

ORIGINAL

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

PRINTED: 10/15/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435071</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/01/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BETHESDA HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>129 W HWY 12 WEBSTER, SD 57274</b>
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F 000	<p><i>Addendums noted with an asterisk per 11/14/14 telephone to facility DON. JTS/DOCHIME</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 32331 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/29/14 through 10/1/14. Bethesda Home was found not in compliance with the following requirements: F157, F226, F253, F281, F323, F329, F371, F425, and F428.</p>	F 000	<p><b>This Response and plan of Correction is not a legal admission that a deficiency exists and is also not to be construed as an admission of interest against the Facility. The Facility has prepared and submitted this Plan of Correction solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within the time parameters set forth by regulation. The submission of the Plan of Correction within this time frame should in no way be considered or construed as agreement with the allegation of noncompliance of admission by the Facility.</b></p>	
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p>	F 157	<p><b>F 157</b></p> <p>Resident #3 chart was reviewed on 10/16/14.</p> <p>Resident #12 chart was reviewed on 10/16/14.</p> <p>No other residents were identified.</p> <p>The Director of Nursing reviewed and revised the Change in Resident Condition or Status policy on 10/27/14 to include immediate physician notification for any change in condition, accident to include falls, a death, or any injury of unknown origin.</p> <p>The change in resident condition or status policy was sent for medical director approval on 10/29/14.</p> <p>On 10/27/14 and 10/29/14 the Director of Nursing (DON) and Nurse Manager (NM) educated nursing staff regarding the change in resident condition or status policy and procedure for notification of physician.</p>	11/20/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Administrator</i>	(X6) DATE <i>10/29/14</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 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.

OCT 30 2014

SD DOH L&C

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F 157	Continued From page 1  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.  This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on record review and policy review, the provider failed to immediately notify the physician: *Of an accident with injury for one of one sampled resident (3) resulting in delayed treatment of injury. *Of one of one resident (12) who had been found without signs of a heart beat or breathing. Findings include:  1. Review of the medical record for resident 3 revealed: *She was admitted on 2/7/13. *She was independent with walking. *On 7/2/14 at 7:30 p.m. she reported to an unidentified certified nursing assistant (CNA) that she had fallen on her way to the bathroom. She had complained of left (L) middle side pain. No redness or swelling was noted by the nurse. *No call had been placed to the physician until the next morning on 7/3/14 at 10:39 a.m. and had been done so only after she had rated her pain as ten out of ten (one is the least amount of pain, ten is the worst pain imaginable). *The resident was then seen by her physician at 11:00 a.m. on 7/3/14 who had ordered an x-ray. It was discovered the resident had two broken ribs on her left side.  Interview on 10/01/14 at 10:30 a.m. with the director of nursing (DON) revealed she had	F 157	Beginning 10/27/14, the Director of Nursing (DON) or designee will audit all condition changes and report to the QA committee on 11/18/14. The results of the audit will be used to educate staff as necessary. The audit results will be utilized by the QA committee to determine ongoing auditing requirements at the monthly [REDACTED] QA committee meeting.  JTS/DCH/ME		

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F 157	Continued From page 2 agreed the physician should have been notified by nursing staff regarding the above fall.  Review of the provider's 2001 Change in the Resident's Condition or Status policy revealed the Charge Nurse "will notify the resident's physician or the on-call physician when there has been an accident or incident involving the resident."  Surveyor: 33265 2. Review of resident 12's complete medical record revealed: *She was admitted on 3/29/14. *She was found by staff without a heart beat and not breathing at 4:52 a.m. on 4/12/14 after her son, who was in the room, had summoned them. *The administrator had been notified at 5:00 a.m. on 4/12/14. *There had been no documentation of the physician being notified of the death.  Interview on 10/1/14 at 12:40 p.m. with the director of nursing revealed she: *Believed they had notified the physician later that morning. *Could not find documentation stating they had notified the physician of the resident's death.  Review of the provider's undated Death policy revealed the staff were to "write in book to notify the doctor in the a.m."	F 157			
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226	<u>F 226</u> Residents #3, 4, 6, 7, and  charts were reviewed, and investigation completed and submitted to DOH on 10/01/14. By 11/20/14, the Director of Nurses or designee will audit all current resident charts for potentially reportable events between 05/01/14 and 09/30/14 and report to DOH/DSS if deemed necessary.	11/20/14	<i>*B JT/SDDOH/MF</i>

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F 226	Continued From page 3  This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on record review, interview, and plan review, the provider failed to ensure they investigated and reported to the South Dakota Department of Health (SD DOH) as required for: *Two of three sampled residents (3 and 6) with falls resulting in injury. *Three of four sampled resident (4, 7 and 8) with bruises and skin tears of unknown origin. Findings revealed:  1. Review of resident 6's medical record revealed: *She was admitted on 3/21/14. *She had a history of falls. *She had diagnoses that had included dementia (forgetfulness) with behavioral disturbances, depressive disorder, agitation, anxiety (feeling of nervousness, fear, apprehension, or worry), and altered mental (changed thinking) status.  Review of resident 6's progress notes revealed: *On 4/10/14 at 4:53 p.m. -"Resident had fall from recliner, tabs alarm [a type of personal alarm] was sounding. -Found resident laying on face in large pool of blood. -Noted large open area to R [right] side of forehead and small open area to bridge of nose." -"Resident cleaned up and was taken to ER [emergency room] in wheelchair...." *On 4/10/14 at 6:04 p.m."Resident returned from Emergency Room..."	F 226	By 11/20/14, the Director of Nurses or designee will audit all current resident charts for non-investigation of variances reported between 05/01/14 and 09/30/14 and report to DOH if deemed necessary.  On 10/16/14 the Director of Nurses, Nurse Manager, CEO and Administrator were educated by Sanford Health Network Nursing Consultant on reporting requirements. The DON received additional education regarding reporting via phone call with DOH on 10/20/14.  On 10/16/14 the Director of Nurses, Administrator and Sanford Health Network Nursing Consultant reviewed the current Abuse Prevention Plan policy, which was effective 09/09/14* see page 5. JTS/DOH/ME  On 10/20/14 the Director of Nurses reviewed the current procedure for investigation of reported events to include Nurse Manager or designee review of all potentially reportable events, prompt notification of administrator and Director of Nursing (DON), along with complete and thorough investigation and documentation of event.  On 10/27/14 and 10/29/14 the Director of Nursing (DON) and Nurse Manager (NM) educated nursing staff on documentation of resident condition changes and procedure for investigation of potentially reportable events.  On 10/27/14 and 10/29/14 the Director of Nursing (DON), Nurse Manager (NM), Administrator and Social Services Director educated all staff on abuse and neglect and what should be reported to the DOH/DSS.		

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F 226	<p>Continued From page 4</p> <p>Review of resident 6's Event Report for 4/10/14 revealed: *She had fallen in her room. *The fall had been unwitnessed. *She had sustained an injury to her right forehead. *She had a laceration (cut), and she had been bleeding. *She had agitation, anxiety, and slurred speech.</p> <p>Random observation and interviews with resident 6 on 9/29/14 through 10/1/14 revealed she was confused to time and had a poor memory of events.</p> <p>Interview on 10/1/14 at 2:15 p.m. with the DON regarding resident 6's fall with major injury on 4/10/14 revealed: *No investigation had been documented to determine events leading up to the unwitnessed fall. *There had been minimal investigation after the fall. *They had not investigated falls with injuries for possible abuse or neglect. *It had not been reported to the SD DOH. *There had needed to have been a more thorough investigation of the fall.</p> <p>Surveyor: 33488 2. Review of the medical record for resident 3 revealed: *She had a history of falls prior to being admitted. *On 7/2/14 at 7:30 p.m.: -She had fallen when attempting to walk to her bathroom. -Immediately after her fall she had "left middle-side" discomfort and right knee pain. -Redness had been noted to her right knee.</p>	F 226	<p>Beginning 10/20/14, the Director of Nursing (DON) or designee will audit all clinical documentation to ensure that all potentially reportable events have been reported to the DOH and DSS if necessary. The DON or designee will report audits to the QA committee on 11/18/14. The results of the audit will be used to educate staff as necessary. The audit results will be used by the QA committee to determine ongoing auditing requirements at the monthly QA committee meeting.</p> <p><i>*(continued from page 4) and posted on 9/9/14 for all staff to read and review with a form signed to ensure understanding of the policy. JT/SDDOH/MF</i></p>	

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F 226	<p>Continued From page 5</p> <p>-She had stated to the nurse that coolness felt good when the nurse touched her left side.</p> <p>-The nurse then applied ice to her left side for comfort.</p> <p>-The nurse documented she would continue to monitor her.</p> <p>-At 8:00 p.m. she continued to complain of discomfort to her left side and had redness to her knee.</p> <p>-At 8:30 p.m. she continued to complain of left sided pain and ice had been re-applied. She also had increased redness to her right inner knee.</p> <p>-At 9:30 p.m. she continued to have left sided discomfort and required assistance to the bathroom. She guarded her left side (the use of the hand to protect an area of the body) while she had repositioned herself in bed. The redness to her knee had begun to turn purple.</p> <p>*On 7/3/14 at 2:30 a.m. she continued to have left side pain and right knee bruising.</p> <p>-At 10:20 a.m. her pain was noted by nursing staff to be on her left lateral rib. She described it as ten out of ten (one being the least and ten having been the worst pain imaginable.) Doctor _____ (physician name) had been called with the request the resident be seen at that time. An appointment had been made for 11:00 a.m. that same day.</p> <p>-At 1:23 p.m. the resident returned from her appointment where she had been found to have two fractured ribs.</p> <p>*No investigation had been documented to determine events leading up to the unwitnessed fall.</p> <p>Interview on 9/30/14 at 3:45 p.m..with the director of nursing, nurse manager, and social worker (SW) revealed:</p> <p>*Their procedure was to complete an event report</p>	F 226		

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F 226	<p>Continued From page 6</p> <p>when a resident fell, whether or not they had an injury.</p> <p>*They had not investigated falls with injuries for possible abuse or neglect.</p> <p>*They concurred their event report would not support if they had evaluated whether the resident's falls had been a result of staff neglect.</p> <p>*They evaluated falls as part of the quality assurance and to prevent further falls.</p> <p>*They had not reported any falls with injuries to the SD DOH.</p> <p>*They had not investigated or reported any bruises or skin tears to SD DOH.</p> <p>*The DON was new to her position and she was unaware they were to have used the state mandated form for reporting any of the above injuries.</p> <p>-She agreed that if they had not done some investigation they could not conclude there was no abuse or neglect that contributed to the fall or injury.</p> <p>*They concurred they had not submitted any reports to the SD DOH for many months.</p> <p>Surveyor: 26180</p> <p>3. Review of resident 7's progress notes revealed:</p> <p>*On 3/13/14 at 2:42 a.m. "Bruising noted to R [right] inner thigh and also down posterior (back) upper leg and knee."</p> <p>*On 3/13/14 at 10:58 a.m. "Notified _____[physician's name] nurse of bruising to L [left] inner/back thigh and down into calf. Await return call."</p> <p>*On 3/13/14 at 11:07 a.m. "Received call from _____[physician's name] nurse, _____[nurses first name] stating he would be up to see resident about 1430 (2:30 p.m.) today."</p> <p>*On 3/13/14 at 2:50 p.m. _____[Physician's name]</p>	F 226		

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F 226	<p>Continued From page 7</p> <p>here to see resident. Orders received to D/C [discontinue] Eliquis [medication to prevent blood clots] and for an X-Ray of right hip/pelvis.</p> <p>*On 3/13/14 at 8:29 p.m. "Continues to have bruising to R thigh and posterior leg down to calf. Bilat [bilateral] (both) groins very red with raised red rash also. States area is very tender."</p> <p>*On 3/14/14 at 10:13 p.m. "Noted purplish areas to down from armpits toward back, some whitish center noted, with some drainage noted to left area."</p> <p>Observation and interview with resident 7 on 9/29/14 and 9/30/14 revealed he was alert, but confused to time and had poor recall (memory) of events.</p> <p>Interview on 9/30/14 at 3:45 p.m. with the DON, nurse manager, and social worker, revealed they had not investigated the bruise resident 7 had nor had they reported it to the SD DOH.</p> <p>Surveyor: 33265</p> <p>4. Review of resident 4's complete medical record revealed:</p> <p>*She had unexplained bruising and skin tears documented on the following dates:</p> <ul style="list-style-type: none"> <li>-9/4/13 bruise to left knee.</li> <li>-11/5/13 bruise to left shin (lower front part of leg).</li> <li>-1/1/14 bruise to unidentified location.</li> <li>-4/23/14 bruise to top of right foot.</li> <li>-5/2/14 bruise to left forearm.</li> <li>-5/4/14 bruise to left knee.</li> <li>-6/3/14 bruise to left shin.</li> <li>-7/10/14 skin tear to right forearm.</li> <li>-7/11/14 bruise to right lower leg and left shin.</li> </ul> <p>*There was no documentation regarding:</p> <ul style="list-style-type: none"> <li>-Investigation of how the above injuries had occurred.</li> </ul>	F 226		

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F 226	<p>Continued From page 8</p> <p>-Reporting injuries of unknown origin to the SD DOH.</p> <p>5. Review of resident 8's complete medical record revealed: *She had unexplained bruising and skin tears documented on the following dates: -8/11/13 bruises on both arms. -8/19/13 skin tear to right arm. -9/29/13 skin tears to right hand, fourth and fifth fingers. -1/18/14 skin tear to left shin. -7/7/14 skin tear to right wrist. *There was no documentation regarding: -Investigation of how the above injuries had occurred. -Reporting injuries of unknown origin to the SD DOH.</p> <p>6. Interview on 10/1/14 at 12:40 p.m. with the director of nursing regarding residents 4 and 8 revealed she believed she was not required to report all bruises and skin tears, but was not sure which bruises or skin tears to report to the SD DOH.</p> <p>7. Review of the provider's 9/9/14 Abuse Prevention Plan revealed: *Definitions included: -A."Serious bodily injury in general means an injury involving extreme physical pain; requiring medical intervention such as surgery, hospitalization or physical rehabilitation. E. Neglect: A failure through inattentiveness, carelessness, seclusion, or omission, without a reasonable justification to provide, timely, consistent, and safe services, treatment, and care necessary to avoid physical harm, mental anguish, or mental illness to a resident."</p>	F 226			

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F 226	Continued From page 9 **It is the responsibility of the Administrator, DON, or social services director to: -1. Investigate or delegate an investigation of any alleged mistreatment, neglect or abuse." -2. Notify the following agencies in accordance with regulations with the required time frame of the alleged mistreatment, neglect or abuse: a. State Ombudsman (advocate). b. Local Ombudsman (advocate). c. Department of Health. 3. A. "It is the responsibility of very BNH [name of facility] employee, facility consultants, attending physicians, family members, visitors, etc to: 1. Report any incident or suspected incident of neglect or resident abuse, including injuries of unknown origin and theft or misappropriation of resident property Bethesda Nursing Home Management."	F 226		
F 253 SS=E	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: 33488 Based on observation, interview, walk-through, and preventative maintenance checklist review, the provider failed to: *Maintain woodwork in a manner that would ensure it had been cleanable and in good repair. *Maintain the nurses station cubicle walls in a manner to ensure they were cleanable and in good repair. Findings include:	F 253 <u>F 253</u>	Beginning on 10/8/14, estimates have been requested for refinishing or replacement of woodwork in the dining room to make sure we have cleanable surfaces.  On 10/24/14, estimates are also being requested for refinishing or replacement of nightstands.  On 10/24/14, Estimates are also being requested for refinishing or replacement of nurse's station walls.  Beginning on 11/18/14, maintenance supervisor will audit all woodwork to ensure that it is a cleanable surface as part of their quarterly facility inspections.	11/20/14

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F 253	Continued From page 10  1. Random observations on 9/29/14 and 9/30/14 of resident's rooms and the dining room revealed: *Wooden facility nightstands found in random residents' rooms had missing varnish and had been visibly worn. *Wooden window frames and wooden doors located in the dining room had missing varnish and were visibly worn.  2. Random observations on 9/29/14 through 9/30/14 of the nurses station cubicle walls revealed missing and broken trim along the base of the cubicle that also had torn and visibly dirty fabric.  Interview and walk-through of the facility on 9/30/14 from 3:30 p.m. to 4:00 p.m. with the administrator and the maintenance supervisor regarding the above woodwork and nursing cubicle revealed: *Numerous nightstands in random residents' rooms had been missing varnish and had bare wood exposed. *Dining room windows had missing varnish on the wooden sills. *A double-door between the kitchen and the dining room had been missing varnish and had exposed bare wood. Staff would use those doors to get residents' meal trays during mealtime from the kitchen and deliver them to the dining room. *The maintenance supervisor revealed: -He was unaware of a formal written maintenance plan. -They would only have performed maintenance on the above items if they had been made aware of their disrepair. -He had observed the need for repairs of the above mentioned woodwork but had postponed	F 253	Beginning 11/18/14, The Maintenance Supervisor or designee will report results of quarterly facility inspections to the QA committee quarterly through July 2015 then on going as determined by the QA committee.		

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F 253	Continued From page 11 them related to other duties. *They agreed the residents' nightstands, windows, and doors had needed regular maintenance to ensure they would have been cleanable and in good repair. *They were both aware of the disrepair to the nurses station. *They had "put off repairing it" as they had hoped to remodel soon. *They agreed residents could become injured from the missing or damaged pieces of trim. *The nurses station cubicle had not been on a preventative maintenance plan. *The maintenance supervisor was unaware of a policy on preventative maintenance.  Review of the provider's undated preventative maintenance Quarterly Room Inspection checklist revealed: *A yes or no was to be circled next to the section "All furniture in good condition?" *Sections to document immediate repairs made or further repairs needed. *A date section to have been filled out by unidentified staff when repairs had been completed.	F 253		
F 281 SS=D	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: 33488 A. Based on observation, interview, record review, and policy review, the provider failed to:	F 281	<b>F 281</b>  Resident # 3 chart reviewed on 10/16/14.  On 10/27/14, the Director of Nursing (DON) updated policy and procedure for Post Fall Assessment to include a complete comprehensive assessment for injury, immediate notification of physician, prompt notification of family, and full investigation of	11/20/14

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F 281	<p>Continued From page 12</p> <p>*Complete a thorough assessment for one of one sampled resident (3) after an unwitnessed fall. *Follow the provider's policy and contact the resident's physician or the on call physician. Findings include:</p> <p>1. Random observations on 9/29/14 through 9/30/14 of resident 3 revealed: *She was independent with transferring from surface to surface and general mobility. *She used a walker for short distances in her room and a wheelchair to propel herself throughout the facility.</p> <p>Review of the medical record for resident 3 revealed: *She had a history of falls prior to being admitted. *On 7/2/14 at 7:30 p.m.: -She had fallen when attempting to walk to her bathroom. -Immediately after her fall she had "left middle-side" discomfort and right knee pain. -Redness had been noted to her right knee. -She had stated to the nurse that coolness felt good when the nurse touched her left side. -The nurse then applied ice to her left side for comfort. -The nurse documented she would continue to monitor her. -At 8:00 p.m. she continued to complain of discomfort to her left side and had redness to her knee. -At 8:30 p.m. she continued to complain of left sided pain and ice had been re-applied. She also had increased redness to her right inner knee. -At 9:30 p.m. she continued to have left sided discomfort and required assistance to the bathroom. She protected her left side while she had repositioned herself in bed. The redness to</p>	F 281	<p>On 10/27/14, the Director of Nursing (DON) updated the policy and procedure for Change in Resident Condition or Status to include immediate physician notification for any change in condition, accident to include falls, a death, or any injury of unknown origin.</p> <p>On 10/29/14, The Change in Resident Condition or Status and Post Fall Assessment policies were sent to medical director for approval.</p> <p>On 10/27/14 and 10/29/14, the Director of Nursing (DON) and Nurse Manager (NM) educated nursing staff on the procedure for falls and performing a complete assessment of an injury.</p> <p>On 10/27/14 and 10/29/14, the Director of Nursing (DON) and Nurse Manager (NM) educated nursing staff on the procedure for notification of a physician after change of condition, which includes all falls.</p> <p>Beginning 10/27/14, the Director of Nursing (DON) or designee will audit all falls for proper procedure and complete assessment and report to the QA committee on 11/18/14. The results of the audit will be used to educate staff as necessary. The audit results will be utilized by the QA committee to determine ongoing auditing requirements at the monthly February QA committee meeting.</p> <p>Resident #12 chart was reviewed on 10/16/14.</p> <p>On 10/27/14, the Director of Nursing (DON) updated the policy and procedure for Death of a Resident to include immediate notification</p>	

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F 281	<p>Continued From page 13</p> <p>her knee had begun to turn purple.</p> <p>*On 7/3/14 at 2:30 a.m. she continued to have left side pain and right knee bruising.</p> <p>-At 10:20 a.m. her pain was noted by nursing staff to be on her left lateral rib. She described it as ten out of ten (one being the least and ten having been the worst pain imaginable.)</p> <p>-After her pain had reached a ten, the nurse called the resident's physician and requested she was seen. An appointment was then made for 11:00 a.m. that same day.</p> <p>-At 1:23 p.m. the resident returned from her appointment where she had been found to have two fractured ribs.</p> <p>*No comprehensive physical assessment had been documented by nursing staff that included an initial full assessment and ongoing assessment.</p> <p>*No investigation of the fall had been done by staff to ensure her safety.</p> <p>*The physician had not been notified until the following day on 7/3/14 after the resident's pain had reached ten out of ten, the worst pain.</p> <p>Interview on 10/01/14 at 10:30 a.m. with the director of nursing (DON) revealed she agreed:</p> <p>*The nurse should have called the physician when the injury had occurred.</p> <p>*The assessment process was lacking and needed to be thorough.</p> <p>Review of the provider's 2001 Change in the Resident's Condition or Status policy revealed the Charge Nurse "will notify the resident's physician or the on-call physician when there has been an accident or incident involving the resident."</p> <p>Review of the provider's 2010 Clinical Protocol-Falls revealed:</p>	F 281	<p>of physician to receive physician order declaring resident deceased and to release the body to the mortuary.</p> <p>On 10/27/14, the Director of Nursing (DON) updated the policy and procedure for Change in Resident Condition or Status policy on 10/27/14 to include immediate physician notification for any change in condition, accident to include falls, a death, or any injury of unknown origin*</p> <p>On 10/27/14 and 10/29/14, the Director of Nursing (DON) and Nurse Manager (NM) educated nursing staff on the procedure for death of a resident and physician notification.</p> <p>Beginning 10/27/14, the Director of Nursing (DON) or designee will audit all deaths for proper procedure and report to the QA committee on 11/18/14. The results of the audit will be used to educate staff as necessary. The audit results will be utilized by the QA committee to determine ongoing auditing requirements at the monthly QA committee meeting.</p> <p><i>JTSDDO/HMF</i></p> <p><i>With all nursing staff notified on 10/27/14 and 10/29/14 regarding the new policy. JTSDDO/HMF</i></p>

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F 281	<p>Continued From page 14</p> <p>*The nurse shall assess, document, and report the following: -Vital signs. -Recent injury, especially a fracture. -Observations of a change in normal movement. -Pain. -Details on how the fall occurred. *Falls should have been categorized and identified as witnessed or unwitnessed. *Staff should have attempted to identify causes of the fall. *Based on the assessment, staff and the physician should have identified interventions to prevent future falls. *Staff (with physician guidance) should have followed up on a fall with an injury to avoid delayed complications such as a fracture that has been ruled out or resolved.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, page 206, revealed: **"The nursing process is critical thinking." **"The assessment is the deliberate and systemic collection of information about a patient to determine current health status."</p> <p>Review of Donna D. Ignatavicius and M. Linda Workman, Medical-Surgical Nursing, 7th Ed., St. Louis, MO, 2013, Chapter 5-Pain: The Fifth Vital Sign, pages 39-62, revealed: *A nursing assessment includes: -Precipitating factors (What happened to cause the pain?) -Aggravating factors (What makes it worse or better?) -Localization of pain (Where is the pain at? Does it stay in same place? Does it travel to other parts of the body?)</p>	F 281		

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F 281	<p>Continued From page 15</p> <p>-Character and quality of pain (Description of pain or severity of pain?)</p> <p>-Duration of pain (How long does it last?)</p> <p>Surveyor: 33265</p> <p>B. Based on record review, interview, and policy review, the provider failed to follow professional standards for the pronouncement of death for one of one sampled record for resident (12). Findings include:</p> <p>1. Review of resident 12's complete medical record revealed:</p> <ul style="list-style-type: none"> <li>*She was admitted on 3/29/14.</li> <li>*Staff found the resident to be without a heart beat and not breathing at 4:52 a.m. on 4/12/14 after her son, who had been in her room, had summoned them.</li> <li>*The administrator had been notified at 5:00 a.m. on 4/12/14.</li> <li>*At 5:36 a.m. staff called the funeral home.</li> <li>*At 6:37 a.m. the funeral home removed the body.</li> <li>*There had been no documentation of the physician having been notified of the death.</li> <li>*There had been no pronouncement of death by the physician.</li> </ul> <p>Interview on 10/1/14 at 12:40 p.m. with the director of nursing revealed the nursing staff had pronounced the death of the resident.</p> <p>Review of the provider's undated Death policy revealed the staff were to:</p> <ul style="list-style-type: none"> <li>*Confirm death by checking for an apical (listening over the heart) pulse and respiration (breathing).</li> <li>*Note the time of death.</li> </ul>	F 281		

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F 281	Continued From page 16 * "Write in book to notify the doctor in the a.m."  Review of a letter dated 8/4/14 from the South Dakota Board of Nursing revealed: *The signing of the death certificate was to be completed by a physician, physician assistant, or nurse practitioner. *The signing of the death certificate cannot be delegated to anyone else. *A licensed nurse cannot pronounce death.	F 281			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, and record review, the provider failed to ensure safe storage of personal care items that could be harmful if accidentally swallowed were not accessible to one of seven sampled mentally impaired residents (2).  1. Random observations on 9/30/14 through 10/01/14 of resident 2's room revealed one bottle 'Lectric Shave and two bottles of Corn Huskers (hand) lotion located on the resident's dresser.  Review of the medical record for resident 2	F 323	On 10/17/14, resident #2's room was organized. All personal care items were placed in a basket on the closet shelf in the resident's room.  By 11/14/14, all cognitively impaired resident rooms will be organized with all personal care items being placed in baskets on the shelf in the closet of their rooms.  On 10/27/14 and 10/29/14, the Director of Nursing (DON) and Nurse Manager (NM) educated nursing staff on the safety risk of personal care items for residents that are cognitively impaired and the importance of placement of these items out of reach.  Beginning 10/27/14, the Director of Nursing (DON) or designee will perform random audits of 4 resident rooms weekly and report to the QA committee on 11/18/14. The results of the audit will be used to educate staff as necessary. The audit results will be utilized by the QA committee to determine ongoing auditing requirements at the monthly QA committee meeting.	11/20/14	

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F 323	Continued From page 17 revealed he had a Brief Interview for Mental Status (BIMS) assessment score in July 2014 of two out of fifteen that meant severe mental impairment.  Interview on 9/30/14 at 4:20 p.m. with resident 2 revealed: *He was unable to identify the personal care products mentioned above that had been located on his dresser. *He was unaware of what they had been used for. *Had asked what this surveyor had thought he should do with them.  Interview on 9/30/14 at 5:00 p.m. with the nurse manager regarding personal care items in resident 2's room revealed she: *Was aware he had a severe mental impairment. *Had not thought about the safety risk to the resident if he swallowed the items mentioned above but agreed it was a hazard. *Agreed the personal care items should be secured. *Was unaware if the provider had a specific policy regarding mentally impaired residents and chemical safety.	F 323			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329			

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F 329	Continued From page 18  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.  This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to identify the use of an unnecessary drug on a PRN (whenever necessary) schedule for 2 of 12 sampled residents (6 and 7) who were on antipsychotic medication (medication capable of affecting the mind) to manage behaviors. Findings include:  1. Review of resident 6's medical record revealed: *She was admitted on 3/21/14. *She had a history of falls. *She had diagnoses that had included dementia (forgetfulness) with behavioral disturbances, depressive disorder, agitation, anxiety (feeling of nervousness, fear, apprehension, or worry), and altered mental (changed thinking) status. *A physician's order dated 4/26/14 "Seroquel (quetiapine) tablet; 25 mg; [milligrams] Amount to	F 329	<u>F 329</u>  On 10/30/14, Bethesda Home contracted with a new Consultant Pharmacist. The Consultant Pharmacist responsibilities will include monthly pharmacy review of all resident's medications to be completed by the 10 <sup>th</sup> of each month for the previous month. The pharmacy review will include reviewing for duplication of medications, correlating diagnosis for all medications, and PRN medication usage. The Consultant Pharmacist will make recommendations for discontinuation of medications and/or gradual dose reductions as they determine appropriate per their review.  On 10/27/14 and 10/29/14, the Director of Nursing (DON) provided education to all staff regarding the importance of using non-pharmacological interventions for behaviors prior to using PRN medications. Also, education was provided to all staff regarding complete documentation of all interventions attempted.  By 11/20/14, the Consultant Pharmacist will review Resident #6's medications, and chart supporting documentation to ensure that it is necessary to treat a specific condition as diagnosed and documented in the clinical record.	11/20/14	

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F 329	<p>Continued From page 19</p> <p>Administer: 25 mg; oral [by mouth] PRN - As Needed May only give one dose daily PRN." *A physician's order dated 4/26/14 for the above order given for "DX [diagnosis] Anxiety state NOS [Not Otherwise Specified]."</p> <p>Review of resident 6's medication administration records from 6/1/14 through 9/29/14 revealed the antipsychotic medication Seroquel on a PRN basis had been used: *Four times in June 2014 for the following reasons: -"Resident agitated and restless," three times. -"Restless et [and] pulling on clothes," one time. *Zero times in July 2014, August 2014, and 9/1/14 up through 9/29/14.</p> <p>Review of resident 6's Progress Notes for 6/5/14 through 6/24/14 revealed there were no documented reasons for giving the medication by nursing for the above four times.</p> <p>Review of resident 6's Point of Care History for 6/5/14 through 6/24/14 regarding any problems or behaviors related to the above Seroquel use revealed: *Two times there was no documentation. *One time she had trouble sleeping/sleeping too much. *One time she had been: -Short tempered, easily annoyed. -Moved slowly or fidgety/restless. -Trouble sleeping/sleeping too much.</p> <p>Interview on 9/30/14 at 5:15 p.m. with the director of nursing (DON) regarding resident 6's PRN order of the antipsychotic medication Seroquel revealed she stated: *The reasons for using the medication were not</p>	F 329	<p>By 11/20/14, the Consultant Pharmacist will review Resident #7's medications, and chart supporting documentation to ensure that the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record.</p> <p>By 11/20/14, the Consultant Pharmacist will review all residents' medications, and chart supporting documentation to ensure that the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. The DON or designee will report to the QA committee on 11/18/14. The audit results will be utilized by the QA committee to determine ongoing auditing requirements at the monthly <del>QA</del> QA committee meeting. <i>JT/SDDH/MF</i></p> <p>On 10/27/14, the Nurse Manager discontinued Resident #6 PRN medications that had not been administered within 30 days and PRN narcotics that had not been administered in 60 days.</p> <p>On 10/27/14, the Nurse Manager discontinued Resident #7 PRN medications that had not been administered within 30 days and PRN narcotics that had not been administered in 60 days.</p> <p>By 11/20/14, and ongoing monthly, the Consultant Pharmacist will review all MARs to determine which medications have not been used for 30 days and narcotics not used in 60 days and recommended discontinuation per standing physician's order.</p>	

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F 329	<p>Continued From page 20 specific.</p> <p>*There were other medications that might have been better to have used for her.</p> <p>*There were behavioral techniques that could have been used instead of the usage of an antipsychotic.</p> <p>*It had been an unnecessary medication.</p> <p>Interview on 9/30/14 at 6:00 p.m. with the nurse manager regarding resident 6's PRN order of the antipsychotic medication Seroquel revealed she stated there could have been better choices in managing her behavior.</p> <p>Interview on 10/1/14 at 10:45 a.m. with the consultant pharmacist regarding resident 6's PRN order given for the Seroquel medication revealed he stated: *For agitation that was "not the best thing to do." *That needed to have been referred to the physician. *There was a policy if a medication had not been used for thirty or sixty days it was to have been discontinued. *He agreed the medication had been an unnecessary medication and needed to have been discontinued.</p> <p>Review of resident 6's revised 10/29/14 care plan revealed: *She had diagnoses that included anxiety and depression with the following documentation: -"Sometimes I get really anxious and need medication to calm down." -She was to have been encouraged to become involved with physical activities and social interactions. -She was to have been encouraged to verbalize feelings, concerns, and fears.</p>	F 329	<p>The Nurse Manager or designee will report the results to the QA committee on 11/18/14. The audit results will be utilized by the QA committee to determine ongoing auditing requirements at the monthly [REDACTED] QA committee meeting. <i>JT/DOH/MF</i></p> <p>On 10/28/14 and 10/29/14, the temp Consultant Pharmacist reviewed all medications to ensure there was a relating diagnosis.</p> <p>On 10/27/14 and 10/29/14, the Director of Nursing (DON) and Nurse Manager (NM) educated nursing staff on requiring diagnosis from Physician when entering medication orders.</p> <p>Beginning 11/1/14, the Nurse Manager or designee will audit the MAR monthly to ensure there are relating diagnoses for each medication. Ongoing education will be provided as needed by the DON or designee. The Nurse Manager or designee will report the audits to the QA committee on 11/18/14. The audit results will be utilized by the QA committee to determine ongoing auditing requirements at the monthly [REDACTED] QA committee meeting. <i>JT/DOH/MF</i></p> <p>On 10/29/14 the Director of Nursing (DON) and Nurse Manager (NM) educated nursing staff on how to best manage behaviors without medication.</p> <p>On 10/29/14, the Director of Nursing (DON) and Nurse Manager (NM) educated nursing staff on documentation of behaviors.</p>		

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F 329	<p>Continued From page 21</p> <p>-She was to have been encouraged to clarify misconceptions.</p> <p>-Seroquel had been restarted on 4/26/14 for anxiety and agitation.</p> <p>*She had dementia with behavioral disturbance with the following documentation:</p> <p>- "Maintain a calm environment and approach to the resident.</p> <p>- Convey an attitude of acceptance toward the resident.</p> <p>- Avoid over-stimulation (e.g. [in example] noise, crowding, other physically aggressive residents)."</p> <p>Review of resident 6's Monthly Medication Chart Review by the consultant pharmacist from 10/25/13 through 9/2/14 for the antipsychotic medication Seroquel revealed there were no recommendations documented on the Seroquel PRN dose.</p> <p>Todd P. Semla et al., Geriatric Dosage Handbook, 16th Ed., American Pharmacists Association, Hudson, Ohio, 2011, p. 1509 and 1513, regarding the medication Seroquel revealed:</p> <p>*It was not approved for the treatment of dementia-related psychosis.</p> <p>*Many elderly patients received antipsychotic medications for inappropriate nonpsychotic behavior.</p> <p>Review of the provider's 10/3/14 Doctor Approved Nursing Protocols policy revealed to have discontinued PRN medications not used in thirty days.</p> <p>Surveyor: 26180</p> <p>2. Review of resident 7's September 2014 physician order report revealed he received the</p>	F 329	<p>Beginning 11/1/14, the Director of Nursing (DON) or designee will audit 5 charts per week for 8 weeks of residents currently prescribed anti-psychotic medications to ensure that there is supporting behavior documentation for the ant-psychotic medications. The DON or designee will educate staff as necessary. The Nurse Manager or designee will report the audits to the QA committee on 11/18/14. The results of the audit will be used to educate staff as necessary. The audit results will be utilized by the QA committee to determine ongoing auditing requirements at the monthly QA committee meeting.</p> <p>By 11/20/14, the Nurse Manager or designee will review all MAR's to determine that nursing staff have documented the reasons for administration of PRN medications.</p> <p>The Director of Nursing (DON) and Nurse Manager provided education on 10/27/14 and 10/29/14 to nursing staff regarding the importance of documentation of PRN medications, the reasons they are being administered, and documentation on the follow up.</p> <p>Beginning 10/27/14, the Director of Nursing (DON) or designee will perform random audits of 4 residents weekly to ensure that there is documentation related to the reason that PRN medications were administered. The Director of Nurses (DON) or designee will educate staff as necessary. The Nurse Manager or designee will report the audits to the QA committee on 11/18/14. The results of the audit will be used to educate staff as</p>	

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F 329	<p>Continued From page 22</p> <p>following medications:</p> <ul style="list-style-type: none"> <li>*Zoloft (antidepressant) tablet 100 milligrams (mg) for depression one time per day started on 7/5/13.</li> <li>*Seroquel (antipsychotic) 25 mg at HS [hour of sleep] for vascular dementia (memory loss caused by lack of blood flow to the brain) and behavioral disturbance started on 1/23/14.</li> <li>*Seroquel 25 mg twice a day for vascular dementia without behavioral disturbance started on 3/27/14.</li> <li>*Trazodone (antidepressant) 50 mg once a day in the evening for depression started on 3/27/14.</li> <li>*Aricept (treatment of dementia) 10 mg daily.</li> <li>*Seroquel 25 mg every 8 hours PRN [as needed] for vascular dementia and behavior disturbance, started on 1/23/14.</li> </ul> <p>-The physician had not specified when the resident could have received that medication. -There was no guidance on how long that PRN antipsychotic could have been used without further review.</p> <p>Review of resident 7's Minimum Data Set (MDS) assessment revealed:</p> <ul style="list-style-type: none"> <li>*On 2/3/14 he had: <ul style="list-style-type: none"> <li>-Exhibited verbal and "other" behaviors, but they had not interfered with care or impacted others.</li> <li>-No indicators of psychosis.</li> </ul> </li> <li>*Received an antidepressant.</li> <li>*On 8/14/14 he had memory loss, impaired decision making, and mild depression.</li> <li>*No indicators of psychosis including hallucinations, or delusions.</li> <li>*Decreased energy, moved slow, and felt tired.</li> <li>*Received an antidepressant and antipsychotic medication.</li> </ul> <p>Review of resident 7's progress notes revealed</p>	F 329	<p>by the QA committee to determine ongoing auditing requirements at the monthly QA committee meeting.</p> <p style="text-align: right;"><i>JT/SDDH/ME</i></p>	

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F 329	<p>Continued From page 23</p> <p>since his admission on 10/14/13 following a fall with a fractured hip he:</p> <ul style="list-style-type: none"> <li>*Had been treated for a urinary tract infection from 12/1/13 through 12/6/13. During that time he was restless at night and confused. He became agitated and wanted to get out of bed. His body temperature fluctuated from cold to hot.</li> <li>*Continued to be restless at night and had fallen as he attempted to get out of bed on 12/12/13, 12/23/13, and 12/27/13.</li> <li>-There was no indication of what time the resident was being put to bed and the role it played in his restlessness.</li> <li>*He complained of hip pain after the falls and received medications as needed for the pain.</li> <li>*On 12/23/13 he had a tooth pulled.</li> <li>*Behaviors that were consistently documented included restless and agitated, attempting to get out of bed.</li> <li>*Received Haldol (antipsychotic) 1 mg for restlessness on 1/13/14, 1/16/14, and 1/17/14, ordered on a PRN basis.</li> <li>-On 1/14/14 the order for Haldol was changed to 2 mg twice a day, and 1 mg PRN by his physician.</li> <li>*On 1/23/14 he was seen by the mental health practitioner, and the order for Haldol was discontinued. An order for Seroquel 25 mg at HS and every 8 hours PRN, and to start the Aricept (medication for dementia) 5 mg every day for 4 weeks, and then to increase it to 10 mg daily.</li> <li>*From 3/14/14 through 3/24/14 received an antibiotic for a chronic inflammatory skin disease.</li> <li>*Was seen by the mental health practitioner on 3/27/14. She had increased the Seroquel to 12.5 mg twice a day and continued with the 25 mg Seroquel at HS. He also received Trazodone 25 mg every HS. A pharmacist recommendation for a gradual dose reduction (GDR) of the</li> </ul>	F 329			

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F 329	<p>Continued From page 24</p> <p>antidepressant had also been reviewed but had been denied due to continued episodes of agitation and behaviors.</p> <p>*From 3/27/14 until 10/1/14 the following behaviors were documented: restless (twice), agitated (once), attempting to get outside (once), and refused to lay down (once).</p> <p>Review of resident 7's mental health consultation revealed:</p> <p>*1/23/14 - He was seen by the certified nurse practitioner (CNP). She stated: "He has a history of both short and long term memory problems as well as anxiety and depression." He had fallen on 10/9/13, fractured his left hip, had surgically repaired.</p> <p>- "He has gradually become more confused and restless. He hallucinates (sees and hears things that are not there) and is agitated. He is not sleeping well at night."</p> <p>- He was started on Haldol [antipsychotic] which was increased on January 14th. Staff have not noted a great deal of improvement since the Haldol was started."</p> <p>- She discontinued the Haldol, and added Seroquel 25 mg at HS and every 8 hours PRN. She also added Aricept 5 mg every day for four weeks, then increased it to 10 mg daily thereafter.</p> <p>- There were no recommendations on how to manage the behaviors without medications.</p> <p>*3/27/14 - He was seen by the CNP who documented "He recently had become more agitated and has exhibited aggressive and combative behavior. He is uncooperative with personal cares and attempts to harm staff when cares are attempted. He is not sleeping at night and having visual hallucinations. He is quite confused this afternoon."</p> <p>- There were no recommendations on behavioral</p>	F 329		

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F 329	<p>Continued From page 25</p> <p>changes and adjustments staff might make to help him sleep without relying on medications.</p> <p>-There was no discussion on the role lack of sleep might have caused in his hallucinations, or confusion.</p> <p>-There was no discussion on attempting to have his previous life routine incorporated into his routine now, such as what time he went to bed, or what had been his pre-bed routine.</p> <p>*Further reviews occurred on 5/22/14 and 8/28/14 with no changes made in his medications.</p> <p>Review of resident 7's 8/19/14 care plan revealed:</p> <p>*Problem: Mood: "I have a diagnosis of depression and anxiety and insomnia. My mood is stable. ____ (Name of mental health agency) provided med (medication) management for my behaviors."</p> <p>-Approaches included "Administer medication: currently receiving Aricept, Seroquel, Trazodone, and Zolof. Monitor and record effectiveness and/or any adverse side effects."</p> <p>*Problem: "Behaviors: I have a diagnosis of vascular dementia with behavior disturbance. I don't understand my need for help with cares and at times become combative and verbal when resisting cares. I need staff to help anticipate my needs-I have periods of restlessness and may need staff to toilet me, reposition me, make sure I am comfortable, offer me food/drink, give me some Tylenol or offer my pain medication."</p> <p>-"Approaches: Resident will continue to have med management for behaviors with ____ [mental health agency and nurse practitioner] Nursing staff will administer Aricept, Seroquel, Trazodone, and Zolof as directed. Monitor and record effectiveness. Report any adverse side effects. Administer pain medication as needed to</p>	F 329			

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F 329	Continued From page 26 minimize restlessness."  Review of resident 7's entire medical record revealed there was no social services documentation of how the social worker had worked with staff to manage the resident's behavior without the use of medications. A further review of the monthly behavior committee minutes revealed it reviewed the medications the resident was on to manage the behaviors, but there was no discussion of specific interventions to manage the behavior without medications. There was no discussion of his behaviors stabilizing due to having been more adjusted to the facility, better pain control, and the rash that had resolved.  Review of resident 7's consultant Pharmacist Drug Regimen Review reports revealed: *On 3/25/14 he completed the February 2014 Pharmacy review with no recommendations. *On 4/29/14 he completed the March 2014 Pharmacy review with no recommendations. *On 5/20/14 he completed the April 2014 Pharmacy Review with no recommendations. *On 6/14/14 he completed the May 2014 Pharmacy review with no recommendations. *On 7/29/14 he completed the June 2014 Pharmacy Review with no recommendations. *On 9/2/14 he completed the July 2014 Pharmacy Review with no recommendations. *On 9/2/14 he completed the August 2014 Pharmacy Review with no recommendations. *He had not addressed that resident 7: -Received duplicate medications for the same diagnosis. -Had no specific physician guidelines for the behaviors that warranted the use of the PRN Seroquel, nor how long that PRN order was in	F 329			

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F 329	<p>Continued From page 27</p> <p>effect.</p> <p>-Had no documented monitoring of adverse side effects of the psychotropic medications he received by nursing staff.</p> <p>-Had no documented discussion or consideration of the interaction of the eighteen scheduled medications he was on.</p> <p>-Had not reviewed the role the urinary tract infection, the chronic skin disease, pain from falls, and adjustment to the facility might have played in his increased confusion and agitation.</p> <p>3. Telephone interview with the consulting pharmacist on 10/1/14 at 10:25 a.m. revealed he: *"Looked at labs [laboratory results], hypnotic tapers [gradual dose reductions], psych [mind altering] meds [medications] every six months or year, indication for antibiotics, or duplication of meds." *Looked at multiple medications for the same diagnosis. *Had not documented if there were no irregularities. *Looked at Seroquel because "nobody liked that." He agreed the indications for the use of Seroquel were not always appropriate including restlessness. *Thought behaviors that warranted the use of psychotropic medications should have been chronic behaviors such as crying, screaming, or so upset they might hurt themselves. *Might or might not address when a resident was on an antidepressant, antianxiety, and an antipsychotic medication. *Had not thought antipsychotic medications were the best for PRN use but deferred to the physician. He would not have addressed that in his monthly reviews.</p>	F 329			

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F 329	Continued From page 28 Review of the provider's 1/1/07 agreement with the mental health agency used for resident 7 revealed: *The ___[name of mental health center] agreed to the following scope of services" -"Assist Facility staff with development of social services case plans based on mutually determined needs. -Recommend to the Facility social services designee provisions for meeting psychosocial needs of the residents. -Assist Facility staff in the development of individual care plans for emotionally and/or behaviorally disturbed patients."  Review of the provider's 9/30/14 Antipsychotic Drug policy revealed: * " ___[Name of facility] will 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. In an effort to discontinue antipsychotic drugs, residents will receive gradual dose reductions and behavioral interventions, unless clinically contraindicated. *Monitoring for efficacy (if effective) and side effects will be incorporated into a comprehensive care plan. *The consultant Pharmacist will do a psychotropic drug review monthly. Based on documentation, the consultant Pharmacist will evaluate the indication of use and need of the medication. *Behaviors will be documented in the clinical record."	F 329			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371			

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F 371	<p>Continued From page 29</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(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, testing, product information sheet, and policy review, the provider failed to maintain proper sanitizing of the wiping cloths during two of two meal observations and during random observations of the kitchen and dishmachine area. Findings include:</p> <p>1. Observation on 9/29/14 at 2:20 p.m. in the kitchen on the clean end of the dishmachine revealed a wet cloth laying on a shelf directly above the clean silverware.</p> <p>Observation on 9/29/14 at 5:16 p.m. in the kitchen on the end of the counter of the two compartment sink revealed: *Two wet cloths laying next to a white bucket. *The liquid in the bucket was tested using a Hydrion 40 test strip (a type of special paper) and was at zero parts per million (ppm). *That test revealed no sanitizer in the sanitizing bucket.</p> <p>Interview on 9/29/14 with dietary assistant G during the observation revealed: *The white bucket had been used as the</p>	F 371	<p><b>F 371</b> 11/20/14</p> <p>On 10/20/14, the dietary services director determined that the current rags lost their effectiveness within 1 hour in the sanitizer.</p> <p>Beginning 10/23/14, the dietary services director replaced the current foodservice rags with Ecolab foodservice wipes.</p> <p>On 10/23/14, the dietary services director audited the effectiveness of the Ecolab foodservice wipes and determined that they were effective for up to 6 hours in the sanitizer solution.*</p> <p>On 10/23/14, education was provided by the dietary services director and RD to all dietary staff on the sanitizing process.</p> <p>Beginning 10/27/14, the dietary services director will audit the sanitizing log to ensure that the documentation is complete.</p> <p>The dietary services director will report the audits to the QA committee on 11/18/14. The results of the audit will be used to educate staff as necessary. The audit results will be utilized by the QA committee to determine ongoing auditing requirements at the monthly * [redacted] QA committee meeting.</p> <p><i>JTSDDOHIME</i></p> <p><i>The sanitizer solution is being tested four times daily by dietary staff with random audits by the certified dietary manager six times per week of the effectiveness of the solution. JTSDDOHIME</i></p>

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F 371	<p>Continued From page 30</p> <p>sanitizing bucket.</p> <p>*She stated she had changed the solution in the bucket at approximately 2:00 p.m. that afternoon after the noon meal.</p> <p>*She had used the sanitizing bucket with the solution for the cloths for wiping down the following areas:</p> <ul style="list-style-type: none"> <li>-Food production.</li> <li>-Food carts.</li> <li>-Steam table and counters.</li> </ul> <p>Interview and testing on 9/29/14 at 5:30 p.m. with the certified dietary manager (CDM) revealed:</p> <p>*She agreed the above white bucket used as the sanitizing bucket tested at zero ppm.</p> <p>*The test revealed no sanitizer in the sanitizing bucket.</p> <p>*The sanitizing liquid in the bucket needed to have been higher than zero ppm.</p> <p>*A level of at least 150 ppm was needed for proper sanitizing.</p> <p>Observation and testing on 9/30/14 at 8:30 a.m. in the kitchen and in the dishroom revealed:</p> <p>*One wet cloth laying on the counter on the two compartment sink next to the white sanitizing bucket.</p> <p>*One white bucket with liquid on the dirty end of the dishroom area.</p> <p>*That bucket was tested using a test strip, and it tested at zero ppm.</p> <p>*The test revealed no sanitizer in the sanitizing bucket.</p> <p>Interview on 9/30/14 during the above observation with dietary assistant K regarding the sanitizing bucket in the dishroom revealed:</p> <p>*That white bucket on the dirty end of the dishroom area was used as a sanitizing bucket.</p>	F 371		

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F 371	<p>Continued From page 31</p> <p>*She had used the wiping cloths in the white bucket to wipe down the dishroom area. *She changed the solution in the bucket every three to four hours.</p> <p>Observation on 9/30/14 at 11:50 a.m. in the kitchen revealed multiple cloths laying beside the white sanitizing bucket on the dirty end of the dishmachine.</p> <p>Interview on 9/30/14 at 1:40 p.m. by telephone with an EcoLab sales representative revealed: *The Oasis Multi-Quat (quaternary) 146 Sanitizer needed to have been at no less than 150 to 200 ppm for an acceptable range for sanitizing. *A level of zero ppm was not an acceptable level for proper sanitizing.</p> <p>Interview on 10/1/14 at 8:50 a.m. and at 9:45 a.m. with the CDM regarding the sanitizing bucket in the kitchen revealed: *The sanitizing bucket solution needed to have been at 150 ppm to 400 ppm. *The wiping cloths needed to have been in the sanitizing solution when not in-use for proper sanitizing of the food counters, dishroom, steam table, and food production areas. *There was a potential for cross-contamination with the liquid in the sanitizing bucket at zero ppm. *The wet sanitizing cloths should not have been out of the sanitizing bucket when not in-use. *That was an area that needed to have been improved on for proper sanitizing in the kitchen.</p> <p>Review of the provider's undated product information sheet on the Oasis 146 Multi-Quat Sanitizer revealed: *It was effective at a range of 150 ppm through</p>	F 371		

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F 371	Continued From page 32 400 ppm. *It was an EPA (Environmental Protection Agency) registered sanitizer for use on hard, non-porous food preparation surfaces. *Directions for use had included: -"Apply Oasis 146 Multi-Quat Sanitizer at proper use solution. -Expose all surfaces of equipment, ware or utensils to the sanitizing solution for a period of not less than one minute. -Air dry."	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH  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.  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.  The facility must employ or obtain the services of a licensed pharmacist who provides consultation	F 425	<u>F 425</u> *#1215 JTS/DDH/MF Resident [redacted] chart was reviewed on 10/16/14, along with the pharmacy return records.  The procedure for discontinued medications was updated on 08/26/14 to include chart documentation of medication name, RX#, and number or amount of medication remaining to be destroyed. A form will also be completed with this information, along with a 2 <sup>nd</sup> nurse verifying the amount remaining and both nurses signing on the sheet.	11/20/14

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F 425	Continued From page 33 on all aspects of the provision of pharmacy services in the facility.  This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on record review and interview, the provider failed to account for medication for one of one sampled resident (12) in a closed record review. Findings include:  1. Review of resident 12's complete medical record revealed: *She had all oral medications discontinued on 4/2/14. *She had a hospice consultation ordered on 4/8/14. Antibiotics were discontinued at that time. *She was found by staff without a heart beat and not breathing at 4:52 a.m. on 4/12/14 after her son, who had been in the room, had summoned them. *The Discontinued Medication Released to Pharmacy forms dated 4/9/14 and 4/17/14 contained all discontinued medications except: -Novolin insulin vial. -Zofran (given for nausea and vomiting). -Calmoseptine cream (used for minor open area or redness of skin).  Interview on 10/1/14 at 12:40 p.m. with the director of nursing regarding resident 12 revealed: *Most of the resident's medications had been discontinued on 4/2/14 and 4/8/14 when she was placed on comfort care. *She believed upon discharge they put left over	F 425	The Director of Nursing (DON) and Nurse Manager completed additional education on this procedure with all nursing staff on 10/27/14 and 10/29/14.  Starting 10/30/14, the Director of Nursing (DON) or designee will perform audits on this procedure weekly through January to ensure that the information is correctly entered into the chart and on the form. The DON or designee will complete ongoing education with staff as necessary.  The Director of Nursing (DON) or designee will report the audits to the QA committee on 11/18/14. The results of the audit will be used to educate staff as necessary. The audit results will be utilized by the QA committee to determine ongoing auditing requirements at the monthly <span style="background-color: black; color: black;">[REDACTED]</span> QA committee meeting.  JT/SDD/HMF	

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F 425	Continued From page 34 insulin vials in the sharps containers. There was no documentation of that. *She believed upon discharge they threw the left over cream in the garbage. There was no documentation of that. *She had not found any record of the return or destruction of the Zofran. *They had no policy or procedure for the destruction of medications following a resident's discharge.	F 425		
F 428 SS=F	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.  This REQUIREMENT is not met as evidenced by: Surveyor: 26180 A. Based on record review, interview, and policy review, the provider failed to ensure drug irregularities for 2 of 11 sampled residents (5 and 7) regarding: *Duplication of medications for a diagnosis. *Appropriate diagnosis or indication for the use of a psychotropic (medication for treatment of mental illness) medication. *Antipsychotics (medication for serious mental disorder) that were ordered on an as needed	F 428	On 10/30/14, Bethesda Home contracted with a new Consultant Pharmacist. The Consultant Pharmacist responsibilities will include monthly pharmacy review of all resident's medications to be completed by the 10th of each month for the previous month. The pharmacy review will include reviewing for duplication of medications, correlating diagnosis for all medications, and PRN medication usage. The Consultant Pharmacist will make recommendations for discontinuation of medications and/or gradual dose reductions as they determine appropriate per their review.  By 11/20/14, Consultant Pharmacist will review Resident #7's medications, and chart supporting documentation to ensure that to ensure that it is necessary to treat a specific condition as diagnosed and documented in the clinical record.  By 11/20/14, the Consultant Pharmacist will review Resident #5's medications, chart and supporting documentation to ensure that to ensure that it is necessary to treat a specific condition as diagnosed and documented in the clinical record.	11/20/14

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F 428	<p>Continued From page 35</p> <p>basis had clear guidelines for their use had been addressed during the monthly pharmacy reviews. Findings revealed:</p> <p>1. Review of resident 7's September 2014 physician order report revealed he received the following medications:                      *Zoloft (antidepressant) tablet 100 milligrams (mg) for depression one time per day started on 7/5/13.                      *Seroquel (antipsychotic) 25 mg at HS [hour of sleep] for vascular dementia (memory loss caused by lack of blood flow to the brain) and behavioral disturbance started on 1/23/14.                      *Seroquel 25 mg twice a day for vascular dementia without behavioral disturbance started on 3/27/14.                      *Trazodone (antidepressant) 50 mg once a day in the evening for depression started on 3/27/14.                      *Aricept (treatment of dementia) 10 mg daily.                      *Seroquel 25 mg every 8 hours PRN [as needed] for vascular dementia and behavior disturbance, started on 1/23/14.                      -The physician had not specified when the resident could have received that medication.                      -There was no guidance on how long that PRN antipsychotic could have been used without further review.</p> <p>Review of resident 7's following Minimum Data Set (MDS) assessments revealed:                      *On 2/3/14 he had:                      -Exhibited verbal and "other" behaviors, but they had not interfered with care or impacted others.                      -No indicators of psychosis (mental illness).                      *Received an antidepressant.                      *On 8/14/14 he had memory loss, impaired decision making, and mild depression.                      *No indicators of psychosis including</p>	F 428	<p>By 11/20/14, the Consultant Pharmacist will review all residents' medications, and chart supporting documentation to ensure that it is necessary to treat a specific condition as diagnosed and documented in the clinical record.</p> <p>Beginning 11/18/14, the Director of Nursing (DON) or designee will report to the QA Committee monthly for four months the results of the Consultant Pharmacist most recent visit.</p>		

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F 428	<p>Continued From page 36</p> <p>hallucinations, or delusions.</p> <p>*Decreased energy, moved slow, and felt tired.</p> <p>*Received an antidepressant and antipsychotic medication.</p> <p>Review of resident 7's progress notes revealed since his admission on 10/14/13 following a fall with a fractured hip he:</p> <p>*Had been treated for a urinary tract infection from 12/1/13 through 12/6/13. During that time he was restless at night and confused. He became agitated and wanted to get out of bed. His body temperature fluctuated from cold to hot.</p> <p>*Continued to be restless at night and had fallen as he attempted to get out of bed on 12/12/13, 12/23/13, and 12/27/13.</p> <p>-There was no indication of what time the resident was being put to bed and the role it played in his restlessness.</p> <p>*He complained of hip pain after the falls and received medications as needed for the pain.</p> <p>*On 12/23/13 he had a tooth pulled.</p> <p>*Behaviors that were consistently documented included restless and agitated, attempting to get out of bed.</p> <p>*Received Haldol (antipsychotic) 1 mg for restlessness on 1/13/14, 1/16/14, and 1/17/14, ordered on a PRN basis.</p> <p>-On 1/14/14 the order for Haldol was changed to 2 mg twice a day, and 1 mg PRN by his physician.</p> <p>*On 1/23/14 he was seen by the mental health practitioner, and the order for Haldol was discontinued. An order for Seroquel 25 mg at HS and every 8 hours PRN, and to start the Aricept (medication for dementia) 5 mg every day for 4 weeks, and then to increase it to 10 mg daily.</p> <p>*From 3/14/14 through 3/24/14 received an antibiotic for a chronic inflammatory skin disease.</p>	F 428		

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F 428	<p>Continued From page 37</p> <p>*Was seen by the mental health practitioner on 3/27/14. She had increased the Seroquel to 12.5 mg twice a day and continued with the 25 mg Seroquel at HS. He also received Trazodone 25 mg every HS. A pharmacist recommendation for a gradual dose reduction (GDR) of the antidepressant had also been reviewed but had been denied due to continued episodes of agitation and behaviors.</p> <p>*From 3/27/14 until 10/1/14 the following behaviors were documented: restless (twice), agitated (once), attempting to get outside (once), and refused to lay down (once).</p> <p>Review of resident 7's 8/19/14 care plan revealed: *Problem: Mood: "I have a diagnosis of depression and anxiety and insomnia. My mood is stable. ___(Name of mental health agency) provided med (medication) management for my behaviors." -Approaches included "Administer medication: currently receiving Aricept, Seroquel, Trazodone, and Zoloft. Monitor and record effectiveness and/or any adverse side effects." *Problem: "Behaviors: I have a diagnosis of vascular dementia with behavior disturbance. I don't understand my need for help with cares and at times become combative and verbal when resisting cares. I need staff to help anticipate my needs-I have periods of restlessness and may need staff to toilet me, reposition me, make sure I am comfortable, offer me food/drink, give me some Tylenol or offer my pain medication." -"Approaches: Resident will continue to have med management for behaviors with ___[mental health agency and nurse practitioner] Nursing staff will administer Aricept, Seroquel, Trazodone, and Zoloft as directed. Monitor and record</p>	F 428		

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F 428	<p>Continued From page 38</p> <p>effectiveness. Report any adverse side effects. Administer pain medication as needed to minimize restlessness."</p> <p>Review of resident 7's entire medical record revealed there was no documented evidence that side effects had been monitored.</p> <p>Review of resident 7's consultant Pharmacist Drug Regimen Review reports revealed:                      *On 3/25/14 he completed the February 2014 Pharmacy review with no recommendations.                      *On 4/29/14 he completed the March 2014 Pharmacy review with no recommendations.                      *On 5/20/14 he completed the April 2014 Pharmacy Review with no recommendations.                      *On 6/14/14 he completed the May 2014 Pharmacy review with no recommendations.                      *On 7/29/14 he completed the June 2014 Pharmacy Review with no recommendations.                      *On 9/2/14 he completed the July 2014 Pharmacy Review with no recommendations.                      *On 9/2/14 he completed the August 2014 Pharmacy Review with no recommendations.                      *He had not addressed that resident 7:                      -Received duplicate medications for the same diagnosis.                      -Had no specific physician guidelines for the behaviors that warranted the use of the PRN Seroquel, nor how long that PRN order was in effect.                      -Had no documented monitoring of adverse side effects of the psychotropic medications he received by nursing staff.                      -Had no documented discussion or consideration of the interaction of the eighteen scheduled medications he was on.                      -Had not reviewed the role the urinary tract infection, the chronic skin disease, pain from falls,</p>	F 428		

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F 428	<p>Continued From page 39</p> <p>and adjustment to the facility might have played in his increased confusion and agitation.</p> <p>2. Review of resident 5's 9/29/14 physician's order report revealed she received the following medications:</p> <p>*Trazodone (for sleep) 50 mg once a day for a diagnosis of nonorganic psychosis, depression, started on 3/20/12.</p> <p>*Zyprexa Aydis (antipsychotic) 10 mg once a day at 9:00 p.m. for hallucinations started on 3/22/12. -A second dose was added on 2/27/14 at 8:00 a.m.</p> <p>*Lorazepam (for antianxiety) 0.5 mg four times a day for anxiety disorder started on 9/27/12. -A second dose was added on 2/21/14 for 1 mg to be given every 6 hours PRN.</p> <p>*Melatonin (for sleep) 3 mg once a day started on 10/15/13.</p> <p>*Twenty-one scheduled medications.</p> <p>Review of resident 5's 7/29/14 care plan review revealed:</p> <p>**Problem: I have a dx of Depressive Nonorganic Psychosis. Some days I have repetitive health complaints. I can be short-tempered/easily annoyed with staff and family. I have a dx [diagnosis] of depression and anxiety. Mood cycles-at times I am pleasant and cooperative, but some days I make negative statements about myself and others. I also have periods of catatonic [nonresponsive to stimulation] states where I will not wake up. Dx: Insomnia."</p> <p>*Approach: (Start Date 5/17/11) Administer Zyprexa Zydis, Effexor XR, Lorazepam and Trazodone as MD [medical doctor] directs. Monitor and record effectiveness and/or any adverse side effects."</p>	F 428			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435071</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/01/2014</b>
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F 428	<p>Continued From page 40</p> <p>Review of resident 5's 2/27/14 mental health consult revealed "Staff report that [resident's name] has had continued episodes on non-responsive behavior. She has also been more delusional [having thoughts not based on reality] confused at times. The recent contributing factor may be a UTI [urinary tract infection] and some issues with her indwelling catheter."</p> <p>Review of resident 5's entire medical record revealed there was no documentation of monitoring of adverse side effects of any medications.</p> <p>Review of resident 5's following consulting consultant Pharmacist Drug Regimen Review reports revealed:                      *On 3/25/14 he completed the February 2014 review with no recommendations.                      *On 4/29/14 he completed the March 2014 review with no recommendations.                      *On 5/20/14 he completed the April 2014 review with no recommendations.                      *On 7/29/14 he completed the June 2014 review with no recommendations.                      *On 9/2/14 he completed the July 2014 review with no recommendations.                      *On 9/2/14 he completed the August 2014 review with no recommendations.                      *There was no documentation of review of:                      -Receiving multiple medications for the same diagnosis.                      -The interaction of the twenty-one scheduled medications she was and the role it played in her confusion and hallucinations.                      -The lack of monitoring of adverse side effects.</p> <p>3. Interview on 9/30/14 at 9:00 a.m. with the director of nursing revealed:</p>	F 428		

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F 428	<p>Continued From page 41</p> <p>*She had recently discussed the need to start working on their medication use with the clinical manager.</p> <p>*They were aware their residents were on many medications, and many of them were duplicates.</p> <p>*She was new in her position, and they were just starting to prioritize what areas they needed to focus on regarding resident care areas including medications.</p> <p>*Their pharmacist had not given a lot of guidance in reducing medications specifically psychoactive medications. He had made recommendations for dose reductions, but the recommendation was usually rejected when the physician reviewed them.</p> <p>Telephone interview with the consulting pharmacist on 10/1/14 at 10:25 a.m. revealed he:          ***Looked at labs [laboratory results], hypnotic tapers [gradual dose reductions], psych [mind altering] meds [medications] every six months or year, indication for antibiotics, or duplication of meds."          *Looked at multiple medications for the same diagnosis.          *Had not documented if there were no irregularities.          *Looked at Seroquel because "nobody liked that." He agreed the indications for the use of Seroquel were not always appropriate including restlessness.          *Thought behaviors that warranted the use of psychotropic medications should have been chronic behaviors such as crying, screaming, or so upset they might hurt themselves.          *Might or might not address when a resident was on an antidepressant, antianxiety, and an antipsychotic medication.          *Had not thought antipsychotic medications were</p>	F 428		

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F 428	<p>Continued From page 42</p> <p>the best for PRN use but deferred to the physician. He would not have addressed that in his monthly reviews.</p> <p>Review of the provider's 9/30/14 Antipsychotic Drug policy revealed: * "____ [Name of facility] will 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. In an effort to discontinue antipsychotic drugs, residents will receive gradual dose reductions and behavioral interventions, unless clinically contraindicated. *Monitoring for efficacy (if effective) and side effects will be incorporated into a comprehensive care plan. *The consultant Pharmacist will do a psychotropic drug review monthly. Based on documentation, the consultant Pharmacist will evaluate the indication of use and need of the medication. *Behaviors will be documented in the clinical record."</p> <p>Surveyor: 33265 B. Based on interview and record review, the provider failed to provide timely monthly medication reviews for one of twelve months by the licensed consultant pharmacist for ten of eleven sampled residents (1, 2, 3, 4, 5, 6, 7, 8, 9, and 11). Findings include:</p> <p>1. Review of residents 1, 2, 3, 4, 5, 6, 7, 8, 9, and 11's complete medical record revealed the monthly review for July 2014 was delayed until 9/2/14.</p> <p>Interview on 10/1/14 at 8:15 a.m. with the director</p>	F 428		

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F 428	Continued From page 43 of nursing revealed they had no policy or procedure regarding monthly medication reviews by the consultant pharmacist.  Interview on 10/1/14 at 10:25 a.m. with consultant pharmacist revealed: *His standard or goal was to do monthly medication reviews on all residents. *He would review the information for May the next month in June and so forth. *He was not able to get to the facility in August 2014 and had done the July 2014 monthly reviews for the residents on 9/2/14.	F 428		

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NAME OF PROVIDER OR SUPPLIER  <b>BETHESDA HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>129 W HWY 12 WEBSTER, SD 57274</b>
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 9/30/14. Bethesda Home was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE *Administrator* (X6) DATE *10/29/14*

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

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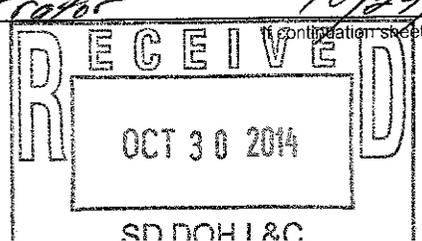
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10706</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/01/2014</b>
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S 000	Initial Comments  Surveyor: 32331 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 9/29/14 through 10/1/14. Bethesda Home was found not in compliance with the following requirements: S206, S210, and S236.	S 000	Addendums noted with an asterisk per 11/14/14 telephone to facility DON. JTS/DDH/MF	
S 206	44:04:04:05 PERSONNEL-TRAINING  The facility must have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs must cover the required subjects annually. These programs must include the following subjects: (1) Fire prevention and response. The facility must conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills must be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) ...Resident rights; (7) Confidentiality of...resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of...residents with unique needs; and (10) Dining assistance, nutritional risks, and hydration needs of...residents.  ...Additional personnel education shall be based on facility identified needs.	S 206	<u>S206</u>  Beginning 10/02/14, the business office added "Creating a Restraint Free Environment" education to each current employee's Silver Chair Learning requirement for the month of October to ensure that required subjects for ongoing education programs are covered. Also, education regarding restraints was provided to all staff during a mandatory in-service on 10/27/14 and 10/29/14.  Beginning 11/01/14, the business office or designee will audit the continued education course requirements. The audit results will be utilized by the QA committee to determine ongoing auditing requirements at the monthly QA committee meeting. * JTS/DDH/MF	11/20/14  *for all staff JTS/DDH/MF

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X6) DATE: *10/29/14*



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S 206	<p>Continued From page 1</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 26180</p> <p>A. Based on interview and policy review, the provider failed to ensure three of three unlicensed assisted personnel/medication aides (UAP/MA) (I, J, and K) had received annual re-training for medication administration. Findings revealed:</p> <p>1. Interview on 10/1/14 at 9:30 a.m. with the director of nursing (DON) and nurse manager revealed: *They had not done any annual re-training on UAP/MAs I, J, and K. *They had documentation of their initial training when they had become a UAP/MA.</p> <p>Review of the provider's undated medication aide policy revealed **Requirements: -A nursing aide to have taken nurse aide training course and medication aide course. -Medication aide must attend continuing education as determined by DON."</p> <p>Surveyor: 32331</p> <p>B. Based on record review, interview, and policy review, the provider failed to ensure all employees received annual training for one of ten mandated annual topics (proper use of restraints). Findings include:</p> <p>1. Review of the staff in-service records for 2013 and 2014 revealed there had been no staff training on proper use of restraints.</p> <p>Interview on 10/1/14 at 8:30 a.m. with the business manager/human resource director confirmed the in-service topic proper use of restraints had not been conducted for all</p>	S 206		

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S 206	Continued From page 2 employees within the annual time frame.  Interview on 10/1/14 at 1:00 p.m. with the director of nursing regarding the in-service topic proper use of restraints revealed: *There needed to have been an annual in-service for all employees. *That was an important in-service since the provider had a resident (6) on a restraint.  Review of the provider's revised 2003 In-Service Training Programs policy revealed: *All personnel participated in regularly scheduled in-service classes. *The ten mandated annual topics including proper use of restraints was not listed on that policy.	S 206		
S 210	44:04:04:06 EMPLOYEE HEALTH PROGRAM  The facility must have an employee health program for the protection of the...residents. All personnel must be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease which may endanger the health of...residents and fellow employees may not return to duty until they are determined by a physician or the physician's designee to no longer have the disease in a communicable stage.	S 210	<p><b>S210</b></p> <p>Beginning 10/02/14, the business office replaced the new employee physical form to ensure that during the physical evaluation of each new employee, it is determined by a licensed health care professional the evaluated person is free of communicable disease to the best of the licensed health care professional's knowledge.</p> <p>Beginning 11/01/14, the business office or designee will audit all new employee physical forms to ensure that the question is on each form and that the question is completed.</p> <p>Audits will be reported to the QA committee starting 11/18/14. The audit results will be utilized by the QA committee to determine ongoing auditing requirements at the monthly <del>QA</del> QA committee meeting.</p> <p><i>JTS/DH/MF</i> * by business manager or designee. <i>JTS/DH/MF</i></p>	11/20/14

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S 210	<p>Continued From page 3</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 26180</p> <p>Based on employee file review and interview, the provider failed to ensure five of five new employees (A, B, C, L, and M) had a health professional evaluate them for freedom of communicable diseases at the time of being hired. Findings include:</p> <p>1. Review of employee health evaluations completed on employees A, B, C, L, and M revealed a health professional had not made a statement regarding them being free of communicable diseases at the time of being hired.</p> <p>Interview on 10/1/14 at 10:40 a.m. with the business office manager/human resources director revealed: *Each new employee was evaluated by a physician. *That evaluation had been completed on employees A, B, C, L, and M was part of their employment files. *That evaluation had not required the health professional to address freedom from communicable diseases for those employees.</p>	S 210		
S 236	<p>44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS</p> <p>Tuberculin screening requirements for healthcare workers or residents are as follows:</p> <p>(1) Each new healthcare worker or resident shall receive the two-step method of Mantoux skin test to establish a baseline within 14 days of</p>	S 236	<p><u>S236</u></p> <p>On 10/29/14, the Infection Control Tuberculin Skin Testing policy was updated to include the first TB test being completed on hire date for all new employees and will be read 48-72 hours later. If the TB test is negative, the employee will have a second TB test administered in the opposite arm one week later and will be read 48-72 hours after. If the two-step TB test is not completed within 14</p>	11/20/14

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S 236	<p>Continued From page 4</p> <p>employment or admission to a facility. Any two documented Mantoux skin tests completed within a 12 month period prior to the date of admission or employment shall be considered a two-step. Skin testing is not necessary if documentation is provided of a previous positive reaction of ten mm induration or greater. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 26180 Based on employee file review, interview, and policy review, the provider failed to ensure three of five new employees (A, B, and C) received the two-step tuberculin (TB) screening within fourteen days of being hired. Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of employee A's file revealed her date of having been hired was 8/7/14. The two-step TB screening had not been completed until 9/17/14. That was over one month after her date of hire.</li> <li>2. Review of employee B's file revealed her date having been hired was 7/18/14. The two-step TB screening had not been completed until 9/28/14. That was over two months after her date of hire.</li> <li>3. Review of employee C's file revealed her date of having been hired was 9/8/14. She had not completed the two-step TB screening at the time of this survey, that would be 23 days after being hired.</li> <li>4. Interview on 10/1/14 at 10:00 a.m. with the</li> </ol>	S 236	<p>days of hire date, the new employee will not be able to work until the second step has been completed.</p> <p>Beginning 11/01/14, the Director of Nursing (DON) or designee will audit the TB binder weekly to ensure that all new hire two-step TB tests are completed within 14 days of hire.</p> <p>Audits will be reported to the QA committee starting 11/18/14. The audit results will be utilized by the QA committee to determine ongoing auditing requirements at the monthly <del>QA</del> QA committee meeting.</p> <p><i>JT/SB/DCH/ME</i></p> <p><i>*by nurse manager or designee JT/SB/DCH/ME</i></p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 236	<p>Continued From page 5</p> <p>nurse manager and the director of nursing revealed:</p> <ul style="list-style-type: none"> <li>*The two-step TB screenings had not been completed within the required fourteen days of having been hired for employees A, B, and C.</li> <li>*Their expectation would have been to have completed them within fourteen days.</li> <li>*They had recently revised their policy, because they were aware the TBs for new hires had not been completed as required.</li> </ul> <p>Review of the provider's 9/25/14 TB control policy revealed:</p> <ul style="list-style-type: none"> <li>*"All new employees must have their first TB skin test administered on the first day of orientation.</li> <li>*Read and record the test 48 -72 hours after it was given.</li> <li>*If the initial test is negative, administer the same dose in the opposite forearm one to three weeks later."</li> <li>*Their newly revised policy still had not met the requirement of completing the TB screening within fourteen days of being hired.</li> </ul>	S 236		
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