Glenco three-door freezer and the True three-door refrigerator had multiple built-up food particles on the bottom of the units and in the door gaskets. The handles were sticky with visible food residue. *The Raetone and the Frigidaire refrigerators had handles that were sticky with visible food residue.</p>	F 371	<p>F371 FOOD, PROCURE, STORE, PREPARE, SERVE SANITARY</p> <p>1. All Refrigeration units and storage area floors cleaned on 3-27-14. All leftovers were dated or discarded immediately, ice packs were placed in containers with lids on 3-25-14. Cleaning cloths were immediately placed in the sanitizing solution. The cooked ham and sausage puree were immediately disposed of on 3-19-14. 2. All residents have the potential to be affected. 3. The Dietary Manager and Registered Dietitian will review and revise as necessary the policy and procedure about maintain safe and sanitary conditions in the kitchen to include ServSafe. The Director of Dining Services or designee educated all dietary staff regarding the proper thawing of meats, refrigerator cleaning schedule, labeling and dating left over food, sanitation cloths need to be left in the sanitizing solution and changed after every meal as needed, ice packs to be stored in containers with lids and the cleaning schedule for storage area on 3-31-14. 4. The Director of Dining Services or designee will audit raw and cooked meats stored and/or thawed separately, common refrigerators clean, leftovers dated and labeled, ice packs not stored with resident food, wash cloths kept in sanitary solution when not in use, all storage areas clean, including floor weekly x 4 and monthly x 3. The Director of Dining Services or designee will report results of audits to the monthly Quality Assurance and Process Improvement (QAPI) for further review and recommendations.</p>	5. 4-22-14

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 371	<p>Continued From page 101</p> <p>*The Glenco one-door refrigerator unit had visible food residue on the bottom of the unit and food particles in the loose door gaskets.</p> <p>*The Traulsen two-door refrigerator unit's handles were sticky with visible food residue, and there was visible food residue on the bottom of the unit.</p> <p>*There were two wet cloths laying on the counter next to the food preparation sink, and one wet cloth laying on the counter of the two-compartment sink next to a blue pitcher and two green buckets.</p> <p>*The wet cloths were not in a sanitizing solution.</p> <p>*The floors under the shelving units in the dry goods storage area had many visible tan, black, and brown spots and debris.</p> <p>Observation on 3/18/14 at 10:20 a.m. in the kitchen revealed the same roast beef as the above thawing in the True refrigerator unit with one package of cooked sausage puree and one package of cooked ham puree laying on top of the roast.</p> <p>Observation on 3/18/14 at 11:08 a.m. in the kitchen revealed two wet cloths located on a three-tiered cart next to the steam table. The wet cloths were not in a sanitizing solution.</p> <p>2. Observation on 3/18/14 at 11:43 a.m. in the east dining room in the refrigerator unit revealed an opened package of Cervelat (a luncheon meat) dated 3/10/14. There was a typed sign on the same refrigerator door with "72 hours window if perishable items."</p> <p>3. Observation on 3/18/14 at 3:45 p.m. in the rehabilitation residents' refrigerator unit revealed one Polar Pack ice pack in the freezer next to two pizzas and two ice cream cups. There was one</p>	F 371		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 371	<p>Continued From page 102 unlabeled Styrofoam cup that contained a yellow product.</p> <p>4. Observation on 3/18/14 at 5:25 p.m. in the therapy refrigerator unit revealed: *Eight Colpacs, two Polar Packs, and four Nordic Ice packs located in the same freezer as an opened, undated package of sausage, a package of vegetables, an opened, undated package of bacon, a container of blueberry cobbler, and an open bin of ice cubes. *A bottle of salad dressing with an expiration date of August 2013. *Two opened undated containers of butter.</p> <p>Interview on 3/18/13 at 5:30 p.m. with the certified dietary manager (CDM) regarding the ice packs in the rehabilitation and therapy refrigerators revealed: *The ice packs were not used by dietary. *He had thought they were used for resident care.</p> <p>Interview on 3/19/14 at 8:00 a.m. with occupational therapist Q and physical therapist R regarding the therapy refrigerator unit revealed: *The cold packs were used for resident care, and the foods located in the same area were foods used for cooking with residents. *Residents often consumed what they had cooked. *They agreed the resident care items should not have been stored with the residents' food.</p> <p>Interview on 3/19/14 at 11:45 a.m. with registered nurse P regarding the therapy refrigerator unit's ice pack revealed the ice pack had been used by therapy for resident care. She agreed the ice pack should not have been stored with resident food.</p>	F 371		

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 371	<p>Continued From page 103</p> <p>5. Interview on 3/20/14 at 4:10 p.m. with the CDM and the registered dietitian (RD) confirmed: *The thawing meat procedure needed to have been followed to prevent cross-contamination. *The door handles and refrigerator units in the kitchen should have been on a more frequent cleaning schedule. *The ice packs used for resident care should not have been stored next to residents' food items. *The wet cloths needed to have been in sanitizing solution when not in use. *The dry goods storage room should have been cleaned and without debris build-up.</p> <p>Interview on 3/25/14 at 3:00 p.m. with the RD revealed: *The therapy refrigerator unit should have been cleaned and monitored by therapy. *The rehabilitation and east dining room refrigerator units were to have been cleaned and monitored by the dietary department.</p> <p>Review of the provider's 2011 Cross-Contamination policy revealed: *Cross-contamination could have occurred when raw foods touched or dripped onto cooked foods. *Sanitizing cloths should have been kept in a clean sanitizing solution. *The cloths were to have been held in a sanitizing solution or changed after sanitizing areas.</p> <p>Review of the provider's undated Cleaning Reach-In Refrigerators and Freezers policy revealed: *The outside of the reach-in refrigerators and freezers were to have been washed thoroughly with warm water and detergent, making sure to have cleaned gaskets with warm water and</p>	F 371		

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

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OMB NO. 0938-0391

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F 371	<p>Continued From page 104 detergent. *The inside of the units were to have been thoroughly washed with warm water and detergent and rinsed with a sanitizing solution.</p> <p>Review of the provider's undated Weekly Cleaning Schedule revealed the reach-in refrigerator was to have been cleaned by the a.m. cook daily including the inside and gaskets.</p> <p>Review of the provider's 2011 Cleaning Storage Areas policy revealed the floors were to have been cleaned daily that included sweeping the complete floor, under shelving, and moving any items on wheels.</p> <p>Review of the provider's undated Daily Cleaning Schedule revealed the dry store room floor was to have been swept and mopped daily by the a.m. cook.</p> <p>Review of the provider's undated Storing Prepared Foods policy revealed: *Food or potentially hazardous food ingredients were to have been stored in a method to avoid cross-contamination. *Discard if not used within "use by" date.</p> <p>Review of the provider's undated Cold Food Storage policy revealed: *All opened containers should have the date opened to ensure the correct rotation. *Dairy products were to have been used by the manufacturer's use by date or seven days after sell by date. *Salad dressings were to have been used three months after opening. *Luncheon meats were to have been used by the manufacturer's use by date or seven days after</p>	F 371		

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 371	Continued From page 105 the sell by date.	F 371		
F 425 SS=E	<p>Review of the provider's undated Storage Times for Refrigerated Foods policy revealed storage times for luncheon meats in an opened package was three to five days.</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, interview, and policy review, the provider failed to ensure: *Non-controlled medications were destroyed or returned to the pharmacy in a timely manner in</p>	F 425	<p>F425 PHARMACEUTICAL SVS- ACCURATE PROCEDURES, RPH</p> <p>1. The non-controlled medications in med room 100, 200, 300, 400,500 and 600 were properly destroyed or returned to the pharmacy by 3-24-14. Audits of medication carts and medication rooms for appropriate disposal of expired medication were completed by 4-09-14. Refrigerator temperatures were immediately recorded for medication room 100/200 and 300/500.</p> <p>2. All residents have the potential to be affected.</p> <p>3. The Director of Nursing and Pharmacist consultant will review and revise as necessary the policy and procedure about ensuring appropriate security, storage and destruction of medications on 4-10-14. The Director of Nursing Services or designee will re educate all licensed nursing staff regarding, the policy and procedure about ensuring appropriate security, storage and destruction of medications by 4-18-14.</p> <p>4. The Director of Nursing Services or designee will randomly audit Medication carts for 5 residents for accurate labeling of medications and expired medications, the medication rooms for controlled medications stored according to policy, IV kits not expired, medications awaiting return to pharmacy or destruction are processed timely, and refrigerator temps completed daily weekly x 4 and monthly x 3. The Director of Nursing Services or designee will report results of audits to the monthly Quality Assurance and Process Improvement Committee (QAPI) for further review and recommendations.</p>	5. 4-22-14

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

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F 425	<p>Continued From page 106</p> <p>three of three medication rooms (100-200 wings), (300-500 wings), and (600 wings).</p> <p>*Beyond-use medications had been removed from four of six medication carts (100, 200, 300, and 500).</p> <p>*An intravenous (IV) kit with expired supplies had been returned to pharmacy.</p> <p>*Medication refrigerator temperatures had been monitored consistently in two of three medication rooms (100-200 wings and 300-500 wings).</p> <p>*Security of controlled (schedule IV and V) medications was maintained in two of three medication rooms (300-500 wings and 600 wing) and one of six medication carts (100 wing). Findings include:</p> <p>1. Observation on 3/20/14 from 2:05 p.m. through 4:30 p.m. of the 100 and 200, 300, 400, and 500, and 600 medication rooms revealed the following non-controlled medications for destruction or return to the pharmacy:</p> <p>*100 and 200 medication room: A three-tier metal cart contained numerous bottles of medication, medication cards, and tubes of ointment for various residents that either the medications had been discontinued or the residents had been discharged from the facility.</p> <p>*300, 400, and 500 medication room:</p> <p>-An IV plastic tub with an expiration date of 1/1/13 contained five bags of 0.9 percent (%) IV fluid that had expired in February 2013, July 2013 (2 bags), August 2013, and November 2013.</p> <p>-A large cardboard box under the handwashing sink contained numerous residents' bottles of medications, medication cards, and tubes of ointments. In the box was a bottle of zoldipem tartrate (schedule IV sleeping medication) 10 milligrams (mg) that contained twenty-one split in half tablets and twenty whole tablets.</p>	F 425		

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

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FORM APPROVED
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F 425	<p>Continued From page 107</p> <p>*600 medication room: -A three-tier cart and a long rectangle shaped table contained numerous residents' bottles of medications, medication cards, and tubes of ointments. A bottle of Lyrica (schedule V medication for pain) 50 mg, three capsules was lying on the three-tier cart. -Both sides of the counter with the handwashing sink in the middle contained numerous residents' bottles of medications, medication cards, and tubes of ointment. -Used IV bags and tubing was lying in the handwashing sink.</p> <p>2. Observation on 3/20/14 at 4:00 p.m. of the 100 wing medication cart revealed: *A bottle of clonazepam (schedule IV seizure medication) for resident 3 lying in the top drawer. *The bottle had been filled by the pharmacy on 1/14/14 with three pills. There were two pills that remained in the bottle.</p> <p>3. Interview on 3/20/14 at 4:30 p.m. with registered nurse (RN) L revealed: *All the bottles of medication, medication cards, and tubes of ointments were waiting to be destroyed or returned to the pharmacy. *RN T was responsible to destroy the medications or complete a return to the pharmacy sheet for the medications that could have been returned to the pharmacy for credit to the residents. *She thought RN T had gotten behind with the medication destruction or return to the pharmacy. *The zoldipem tartrate and the Lyrica should not have been intermingled with the non-controlled medications. The bottles should have been put in the locked box that contained scheduled medications and should have been destroyed by</p>	F 425		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS			STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106		
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F 425	<p>Continued From page 108 the pharmacist and a RN. *The bottle of clonazepam for resident 3 should have been in the locked box on the medication cart and counted every shift. *All scheduled medications were kept in the locked boxes on the medication carts and counted every shift.</p> <p>Interview on 3/20/14 at 4:35 p.m. with the director of nursing services (DNS) regarding the above revealed she: *Confirmed RN T was responsible to destroy the medications or return them to pharmacy if appropriate. RN T had other job duties and had gotten behind in the medication destruction. *Felt there was no problem with the build-up of medications since they were stored in secure medication rooms. *Confirmed the zoldipem tartrate and the Lyrica should have been put in the locked box that contained medications that should have been destroyed by the pharmacist and an RN. *Confirmed the IV bags and tubing should not have been in the 600 medication room's handwashing sink.</p> <p>4. Observation on 3/20/14 from 2:05 p.m. to 4:30 p.m. of the medication carts revealed the following expired medications: *100 wing: A bottle of hydrogen peroxide expired February 2014. *200 wing: A medication card that contained one tablet of Dansetron expired 2/22/13. *300 wing: A bottle of hydrogen peroxide expired February 2014. -A bottle of rubbing alcohol expired December 2013. -A tube of glucose 15 expired November 2013.</p>	F 425			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 425	<p>Continued From page 109</p> <p>-A box of Sudogest expired January 2014. *500 wing: Two bottles of hydrogen peroxide expired November 2013 and February 2014.</p> <p>Interview on 3/20/14 at 4:10 p.m. with RN L regarding the expired medications in the medication carts revealed they should have been removed from the medication carts by any nurse who had observed they were expired.</p> <p>5. Review of the provider's December 2012 Disposal of Medications policy revealed: **"Discontinued medications and/or medications left in the nursing care center after a resident's discharge, which do not qualify for return to the pharmacy, are identified and removed from current medication supply in a timely manner for disposition." **"The DNS and the consultant pharmacist will monitor for compliance with federal and state laws and regulations regarding the disposal of medications." **"Controlled (scheduled) medications II, III, IV, and V remaining in the nursing care center after the order has been discontinued are retained in the nursing care center in a securely double locked area with restricted access until destroyed as outlined by state regulation."</p> <p>5. Review of the March 2014 medication refrigerator monitoring logs revealed no documentation for daily monitoring of the temperatures for: *300, 400, and 500 wing medication refrigerators for eight days. *600 medication refrigerator for six days.</p> <p>Interview on 3/20/14 at 4:15 p.m. with RN L</p>	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
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F 425	Continued From page 110 regarding the medication refrigerators revealed: *The night shift was responsible to document the medication refrigerator temperatures on a daily basis. *She confirmed there was not daily documentation of the medication refrigerator temperatures.	F 425			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441	F441 INFECTION CONTROL, PREVENT SPREAD OF ILLNES 1. The following items were completed. Education to nurse I on following proper guidelines for disinfecting the tub on 4-8-14. Clean linen were immediately removed from the 300 hallway. All personal care items were placed in containers and labeled for each resident on 4-02-14. The soiled hand towels were removed from the counters by the sink area in room 401, 407, 414 and 415 upon discovery. All razors were checked and cleaned on 3-27-14. Floor mat in room 407B was cleaned on 3-25-14. Hydrocollator was cleaned on 3-25-14. Therapy room stove/drawer/microwave and lift were cleaned on 3-25-14. Catheter bags were audited and properly covered or removed from the floor if needed immediately All filters of oxygen concentrators were cleaned immediately. Housekeeping staff were educated on proper handwashing on 4-15-14. Beauty shop drawers were cleaned on 3-25-14. 2. All residents have the potential to be affected. 3. The Administrator, Director of Nursing and interdisciplinary team will review and revise as necessary the policy and procedure about infection prevention and control to include the findings cited in the deficiency on 4-10-14. The Director of Nursing Services or designee will re educate all staff on infection control policy to include tub disinfecting, cleaning of oxygen concentrator filters, personal care items storage, soiled linen removal, razor cleaning, appropriate hand hygiene, hand washing and glove use by 4-18-14. The Director of Rehabilitation will educate all therapy staff on the proper cleaning of the stove, microwave, lift, drawer and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106		
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F 441	<p>Continued From page 111 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, record review, and policy review, the provider failed to ensure sanitary conditions were maintained: *To prevent cross-contamination after disinfecting one of one whirlpool tub (500 wing). *The delivery of clean linen to residents on isolation in a sanitary manner (300 wing). *For residents' personal care items in shared rooms on one of six halls (400 wing). *To prevent cross-contamination after the use of and removal of residents' personal clothing and towels in shared rooms on one of six halls (400 wing). *To ensure electric razors had been cleaned and were free from compacted hair and dried skin debris of 4 of 4 observed razors in residents' rooms (413 beds A and B, 407, and 404) and in 4 of 4 observed community rooms (bathing rooms 200, 400, and 500, and the therapy room). *To ensure the cleanliness for one of three observed floor mats (room 407). *For one of one Hydrocollator unit in the therapy room. *For one of one observed microwave in the therapy room. *For one of one observed stove in the therapy room.</p>	F 441	<p>hydrocollator by 4-18-14.</p> <p>4. The Director of Nursing Services or designee will audit 5 balls for proper guidelines followed for proper tub disinfection, personal care items marked and not comingled with non-personal care items, soiled linens properly stored, razors clean, floor mats clean, no laundry hanging on side rails, foley bags covered, oxygen concentrator filters clean, proper hand washing, hydrocollator clean, therapy microwave, stove and lift clean. weekly x 4 and monthly x 3. The Director of Nursing Services or designee will report results of audits to the monthly Quality Assurance and Process Improvement Committee (QAPI) for further review and recommendations.</p>	5. 4-22-14

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

PRINTED: 04/09/2014
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OMB NO. 0938-0391

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F 441	<p>Continued From page 112</p> <p>*To ensure one of four randomly observed resident's (25) Foley drainage bag (collects urine) was not lying on the floor.</p> <p>*To ensure oxygen concentrator filters had been cleaned and were free from lint of 6 of 6 randomly observed residents' rooms (401, 403, 404, 406, 413, and 415) and of 2 of 4 observed community rooms (400/500 wing dining room and the therapy room).</p> <p>*For proper handwashing by the housekeeping department between the cleaning of all residents' rooms.</p> <p>*To ensure the cleanliness of two of four observed drawers in the beauty salon.</p> <p>Findings include:</p> <p>1. Observation and interview on 3/20/14 from 9:50 a.m. through 10:10 a.m. of registered nurse (RN) I during and after the disinfecting of the whirlpool tub on the 500 wing revealed:</p> <p>*He had finished bathing a resident who had Methicillin resistant staphylococcus aureus (MRSA) (a bacteria that is resistant to antibiotics).</p> <p>*Without the use of gloves he:</p> <ul style="list-style-type: none"> -Retrieved a spray bottle of Cen-Kleen (disinfectant cleaner) and sprayed the entire tub. -Retrieved a long handled scrub brush from out of a plastic bag. -Used the brush to scrub down the entire tub. -Touched several areas inside of the tub during the scrubbing process. -Placed the scrub brush back inside of the plastic bag. <p>*He left the tub room to do a dressing change on another resident without washing his hands.</p> <p>*At 10:05 a.m. he:</p> <ul style="list-style-type: none"> -Retrieved this surveyor to observe the rinsing process of the whirlpool tub. -Prepared to rinse the tub without sanitizing or 	F 441		

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
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F 441	<p>Continued From page 113</p> <p>washing his hands.</p> <p>*Without the use of gloves he:</p> <ul style="list-style-type: none"> -Touched the knobs on the tub to turn on the water. -Picked up the hose to rinse the tub free from disinfectant. <p>*While he had been rinsing the tub the water sprayed this surveyor on the face, glasses, and arms.</p> <p>*This surveyor had been standing approximately three feet behind RN I.</p> <p>*When he completed rinsing the tub he picked up a towel and dried his arms and hands.</p> <p>*He placed the towel on a wooden shelf located behind the tub.</p> <p>*Without the use of gloves he:</p> <ul style="list-style-type: none"> -Opened the tub door. The base of the tub where the door rested revealed a red colored substance that appeared to be blood. -Grabbed a set of keys hanging on a hook by a cupboard located by the tub. -With those keys he opened the cupboard door and retrieved a Clorox germicidal wipe and wiped up the red substance. -Grabbed a roll of garbage bags from inside of the cupboard and pulled off a bag. He laid that bag directly on the floor. -Laid the soiled Clorox germicidal wipe on top of the garbage bag. -Closed the cupboard door and returned the keys to the hook. <p>*He left the room without washing his hands and returned with a red biohazardous bag.</p> <p>*Without gloves he picked up the garbage bag with the Clorox germicidal wipe and placed it inside the biohazardous bag.</p> <p>Interview on 3/20/14 at the time of the observations with RN I revealed he would not</p>	F 441			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
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F 441	<p>Continued From page 114</p> <p>have worn gloves during the disinfecting process of the whirlpool tub. He agreed improper technique had been used in disinfecting of the tub.</p> <p>Interview on 3/25/14 at 10:00 a.m. with the director of nursing services (DNS) revealed: *She had been in charge of infection control. *She had not done any education on the whirlpool tub cleaning. The directions had been posted on the wall. "It should not have been difficult for them to follow." *She had not done any audits on whirlpool tub cleaning. *She would have expected RN I to wear gloves. *She was unsure if he should have worn protective eyewear or a clothing protector. *She confirmed sanitary precautions had been broken, there was potential for cross-contamination for any residents receiving a whirlpool tub bath and cares after the disinfecting process of the tub.</p> <p>Review of the provider's undated Directions on How to Use and Clean the Whirlpool policy revealed personal protection equipment (PPE) was to have been worn. The PPE items were gloves, gowns, masks, and eye protection.</p> <p>2. Interview on 3/18/14 at 9:55 a.m. with laundry aide O regarding the delivery of clean linens revealed he would not have delivered any linens inside an isolation room. He would have left the linens for the other staff to deliver.</p> <p>Observation on 3/18/14 at 2:00 p.m. revealed clean linens hanging on the railing outside of resident room 301. The resident in room 301 had been placed on isolation (had to remain in his</p>	F 441			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
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F 441	<p>Continued From page 115</p> <p>room due to an infection). The linens had been uncovered. Several unidentified staff members and residents had passed by the room.</p> <p>Interview on 3/18/14 at the time of the above observation with the laundry director confirmed there had been a potential for cross-contamination. The laundry should have been delivered into the room.</p> <p>Interview on 3/25/14 at 10:05 a.m. with the DNS regarding the above observation revealed she had witnessed the linens hanging on the resident's railing. She had never witnessed that occurrence before. She would have expected the laundry department to give the linens to a staff member to deliver directly into the isolated room.</p> <p>Review of the provider's October 1994 Folding, Storing, and Distributing Clean Linen policy revealed no instructions on how to deliver linens to the residents' rooms.</p> <p>3. Random observations from 3/17/14 through 3/20/14 of the 400 wing shared residents' rooms (401, 403, 407, 409, 411, 414, 417, and 415) revealed: *The counter areas by the sinks had multiple residents' care items co-mingled together. The items included: -Bottles of lotion. -Bottles of mouth wash. -Toothbrushes and toothpaste. -Denture cups without lids. -Combs and brushes. -Spray bottles and tubes of body cleanser. -Deodorant. -Bottles of powder. -Perfume and cologne.</p>	F 441			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 441	<p>Continued From page 116</p> <ul style="list-style-type: none"> -Razors. -Hydrogen peroxide. -Bottles of shampoo and conditioner. <p>*All of the above items had not been marked with a resident's name.</p> <p>Interview on 3/25/14 at 10:23 a.m. with the DNS revealed she had been unaware of the unmarked items. Each team member on the interdisciplinary department team (IDT) had been assigned wings to check. They had random audits to use for such purposes. She would have expected all of the residents' personal items to have been properly marked.</p> <p>4. Random observations from 3/17/14 through 3/20/14 of the 400 wing shared residents' rooms (401, 407, 414, and 415) revealed:</p> <ul style="list-style-type: none"> *Multiple soiled white hand towels. *The hand towels had been observed in several rooms on the counters by the sink area. *The counters contained the same multiple resident use items as listed above in finding 3. *On several occasions the towels had been laying directly on top of those items. <p>Interview on 3/20/14 at 10:30 a.m. with licensed practical nurse U confirmed no soiled linens should have been placed on top of the counter by residents' personal use items.</p> <p>Interview on 3/25/14 at 10:25 a.m. with the DNS revealed she had not been aware of the above issue. The IDT should have recognized the soiled linen issue upon random walk abouts and auditing. No soiled linens should have been placed or left on the counters in any of the residents' rooms.</p>	F 441		

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 441	<p>Continued From page 117</p> <p>5. Random observations from 3/17/14 through 3/20/14 of 8 electric razors revealed: *The razors had been located in: - Residents' rooms 404, 407 bed A, and 413 both beds A & B. -Three tub rooms (200, 400, and 500 wings). -One therapy room. *The inside of the razors had been compacted with hair and dried skin debris.</p> <p>Interview on 3/25/14 at 10:15 a.m. with the DNS revealed: *She would have expected the staff to wipe the razor off with either a disinfectant wipe or alcohol. *The razors should have been cleaned after each use.</p> <p>No policy and procedure had been provided upon request from this surveyor for the cleaning and disinfecting process of razors.</p> <p>4. Random observations from 3/18/14 through 3/20/14 of residents' room 407 revealed: *Resident 4 required the use of a floor mat. *The floor mat had been laid directly on the floor when he was resting in bed. *The floor mat had been used as a safety measure in case the resident fell out of bed. *There had been three quarter sized dried brown spots observed on the mat. The brown spots appeared to be stool from a bowel movement. *The brown spots remained on the floor mat through the entire observation period.</p> <p>Interview on 3/25/14 at 1:20 p.m. during the environmental walk through with the maintenance director, administrator, and housekeeping/laundry director revealed: *They had not been aware of the soiled floor mat.</p>	F 441		

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 441	<p>Continued From page 118</p> <p>*They had no plan in place for who was responsible for the cleaning the floor mats or when that should have been done.</p> <p>5. Observation on 3/18/14 at 10:10 a.m. of a room next to the therapy department revealed: *Inside the room had been a large Hydrocollator unit (hot pack heating unit). *The Hydrocollator unit had been: -Warm to the touch. -Plugged in and filled with several Hydrocollator pads that were sitting in hot water. -Continuously left on. *The Hydrocollator unit had a large amount red/rust colored areas surrounding the lid and the top edges of the unit (photo 7). *The Hydrocollator unit had a large amount of rust/brown colored sediment resting inside of the unit. The sediment had been located underneath the Hydrocollator pads.</p> <p>Interview on 3/20/14 at 9:00 a.m. with physical therapy assistant X confirmed the above findings. He had not been responsible for the cleaning of the Hydrocollator unit. He did not know who would have been responsible for the cleaning.</p> <p>Review of the Hydrocollator equipment cleaning and temperature tracking form revealed: *The dates on the form had been 1/10/11 through 4/5/11. No other dates could be found. *There had been no signatures or dates documented in the cleaning slot. *The Hydrocollator unit was to have been cleaned at least monthly.</p> <p>Interview on 3/20/14 at 4:47 p.m. with the director of the rehabilitation department confirmed the above findings. She did not know who would have</p>	F 441			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106		
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F 441	<p>Continued From page 119</p> <p>been responsible for the cleaning and upkeep of the unit. She could not tell this surveyor when the last time it had been cleaned.</p> <p>6a. Observation on 3/18/14 at 10:15 a.m. of the therapy room revealed: *A kitchen area with a microwave unit on the counter. -Inside of the microwave unit there was brown/tan colored debri. -The debri was stuck to the sides, top, bottom, and plate of the microwave unit.</p> <p>b. Observation on 3/18/14 at 10:20 a.m. of the therapy room kitchen area revealed: *A white colored stove. *The stove had black/gray sticky debri stuck to the outside of the bottom drawer. *Inside of the bottom drawer contained cooking pans. Underneath the cooking pans the drawer had black/brown colored debris.</p> <p>Interview on 3/20/14 at 4:50 p.m. with the director of the rehabilitation department confirmed the above findings. She stated all the therapists in the department were responsible for the cleaning and upkeep of the microwave and stove.</p> <p>Review of the provider's 12/26/12 Department Cleaning and Maintenance Schedule for the therapy department revealed: *"Equipment will be checked, sanitized and maintained according to its specific properties and manufacturer's recommendations." *"Equipment will be cleaned on a monthly basis unless required more frequently." *The Hydrocollator unit was to have been emptied and cleaned every two weeks. *The therapy department was to have</p>	F 441		

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 441	<p>Continued From page 120 coordinated with the housekeeping department on the cleaning of the kitchen appliances.</p> <p>7. Random observations on 3/24/14 from 8:30 a.m. through 11:15 a.m. of resident 25 revealed: *She had been lying in her bed. *She had a Foley catheter and bag (for collection of urine) draped over the side of her bed. *The bag laid directly on the floor during the entire time documented above.</p> <p>Interview on 3/25/14 at 10:20 a.m. with the DNS confirmed the catheter bag should not have been lying directly on the floor. The staff should have placed it on the side of the bed.</p> <p>8. Random observations from 3/18/14 through 3/20/14 of oxygen concentrators revealed: *The oxygen concentrators had been located in several residents' rooms (401, 403, 404, 406, 413, and 415), the 400/500 wing dining room, and the therapy room. *The filters on the oxygen concentrators had been dirty with white/gray debri. The debri made a small clouded area when poked by this surveyor.</p> <p>Interview on 3/25/14 at 10:25 a.m. with the DNS revealed: *The night nurses had been responsible for the cleaning of the oxygen concentrator filters. *They should have: -Cleaned the oxygen concentrator filters on Tuesday nights. -Documented on the treatment administration record on Tuesdays upon completion of the cleaning of the filters.</p> <p>9. Observation on 3/19/14 at 8:10 a.m. of</p>	F 441		

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2014
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F 441	<p>Continued From page 121</p> <p>housekeeping aide Y cleaning a residents' room on 100 wing revealed she had removed her gloves after cleaning the room. She had not washed or sanitized her hands prior to putting on another pair of gloves. She had been preparing to clean another resident's room.</p> <p>Interview on 3/19/14 with housekeeping aide Y at the time of the observation revealed she would randomly wash or sanitize her hands between the cleaning of residents' rooms. She would not have washed her hands between each room or glove change.</p> <p>Interview on 3/19/14 at 8:45 a.m. with the housekeeping director confirmed the housekeeping aide should have washed or sanitized her hands between each resident's room or changing of her gloves.</p> <p>Review of the provider's 2006 Hand Washing policy revealed: *Purpose: -"Medical asepsis (cleanliness) to control infection." -"To reduce transmission of organisms from resident to resident." -"To reduce transmission of organisms from nursing staff to resident." -"To reduce transmission of organisms (bacteria) from resident to nursing staff." *General instructions: -"Wash hands before and after resident contact." -"Wash hands when soiled."</p> <p>10. Observation on 3/20/14 at 8:32 a.m. of the beauty salon revealed: *Two drawers with hair clippings and several brown colored dried debris on the bottom.</p>	F 441		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 441	Continued From page 122 *Inside one of the drawers had been a note stating "dirty combs." A hair trimmer had been inside of that drawer. *Inside the other drawer there had been two curling irons. Interview on 3/20/14 at 9:00 a.m. with the beautician revealed she had been responsible for the cleaning of the drawers. The curling irons and hair trimmers had been shared items used for the residents. She had confirmed the two drawers had the potential for cross-contamination. Review of the provider's October 2009 Infection Control policies and procedures revealed: **"This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections." *The provider was to have "Maintained a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public." **"Provide guidelines for the safe cleaning and reprocessing of reusable resident care equipment." **"The Quality Assessment and Assurance Committee, through the Infection Control Committee, shall oversee implementation of infection control policies and practices, and help department heads and managers ensure that they are implemented and followed."	F 441			
F 490 SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and	F 490			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 490	Continued From page 123 efficiently 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: 18560 Based on observation, interview, record review, job description review, and policy review, the provider failed to ensure the facility was operated and administered in a manner that attained or maintained the highest practicable physical, mental, and psychosocial well-being of each resident. Findings include: 1. Interview on 3/26/14 at 1:00 p.m. with the administrator confirmed the overall operation and administration of the facility was her responsibility. Review of the executive director's job description revealed the purpose of the position was to lead and direct the overall operations of the facility in accordance with customer needs, government regulations, and company policies. Interviews, observations, record reviews, and policy reviews throughout the course of the survey revealed the administration had not ensured all residents attained and/or maintained their highest practicable physical, mental, and psychosocial well-being. Refer to F167, F170, F176, F223, F241, F242, F248, F250, F253, F280, F281, F309, F314, F323, F327, F329, F371, F425, F441, and F514.	F 490	F490 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING Please refer to plan of correction for F167, F170, F176, F223, F241, F242, F248, F250, F253, F280, F281, F309, F314, F323, F327, F329, F371, F425, F441, F490, F514, K018, K027 and K044. Golden Living Area Vice President (AVP) or designee will perform audits of the monthly QAPI committee minutes to ensure that facility is being administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well being of each resident monthly x 3. Audits will be presented by Golden Living AVP or designee to the monthly QAPI committee for review and recommendations.	5. 4-22-14	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB	F 514			

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F 514	<p>Continued From page 124 LE</p> <p>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.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to ensure documentation was completed for: *One of one sampled resident (16) on peritoneal dialysis (procedure to remove wastes from the blood). *One of two sampled residents (5) on house (nutritional) supplements. *One of one sampled resident (3) who received Mighty shakes. *One of eight sampled residents (15) who needed assistance with toileting. Findings include:</p> <p>1. Review of resident 16's medical record revealed he had been admitted on 1/27/14. He had a 2/26/14 physician's order to receive peritoneal dialysis at the facility. According to the physician's order staff were to obtain and record his daily weight on the dialysis flow sheet every</p>	F 514	<p>F514 RESIDENT RECORDS COMPLETE, ACCURATE, ACCESSIBLE</p> <p>1. Resident # 16's dialysis flow sheet completed as directed on 3-24-14. Resident 3's supplement order was updated in the medication administration record for % ingested documented on 3-27-14. Resident #5 supplement was discontinued 2-1-14. Resident 15 was evaluated after a 2 week of trial non-qed night time toileting and it was determined that toileting plan would be re initiated on 4-17-14.</p> <p>2. All residents have the potential to be affected.</p> <p>3. The Director of Nursing Services or designee will educate all licensed nursing staff regarding documenting the % ingested for supplements, completion of dialysis flow sheet and ensuring complete documentation in the treatment record when necessary by 4-18-14.</p> <p>4. The Director of Nursing Services or designee will audit 5 residents' MAR for % of supplement ingested, complete documentation of the treatment record and peritoneal dialysis flow sheet completion for any residents receiving peritoneal dialysis weekly x 4 and monthly x 3. The Director of Nursing Services or designee will report results of audits to the monthly Quality Assurance and Process Improvement Committee for further review and recommendations.</p>	5. 4-22-14

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 514	<p>Continued From page 125 morning at 9:00 a.m.</p> <p>Interview on 3/25/14 at 10:20 a.m. with a registered nurse from the contracted dialysis center revealed staff were to record weight, blood pressure, percent of fluid given, initial drain, total ultrafiltration (UF), and average dwell time on the flow sheets daily. The flow sheets were then supposed to be sent with the resident to his next appointment. The dialysis center used the flow sheets to verify dialysis was getting done and to change orders.</p> <p>Review of resident 16's flow sheets from 1/28/14 through 3/24/14 revealed: *No documentation had been entered on fourteen of the fifty-six days. *Of the forty-two days where documentation had been done: -Weights had not been recorded on eleven days. -Blood pressure had not been recorded on seven days. -Percent of fluid given had not been recorded on twenty-four days. -Initial drain had not been recorded on three days. -Total UF had not been recorded on three days. -Average dwell time had not been recorded on two days.</p> <p>Interview on 3/25/14 at 3:20 p.m. with the director of nursing services (DNS) revealed she was not aware the flow sheets had not been thoroughly completed.</p> <p>2. Review of resident 5's 7/1/13 through 2/1/14 medication administration records (MAR) revealed he was supposed to have a house supplement three times per day. Throughout that time frame an X had been used thirty-seven</p>	F 514			

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 514	<p>Continued From page 126</p> <p>times to indicate what percent he had consumed. The X had no meaning according to the chart codes.</p> <p>Interview on 3/18/14 at 11:50 a.m. with licensed practical nurse M regarding resident 5's MARs revealed she did not know what the X meant.</p> <p>Interview on 3/19/14 at 7:50 a.m. with the DNS revealed staff should have been putting an amount of how much he had consumed of the house supplement instead of an X.</p> <p>Review of the provider's 2011 House Supplement policy revealed the percent of supplement consumed should have been recorded.</p> <p>Surveyor: 18560</p> <p>3. Review of resident 3's medical record revealed: *A physician's order dated 8/6/13 for dietary supplements of Mighty shake, 206 juice, or Ensure twice a day after meals. *The February 2014 and March 2014 MARs had not documented how much of the above dietary supplements had been consumed.</p> <p>Interview on 3/24/14 at 3:30 p.m. with the DNS confirmed resident 3's MARs should have reflected how much she had consumed of the dietary supplement.</p> <p>4. Review of resident 15's January 2014, February 2014, and March 2014 treatment record revealed he was to be taken to the bathroom or offered the urinal every four hours during the night time. The following months revealed documentation had not occurred: *In January sixteen times.</p>	F 514		

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

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F 514	Continued From page 127 *In February seventeen times. *In March seven times. Interview on 3/26/14 at 8:10 a.m. with the DNS confirmed the above documentation should have been done.	F 514		

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

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PRINTED: 03/26/2014
FORM APPROVED
OMB NO. 0938-0391

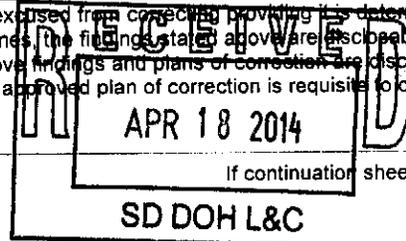
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/19/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS	STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106
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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 3/19/14. Golden LivingCenter-Covington Heights (Building 01, original 1973 structure) 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 upon correction of deficiencies identified at K018, K027, and K044 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
K 018 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p>	K 018	<p>K018</p> <ol style="list-style-type: none"> The door marked as "in" from the corridor to the kitchen was adjusted to latch properly on 3-19-14. End cap hardware were ordered to repair the two sets of double-doors from the corridor to the east dining room on 4-17-14. All residents have the potential to be affected. The Director of Maintenance or designee will educate all staff on maintaining horizontal exit doors in operating condition so they fully close and latch by 4-18-14. The Director of Maintenance or designee will audit all horizontal exit doors for proper closure weekly x 4 and monthly x 3. The Director of Maintenance or designee will report results of audits monthly to the monthly Quality Assurance and Assessment Committee for further review and recommendations. 	5, 4-22-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane Jorgay TITLE: Executive Director (X6) DATE: 4-17-14

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



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

PRINTED: 03/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/19/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106		
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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation, testing, and interview, the provider failed to maintain one randomly observed corridor door and two randomly observed sets of corridor doors in operating condition. Findings include: 1. Observation at 9:00 a.m. on 3/19/14 revealed the door marked as "in" from the corridor to the kitchen would not latch into the frame. Testing of that door at the time of the observation revealed the latch bolt was not properly lined up with the strike plate in the door frame. Interview with the maintenance supervisor at the time of the observation revealed those doors had closed during previous monthly checks. He agreed hardware adjustment was necessary and had the door fixed prior to completion of the survey. 2. Observation at 11:00 a.m. on 3/19/14 revealed both sets of double-doors from the corridor to the east dining room would not properly close and latch into the door frames. The north set of double-doors would not fully close due to the door coordinator not allowing the doors to close. The automatic flush bolt on the inactive leaf of those doors was also missing preventing the doors from latching. The south set of double-doors would not latch, because the automatic flush bolt in the inactive door leaf would not properly engage into the door frame. Interview with the maintenance supervisor and the administrator at the time of the observation revealed those doors were missed during the monthly checks and required maintenance.	K 018		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/19/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106		
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K 018	Continued From page 2	K 018		
K 027 SS=D	<p>Failure to maintain corridor doors as required increases the risk of death or injury due to fire. This deficiency affected three of the numerous corridor doors in the building.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation, testing, and interview, the provider failed to maintain one of five sets of smoke barrier doors adjacent to room 301 in operating condition. Findings include:</p> <p>1. Observation at 10:30 a.m. on 3/19/14 revealed the north leaf of the smoke barrier doors adjacent to resident room 301 would not close when allowed to operate with the door closer. Testing of that door at the time of the observation revealed the bottom of the door was dragging on the carpet preventing the door from swinging shut. Interview with the maintenance supervisor and the administrator at the time of the observation revealed those doors had closed during previous</p>	K 027	<p>K027</p> <ol style="list-style-type: none"> The latch was adjusted on the smoke barrier door adjacent to room 309 to enable the door to close properly on 3-19-14 All residents have the potential to be affected. The Director of Maintenance or designee will re educate all staff on maintaining horizontal exit doors in operating condition so they fully close and latch by 4-18-14. The Director of Maintenance or designee will audit all horizontal exit doors for proper closure weekly x 4 and monthly x 3. The Director of Maintenance or designee will report results of audits monthly to the monthly Quality Assurance and Assessment Committee for further review and recommendations. 	5. 4-22-14

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106		
(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 044	Continued From page 4 and latch into the frame. Testing of those doors at the time of the observation revealed the door would not close due to the bottom of the door dragging on the carpet. Interview with the maintenance supervisor and the administrator at the time of the observation revealed those doors had closed during previous monthly checks. They agreed adjustment was necessary. This deficiency affects residents located in building 01 and building 02.	K 044		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 03/19/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS	STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106
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K 000 INITIAL COMMENTS

Surveyor: 14180
A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/19/14. Golden LivingCenter-Covington Heights (Building 02, 1995 acute care and therapy addition) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.

The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiency identified at K044 in conjunction with the provider's commitment to continued compliance with the fire safety standards.

K 044 NFPA 101 LIFE SAFETY CODE STANDARD
SS=E
Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5

This STANDARD is not met as evidenced by:
Surveyor: 14180
Based on observation, testing, and interview, the provider failed to maintain two of two sets of 90 minute horizontal exit doors in operating condition. Findings include:

1. Observation at 11:30 a.m. on 3/19/14 revealed the west leaf of the 90 minute cross-corridor horizontal exit doors separating the nursing home and the therapy area would not fully close and latch into the frame. Testing of those doors at the time of the observation revealed the door would not close due to the bottom of the door dragging on the carpet. Interview with the maintenance

K 000 Addendums noted with an asterisk per 4/21/14 telephone to facility administrator. JB/SSDDH/MF

K 044 *K044

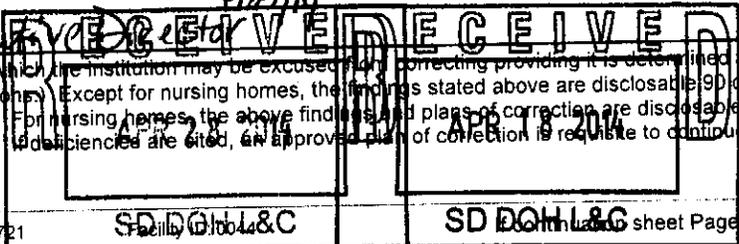
- The west leaf of the 90 minute cross-corridor horizontal exit door separating the nursing home and the therapy area and the south leaf of the 90 minute cross-corridor horizontal exit doors separating the nursing home and rehabilitation area. were adjusted to properly close and latch into the frame 4-17-14.
- All residents have the potential to be affected.
- The Director of Maintenance or designee will re educate all staff on maintaining horizontal exit doors in operating condition so they fully close and latch by 4-18-14.
- The Director of Maintenance or designee will audit all horizontal exit doors for proper closure weekly x 4 and monthly x 3. The Director of Maintenance or designee will report results of audits monthly to the monthly Quality Assurance and Assessment Committee for further review and recommendations.

JB/SSDDH/MF

x 4/21/14
JB/SSDDH/MF

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Diane Jorgay* EXECUTIVE DIRECTOR **4/25/14** TITLE DATE

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



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____		(X3) DATE SURVEY COMPLETED 03/19/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106		
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K 044	<p>Continued From page 1</p> <p>supervisor and the administrator at the time of the observation revealed those doors had closed during previous monthly checks. They agreed adjustment was necessary.</p> <p>2. Observation at 11:40 a.m. on 3/19/14 revealed the south leaf of the 90 minute cross-corridor horizontal exit doors separating the nursing home and the rehabilitation area would not fully close and latch into the frame. Testing of those doors at the time of the observation revealed the door would not close due to the bottom of the door dragging on the carpet. Interview with the maintenance supervisor and the administrator at the time of the observation revealed those doors had closed during previous monthly checks. They agreed adjustment was necessary.</p> <p>This deficiency affects residents located in building 01 and building 02.</p>	K 044		

LIFE SAFETY CODE QUALITY ASSURANCE CHECKLIST - Nursing Facilities, Hospitals, ASC's

Facility Name GOLDEN LIVING - COVINGTON HEIGHTS

Town SIoux FALLS

Survey Type Standard Revisit Complaint

Survey Dates 3/19/14

LSC Surveyor JIM BAILEY

At the start of a survey, request the following information from the facility:

- | | |
|---|--|
| 1. Copy of the evacuation plan | 5. Fire sprinkler system reports (if applicable) |
| 2. Fire drill record for the last 12 months | 6. Battery Smoke Detector Test Log (if applicable) |
| 3. Smoking policy | 7. Generator Test Log |
| 4. Fire alarm system inspection reports | 8. Sprinkler/Fire alarm out of service policy |

Submit by computer within 2 working days after a survey, revisit, or complaint survey.

- CMS 2567 3 # of Tags (highest S/S E) CMS 670 Team and Workload Report
- State Deficiencies _____ # of Tags None CMS 2567B

Submit the items in a standard survey packet. Submit at least the items in a revisit or complaint survey packet. All forms must be completed in ink. No forms may be completed in pencil.

- CMS 2786R LSC Form 2 # of forms Exit Conference Record
- CMS 2786T FSES Form _____ # of forms (if applicable) Signed CMS 2567B
- Nursing Facility Licensure Survey Summary form (optional) State Deficiencies corrected? Yes ___ No ___

Comments regarding:

Difficulties with the survey

Technical assistance given.

ALTHOUGH DEFICIENCIES WERE WRITTEN I SUGGEST THEY NEED TO SPEND A LOT MORE TIME CHECKING DOORS.

Immediate Jeopardy?
Yes

Recommendations:

Note: If S/S is G or higher on this survey and the previous survey, recommend a Category I remedy and timing ASAP

<p>Revisit survey</p> <p><i>Recommend revisit if S/S is D or higher, onsite if S/S is G or higher. Explain if recommendation is contrary to this</i></p> <p><input type="checkbox"/> No revisit</p> <p><input checked="" type="checkbox"/> Phone revisit</p>	<p><input type="checkbox"/> Onsite,</p> <p><input type="checkbox"/> State tags <input type="checkbox"/> Onsite, <input type="checkbox"/> Offsite</p>
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SOUTH DAKOTA DEPARTMENT OF HEALTH

ORIGINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10683	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS	STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106
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S 000	<p>Initial Comments</p> <p>Surveyor: 18560 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 3/17/14 through 3/20/14 and from 3/24/14 through 3/26/14. Golden LivingCenter-Covington Heights was found in compliance.</p>	S 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Diane Jorgay</i>	TITLE <i>Executive Director</i>
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STATE FORM

021189

GJ1B11

RECEIVED 4/17/14

If continuation sheet 1 of 1

APR 18 2014

SD DOH L&C