

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2014
NAME OF PROVIDER OR SUPPLIER AURORA-BRULE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383	
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F 000	<p><i>Addendums noted with an asterisk per 2/24/14 telephone to facility administrator. TN/SOOH/JJ</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 26180 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/14/14 through 1/15/14. Aurora-Brule Nursing Home was found not in compliance with the following requirements: F248, F279, F280, F281, F314, F323, F327, F329, F441, and F520.</p>	F 000	<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:</p>	
F 248 SS=E	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on record review, interview, and policy review, the provider failed to maintain an effective activities program for two of two sampled residents (5 and 7). Findings include:</p> <p>1. Review of the activity director's November 2013, December 2013, and January 2014 calendar of activities and her activities attendance form revealed: *She had a personal calendar with one to two activities planned per day. *On several days one of the two activities had been listed as one-to-ones. *There had been no documentation of residents receiving one-to-one activities. *The activities attendance form had columns for</p>	F 248	<p>Resident 5 and 7's individualized activity programs were reviewed to ensure the resident's interests and physical, mental, and psychosocial well-being are being met.</p> <p>All other residents' individual activity programs were reviewed to ensure their interests and physical, mental, and psychosocial well-being are being met.</p> <p>Administrator and Activity Director reviewed and revised the activity departments policies and procedures so that they include accurate assessment of individual resident needs, a review of the residents who may benefit from individual one-to-one activities including previous resident preferences, likes and dislikes, definition of one-to-one activity, and planning and documenting activities.</p>	

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

TITLE

(X6) DATE

Kevin Hill

Administrator

2-12-14

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.

FEB 14 2014

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F 248	<p>Continued From page 1 resident names, "a.m.", "coffee", and "p.m." *A check mark had been placed next to activities that the residents had attended. *She had no individualized documentation of what activities the residents had attended.</p> <p>2. Review of resident 5's 8/26/13 Minimum Data Set (MDS) assessment revealed she had a Brief Interview for Mental Status (BIMS) interview score of three indicating severely impaired mental cognition (thinking).</p> <p>Review of resident 5's complete medical record revealed she had no documentation of any one-to-one activities having been offered or given.</p> <p>3. Review of resident 7's 11/15/13 MDS assessment revealed she had a BIMS score of eight indicating she had moderately impaired mental cognition.</p> <p>Review of resident 7's complete medical record revealed she had no documentation of any one-to-one activities having been offered or given.</p> <p>4. Interview on 1/14/14 at 3:20 p.m. and on 1/15/14 at 2:15 p.m. with the activities director revealed she: *Had no one-to-one activity policy. *Did one-to-one activities with anyone unable to participate in regularly scheduled activities. *Did not have any residents currently in need of one-to-one activities. *Did not document one-to-one activities. *Had no individualized activities program. *Had not provided residents with an activities calender in their rooms.</p>	F 248	<p>Administrator and Activity Director will present education to all staff that may assist with the provision of activities.</p> <p>The Activity director or designee will audit the individualized activity program for every resident one time each week for one month and once a month for two more months to ensure that the residents interests and physical, mental and psychosocial well being are met.</p> <p>The Activity Director or designee will present the finding of the audits at the monthly QAPI meetings with further follow-up as recommended by the committee.</p>	3/6/14	

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F 248	Continued From page 2 *Agreed activities were not individualized and had not been documented appropriately.	F 248			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy	F 279	Resident 1's care plan was reviewed to ensure that a comprehensive care plan had been developed to include the services to be provided to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as well as measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment All other residents' care plans were reviewed to ensure that a comprehensive care plan had been developed to include the services to be provided to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being as well as measurable objectives and timetables to meet the residents' medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. Administrator, Director of Nursing, and interdisciplinary team reviewed and revised the policies and procedures for the care planning process so that they include accurate resident assessments with weaknesses and strengths identified, decision-making using the CATs and CAAs as well as other relevant information, individual care plan development with goals and time frames while including the resident		

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F 279	Continued From page 3 review, the provider failed to ensure one of one new admission of a resident (1) had a care plan. Findings include: 1. Review of resident 1's medical record revealed: *He had been admitted on 1/1/14 from their assisted living center. *He had not had a care plan implemented at the time of his admission. *He did not have an interim care plan that had been developed since his admission. -That had been two weeks ago. Interview on 1/14/14 at 2:00 p.m. with the director of nursing and the social services designee regarding resident 1 revealed: *They confirmed he did not have a care plan. *It would be their normal procedure to start a care plan at the time a resident had been admitted. *They had not developed a care plan yet for him. *They did not have a care plan policy.	F 279	and their family, implementing the care plan, and on-going evaluations of the care plans change, resolve, discontinue, or continue any of the goals set. Administrator, Director of Nursing, and interdisciplinary team will present education to all staff that may assist in the process of care planning. The Director of Nursing or designee will audit care plans for every resident once a week for one month and once a month for two more months to ensure that the residents' comprehensive care plans include the services to be provided to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being as well as measurable objectives and timetables to meet the residents' medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The Director of Nursing or designee will present the findings of the audits at the monthly QAPI meetings with further follow-up as recommended by the committee.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	F 280	Resident 3, 6, and 9's care plans were reviewed to ensure that a comprehensive care plan had been developed within 7 days after the completion of the comprehensive assessment prepared by the interdisciplinary team including the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the residents' needs, and, to the extent practicable, the participation of the resident, the resident's family or the residents' legal representative and periodically reviewed and revised by the interdisciplinary team	3/6/14

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F 280	Continued From page 4 and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on interview, record review, and policy review, the provider failed to ensure resident care plans reflected the activities of daily living (ADL) and activity preferences for three of nine sampled residents (3, 6, and 9). Findings include: 1. Review of resident 3, 6, and 9's care plans revealed they did not address the amount of assistance needed for ADLs for the following: *Bed mobility (how the resident repositions in the bed). *Transfers (example: moving from bed to wheelchair). *Locomotion on and off the unit (how the resident moves between locations). *Dressing. *Eating (how the resident eats and drinks, regardless of the skill). *Toilet use (use of the restroom). *Personal hygiene. *Bathing. Review of the activity assessments for the above residents revealed resident specific likes and dislikes. Those likes and dislikes had not been carried over to their care plans for implementation.	F 280	All other residents' care plans were reviewed to ensure that a comprehensive care plan had been developed within 7 days after the completion of the comprehensive assessment prepared by the interdisciplinary team including the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the residents' needs, and, to the extent practicable, the participation of the resident, the resident's family or the residents' legal representative and periodically reviewed and revised by the interdisciplinary team Administrator, Director of Nursing, and interdisciplinary team reviewed and revised the policies and procedures of the care plan development so that they include resident, resident's family, or legal representative participation, the amount of assistance need with ADLs for bed mobility, transfers, locomotion on and off the unit, dressing, eating, toilet use, personal hygiene, bathing, and resident's activity likes and dislikes to ensure that resident care plans reflect the ADL and activity needs of the resident. Director of Nursing, Administrator, and interdisciplinary team will present education to all staff who may assist in developing resident care plans.		

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F 280	Continued From page 5 Interview on 1/15/14 at 9:00 a.m. with the director of nursing (DON) confirmed she would have expected the care plans to reflect the above residents current status. Review of the Minimum Data Set (MDS) 3.0 Quality Measures User's Manual (v 8.0 04/15/13) page 1-9 revealed a step in using the resident assessment instrument (RAI) process should have been care planning, which was "Establishing a course of action with input from the resident, resident's physician and interdisciplinary team that moves a resident toward resident-specific goals utilizing individual resident strengths and interdisciplinary expertise; crafting the [how] of resident care." Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, MO., 2013, p. 23, revealed competencies are essential for nursing and one of the competencies is to "Work in Interdisciplinary teams where care is integrated to ensure that care is continuous and reliable." The provider did not have a policy for care planning.	F 280	Director of Nursing or designee will audit care plans for every resident twice a month for 3 months to ensure that the care plans are up-to-date and addressing the current ADL and activity needs of each resident. The Director of Nursing or designee will present the findings of the audits at the monthly QAPI meetings with further follow-up as recommended by the committee.	3/6/14
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 32333	F 281	Residents 1, 3, 5, 6, 11, and 12's MAR was reviewed to ensure appropriate time in task/process to chart for medication administration Resident 5's physician orders were reviewed to ensure appropriate monitoring and audits were being completed as ordered on wanderguard and battery function.	

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F 281	<p>Continued From page 6</p> <p>Based on interview, record review, and policy review, the provider failed to:</p> <ul style="list-style-type: none"> *Appropriately document medication administration to six of nine sampled residents (1,3, 5, 6, 11 and 12) and ensure appropriate documentation of medication orders on the medication administration record (MAR) and, or treatment administration record (TAR) for one of nine sampled residents (5). *Ensure accurate assessment and documentation of falls for one of five sampled residents (3) with falls. *Have physician ordered chest x-rays performed yearly on two of two sampled residents (3 and 9) who had a positive reaction to tuberculin skin testing. *Provide an accurate assessment for the use of side rails for one of one sampled cognitively impaired (mental impairment) resident (2) with side rails on the bed. <p>Findings include:</p> <p>1a. Observation and interview on 1/14/14 at 9:25 a.m. with registered nurse A after she had finished medication pass revealed:</p> <ul style="list-style-type: none"> *She had obtained resident 5's MAR from the MAR book. *She began to document she had given the resident's morning medications. *She had stated she was in a rush this morning, so she had not documented when she had given them. <p>Interview on 1/15/14 at 10:40 a.m. with the director of nursing confirmed her expectation would have been medications would have been documented immediately after they were administered.</p>	F 281	<p>Resident 3's medical record was reviewed to ensure that there was assessment and appropriate documentation and follow-up care of the resident's falls.</p> <p>Residents 3 and 9's medical record was reviewed to ensure that appropriate follow up and care had been provided for positive reaction to tuberculin skin testing.</p> <p>Resident 2's medical record was reviewed to ensure that assessment and appropriate documentation and follow-up was provided for the use of side rails.</p> <p>All other residents' physician orders and medical records were reviewed to ensure appropriate monitoring and documentation.</p>	3/6/14	

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F 281	<p>Continued From page 7</p> <p>b. Review of resident 5's 1/7/14 physician's orders revealed: *An order to monitor the Wanderguard (an alarm system) and battery function weekly. *An order to monitor placement of the Wanderguard daily every morning.</p> <p>Review of resident 5's January 2014 MAR and TAR revealed the above stated orders had been omitted.</p> <p>c. Interview on 1/15/14 at 10:40 a.m. with the director of nursing revealed the above stated physician's orders should have been documented on the MAR and, or TAR.</p> <p>Surveyor: 32572 2. Review of January 2014 copied MARs of residents 3 and 6 received from RN A at 10:00 a.m. on 1/14/14 revealed 8:00 a.m. scheduled medications had not been documented as administered, by initialing when they had been given.</p> <p>Observation of medication passes on 1/14/14 from 11:10 a.m. through 11:30 a.m. revealed(RN) A had pre-signed the medication administration records (MAR) prior to administration of medications to residents 1, 11, and 12.</p> <p>Review of the provider's updated 11/9/12 General Medication Administration Policy and Procedure revealed no statement as to when documentation should occur.</p> <p>Review of the provider's revised 3/21/09 Pharmaceutical Services policy revealed a statement "When medications are administered to a resident, it will be immediately initialed on the</p>	F 281	<p>The Director of Nursing reviewed and revised the policies and procedures as necessary in regards to medication administration including the appropriate time in the task and process of chart administration, the assessment and appropriate documentation and follow-up for the care of a resident who has fallen, the assessment and appropriate documentation and follow-up for resident and the use of side rails, and ensuring that the appropriate care and follow-up for residents with positive reaction to tuberculin skin testing.</p> <p>The Director of Nursing will present education to all nursing staff that may assist with the provisions of medication administration, assessing and appropriately documenting and follow-up care for residents who have fallen, assessing and appropriately documenting and follow up for residents and use of side rails, ensuring appropriate care and follow-up for residents with positive reactions to tuberculin skin testing.</p>		

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F 281	<p>Continued From page 8</p> <p>medication administration record (MAR)."</p> <p>Interview on 1/15/14 at 9:00 a.m. with the DON confirmed she would have expected the MAR to have been signed immediately after the resident had taken the medications.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, MO., 2013, p. 586, revealed "Record each medication on the patient's MAR as soon as you give medications to a patient."</p> <p>Review of a resolution issued by the South Dakota Board of Nursing at its September 12-13, 2006 meeting revealed: *Approved nursing education programs in the state had verified the standard for documentation of medication administration taught in nursing education was that documentation occurred following the administration of medication. *It was the position of the South Dakota Board of Nursing that the standard for safe administration of medication included the practice of documenting medication following administration to the patient.</p> <p>3. Review of resident 3's medical record revealed: *The Fall Tracking Log indicated four falls had occurred from 4/15/13 through 10/31/13 and had not been thoroughly assessed. -The log had the following areas to be assessed of conditions/diagnosis, appliance/device, medication, and environmental hazards. -The log indicated only the dates and times of the falls. -There had not been evaluations of conditions/diagnosis, appliance/devices,</p>	F 281	<p>The Director of Nursing or designee will audit the medication administration processes, the documentation and follow-up care for residents who have fallen, the documentation and follow-up for residents and the use of side rails, and the care processes for residents with positive reactions to tuberculin skin testing for every resident once a week for one month and once a month for two more months to ensure that the services provided and arranged by the facility are meeting professional standards of quality.</p> <p>The Director of Nursing or designee will present the findings of the audits at the monthly QAPI meetings with further follow-up as recommended by the committee.</p>		

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F 281	<p>Continued From page 9 medication, and environmental hazards as listed on the form.</p> <p>Interview on 1/15/14 at 9:00 a.m. with the DON stated she would have expected the fall log to have been completed by assessing all areas of the log, a fall risk assessment completed after the fall, and the provider's Fall and Accident Prevention Policy and Procedure to have been followed.</p> <p>Review of the provider's 10/14/11 Fall and Accident Policy and Procedure revealed the purpose was to have "Provided a save (safe) and accident free environment." The policy did not indicate the DONs expectation on what needed to have been done after a resident's fall.</p> <p>4. Review of resident 3's medical record revealed: *The resident had a positive tuberculin skin test (TB) (indicated exposure to a highly communicable lung disease). *The physician had ordered a yearly chest x-ray (CXR) on 7/25/12. *Resident 3's last CXR had been on 9/19/12.</p> <p>Interview on 1/15/14 at 8:30 a.m. with the infection control nurse confirmed she had been unable to find the results of yearly CXRs. She would phone the local clinic for CXR results to place in the medical record. At 9:40 a.m. on that same day the infection control nurse reported to this surveyor the clinic had been unable to obtain any other CXR results for resident 3.</p> <p>Interview on 1/15/14 at 9:00 a.m. with the director of nursing (DON) confirmed she would have expected physician's orders to have been</p>	F 281		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2014
NAME OF PROVIDER OR SUPPLIER AURORA-BRULE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383	
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F 281	<p>Continued From page 10 followed.</p> <p>Review of the providers 10/18/12 TB Policy and Procedure revealed "Each employee or resident with a history of tuberculosis (tuberculosis), shall be evaluated annually by a physician and a record maintained of presence or absence of symptoms."</p> <p>Surveyor: 33488 Preceptor: 25107</p> <p>5. Interview and medical record review on 1/15/14 at with the director of nursing (DON) at 11:10 a.m. regarding resident 9 revealed: *He had a positive tuberculin (TB) reaction. *A physician's order since Sept 2012 to have a yearly x-ray. *No yearly x-ray had been done as ordered. *She had agreed the resident should have had his yearly chest x-ray.</p> <p>Review of Donna D. Ignatavicius and M. Linda Workman, Medical-Surgical Nursing: Patient Centered Collaborative care, 7th Ed., Elsevier, St Louis Mo., 2013, page 655, revealed: *Once a person's skin test was positive for TB, a chest x-ray is necessary to detect active TB. *Yearly screening is needed and important to prevent the spread of TB.</p> <p>6. Observation and interview on 1/14/14 at 9:13 a.m. with resident 2 in her room revealed: *She responded to her name when called. *She responded to questions with random words in an attempt to communicate when spoken to. *A half side rail had been attached to the right side of her bed. *The left side of her bed had been against the</p>	F 281		

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F 281	<p>Continued From page 11 wall.</p> <p>Interview with the social services designee (SSD) on 1/14/14 at 9:40 a.m. revealed: *The resident was cognitively impaired (decreased mental function) and answered when spoken to but was unable to converse more than a few words. *That had been the resident's normal speech for many years.</p> <p>Interview and medical record review on 1/14/14 at 11:11 a.m. with certified nursing assistant (CNA) C regarding resident 2's side rail revealed: *Staff raised the half side rail to a locked position when the resident had been in bed resting or sleeping. *There had been an order dated 5/2/12 on the current care plan and treatment record for the half side rail to have been used "per resident request for repositioning and transfers." *She had "never seen the resident use the side rails for transferring or repositioning in bed in five years" while she had been employed at the facility. *The resident relied on staff for extensive assistance for transfer and repositioning. *The resident had not assisted with those activities.</p> <p>Review of the medical record revealed a Bed Rail Safety Notification form signed and dated by the resident on 5/21/12 stated she "understood the risks of using side rails."</p> <p>Interview and medical record review on 1/14/14 at 11:50 a.m. with the DON regarding resident 2's side rails revealed: *The resident had been admitted to the facility in</p>	F 281			

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F 281	Continued From page 12 2003 with a diagnosis of dementia (memory loss.) *She agreed due to the resident's impaired mental status, she would have been unable to understand bed rail safety as stated and signed the above mentioned form. *The nursing assessment dated 5/21/12 on the Restraints and Side Rail Utilization Assessment form had been marked "not completed per resident request." *She had agreed they had not completed an appropriate nursing assessment on the ability of the resident to use side rails effectively and safely for the purpose of transferring and repositioning. Review of the provider's policy on side rails written May 2012 revealed the nurse would complete an assessment on side rails and would reassess their use quarterly.	F 281			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Preceptor: 25107 Based on observation, interview, record review, and policy review, the provider failed to prevent	F 314	Resident 2 was assessed and observed to ensure that treatment and services were provided to prevent and heal pressure sores. All other residents were assessed and observed to ensure that treatment and services were provided to prevent and heal pressure sores.		

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F 314	<p>Continued From page 13</p> <p>the reoccurrence of a pressure ulcer (an injury to the skin and underlying tissue caused by unrelieved pressure, usually over a bony area.) for one of one sampled resident (2). Findings include:</p> <p>1. Observation and interview on 1/14/14 from 11:11 a.m. through 11:20 a.m. with certified nursing assistant (CNA) C regarding resident 2's pressure ulcer revealed: *The resident had an open area to her coccyx (area at the bottom of spine) measuring approximately 0.5 x 1.5 centimeters (cm) Stage 2 (A stage where the skin blisters or forms an open sore) pressure ulcer. *She had applied wet gauze to the ulcer after providing private area care. *She had been unaware of a physician's order to apply duoDERM (a dressing used to protect the skin from further breakdown) and had been told to use gauze by nursing staff. *She had been employed for five years with the provider, and the pressure ulcer had been a reoccurring problem for the resident.</p> <p>Interview and medical record review on 1/14/14 at 11:40 a.m. with registered nurse (RN) A regarding resident 2's pressure ulcer revealed she: *Was aware the pressure ulcer reoccurred. *Had not been using the duoDERM as ordered by the physician. *Stated, "We are just watching it to see if it gets worse." *Had described the resident's pressure ulcer as a Stage 2 pressure ulcer when asked. *Stated a Stage 3 pressure ulcer (The skin would develop an open, sunken hole called a crater and there would be damage to the tissue below the skin.) would indicate an intervention would be</p>	F 314	<p>The Director of Nursing, Medical Director, and interdisciplinary team reviewed and revised the necessary policies and procedures about skin concerns and pressure ulcers to include a screening for pressure ulcer risk, developing an individual pressure ulcer care plan, assessing and reassessing of pressure ulcers, the monitoring of treatment and prevention of pressure ulcers, and staff education and training about skin concerns and pressure ulcers.</p> <p>The Director of Nursing and interdisciplinary team will present education to all staff on skin concerns and pressure ulcer treatment and prevention.</p> <p>The Director of Nursing or designee will audit the treatment and prevention of pressure ulcers for every resident once a week for one month and once a month for two more months to ensure that residents who enters the facility without pressure sores does not develop pressure sores unless the resident's clinical condition demonstrates that they were unavoidable and that a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p>		

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F 314	Continued From page 14 needed. Interview and medical record review on 1/14/14 at 11:50 a.m. with the director of nursing (DON) regarding resident 2's pressure ulcer revealed: *The resident had diagnoses of diabetes and dementia (memory loss), and a history of pressure ulcers. *She had been unaware the pressure ulcer had reoccurred. *She had thought nursing staff had been using the duoDERM as ordered and had care planned the pressure ulcer. *The pressure ulcer had been documented by nursing staff as open on 1/11/14. Interview on 1/14/14 at 4:40 p.m. with the medical director regarding resident 2 revealed he: *Stated the nursing staff were usually "pretty good" about notifying him of changes. *Had not been aware the resident's pressure ulcer had reoccurred until he had arrived on that day at the facility. *Had not been concerned with staff not using the duoDERM dressing as ordered. *Had preferred gauze as the dressing of choice. *Stated "as far as I'm concerned this is an ongoing issue that will only heal with repositioning every 1-2 hours and adequate nutrition." Interview on 1/15/14 at 10:45 a.m. with the dietary manager regarding resident 2's nutritional status revealed: *The resident would often eat all of her breakfast but rarely ate lunch or dinner. *She had been offered a "standard nutritional supplement" daily. *Her supplement would be changed to a high protein supplement called Liquicel 1 oz daily while	F 314	The Director of Nursing or designee will present the findings of the audits at the monthly QAPI meeting with further follow-up as recommended by the committee.	3/6/14	

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F 314	<p>Continued From page 15</p> <p>her ulcer had been open (Stage 2 or greater). *That supplement would be discontinued approximately seven days after her ulcer healed. *She agreed there had been no preventative measure in place by dietary to give the resident additional protein when the ulcer was healed to prevent it from re-opening.</p> <p>Interview and record review on 1/15/14 at 11:10 a.m. with the DON regarding interventions to prevent resident 2's pressure ulcer from reoccurring revealed: *There had been no attempt to use a special mattress on the resident's bed to prevent pressure while sleeping or laying. *There was a foam pad in the resident's wheelchair instead of a pressure relieving gel pad. *She agreed the foam pad was not an appropriate pressure relieving device. *CNA documentation showed the resident had been repositioned only once every shift (day, evening, and night.) *She would have expected the resident to have been repositioned every one to two hours. *She agreed dietary had not tried maintaining the increased protein and extra nutrition to prevent the pressure ulcer from reoccurring. *She agreed the care plan was not adequate to meet the special needs of the resident. *She agreed the nursing staff had not appropriately assessed, documented, and intervened to prevent the pressure ulcer from reoccurring. *She agreed the provider had not notified the physician regarding a significant change in the resident's health.</p> <p>Review of the medical record revealed the</p>	F 314		

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F 314	Continued From page 16 resident's current laboratory report dated 11/16/13 had shown a low albumin level of 3.3 g/dl (grams/deciliter.) Normal range was 3.5-4.8 g/dl (a protein made by the liver used to help measure malnutrition.) Review of the provider's undated Wound Assessment Policy and Procedure stated wounds were to be evaluated once a week or whenever a change occurred and that the physician should have been notified of "all problems with skin integrity." Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, Chapter 48-Skin integrity and Wound Care, pages 1176-1229, revealed: **"Nurses constantly observe for skin integrity and identify at-risk patients from developing pressure sores. Nursing interventions focus on prevention." **"Nurses understand factors affecting pressure ulcer formation and wound healing." **"Nurses apply the WOCN (wound, ostomy, and continence nurse) standards for prevention of pressure sores and assessment for skin integrity, prevention and treatment."	F 314		
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.	F 323	Resident 9's smoking assessment was reviewed to ensure that proper assessment and a safe environment was provided for Resident 9 so that Resident 9 receives adequate supervision and assistance devices to prevent accidents.	

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F 323	<p>Continued From page 17</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Preceptor: 25107 Based on observation, record review, interview, and policy review, the provider failed to: *Conduct a smoking assessment for one of one sampled resident (9) who smoked cigarettes. *Store hazardous chemicals in a safe manner to protect all residents. Hazardous chemicals were inappropriately stored in the resident bathrooms, the hallway, and the bathing area of the 200 wing. Findings include:</p> <p>1. Interview and medical record review with the director of nursing (DON) on 01/14/14 at 6:00 p.m. regarding resident 9 revealed: *He had been re-admitted to the facility on 03/06/13. *The resident had been a tobacco smoker. *He would go outside to smoke cigarettes multiple times daily. *There had been no smoking assessment documented in his medical record since his original admission in 2011. *She agreed that should have been done.</p> <p>Review of the provider's Resident Smoking Policy dated January 2011 stated residents would be evaluated quarterly of their cognitive (mental) ability related to smoking.</p> <p>2. Random observations on 1/14/14 from 7:50 a.m. to 11:30 a.m. revealed: *Super Sani-Cloth Germicidal Wipes had been stored in resident's bathrooms including bathrooms of residents with cognitive impairment (mental decline). *The wipes had been stored in a wall mounted</p>	F 323	<p>All other residents' smoking assessments were reviewed to ensure that proper assessments and a safe environment were provided for all residents who smoke so that each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>The residents bathrooms, bathing areas, and medication carts were observed to ensure that they remained free of accident hazards and chemicals as is possible.</p> <p>All other resident areas were observed to ensure that they remained free of accident hazards and chemicals as is possible</p> <p>Administrator, Director of Nursing, and interdisciplinary team reviewed and revised the chemical storage, chemical waste management, and resident smoking policies so that they included the appropriate care and stores of super sani-cloth germicidal wipes and other hazardous items and chemicals, and the proper assessment of residents who smoke.</p> <p>The Administrator and Director of Nursing will present education to all staff who may assist with the provision of residents who smoke and chemical safety.</p>	

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F 323	Continued From page 18 bracket above the toilet but within reach of residents. *All resident bathrooms were equipped with the wall mounted brackets that the wipes were stored in. *Across the front of the bracket a sign had been placed that read "DO NOT USE ON SKIN." Review of the Material Safety Data Sheet (MSDS) for Super Sani-Cloth Germicidal Wipes revealed: **"The product caused irreversible eye damage." **"Under the condition of the study, moderate irritation was evident at 72 hours. Harmful if absorbed through skin." **"Symptoms may include redness, edema, drying, defatting, and cracking of the skin." 3. Random observations on 1/14/14 from 7:50 a.m. to 11:30 a.m. revealed: *A one gallon plastic container with a large twist off lid approximately 2 to 2 1/2 inches in diameter had been placed on top of the medication cart. *The plastic container was not secured to the cart in any way and was accessible to anyone passing by the cart. *The plastic container was a SMS sharps management system that contained a liquid and was used for the disposal of syringes and sharp items (both referred to as sharps). *The medication cart had been pushed up and down all of the resident hallways and into the dining room by nursing staff while they performed medication passes. *After the nurse had performed tasks that required the use of sharps the nurse would then remove the twist off lid, drop the sharps item into the liquid, and replace the lid. *The container was left unattended in the resident	F 323	The Director of Nursing or designee will audit the resident smoking assessments monthly for 3 months to ensure proper assessments were completed. The Director of Nursing or designee will audit the chemical storage once a week for 4 weeks and once a month for two more months to ensure that the resident environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents. The Director of Nursing or designee will present the findings at the monthly QAPI meetings with further follow up as recommended by the committee.	3/6/14

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F 323	<p>Continued From page 19</p> <p>hallways when the nurse entered the residents' rooms to administer medication and treatments. *Residents' were observed passing the cart when it was left unattended. *The lid to the plastic container had no safety mechanisms and was easily removable when observed being taken off.</p> <p>Review of the MSDS for the chemical in the SMS sharps management system revealed: **"Caution: Harmful if inhaled, ingested, or absorbed through skin. May cause eye or skin irritation." **"Direct contact may cause moderate irritation. Material may penetrate skin and cause nausea with prolonged or repeated contact." *May produce tissue irritation, headache, drowsiness or unconsciousness if inhaled. **"May cause gastric irritation. One or more ingredients may be toxic if swallowed."</p> <p>4. Observation on 1/14/14 at 2:22 p.m. in the bathing area for the residents of the 200 hall revealed: *An aerosol can of Germicidal Foaming Cleaner was located in the cabinet and had been stored within inches of an aerosol can of underarm deodorant spray (photo 1). *It was also located next to latex gloves and other resident personal care items.</p> <p>Review of the MSDS for the Germicidal Foaming Cleaner revealed the product was irritating to skin and may cause discomfort and pain.</p> <p>5. Interview on 1/15/14 at 12:58 p.m. with the DON regarding storage of hazardous chemicals revealed: *Hazard chemicals such as the Super Sani-Cloth</p>	F 323		

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F 323	Continued From page 20 Germicidal Wipes should not have been stored in residents' bathrooms where they were accessible to residents. *The SMS sharps management system contained a hazardous chemical and should not have been stored in or transported up and down the halls unsecured where residents were present. *She had observed the sharps management container spill when a person had bumped the medication cart while the lid was off. *She had not been aware the aerosol can of Germicidal Foaming Cleaner was being stored with the aerosol can of deodorant, latex gloves, and other resident care items. *Hazardous cleaners such as Germicidal Foaming Cleaner should not have been stored with or next to resident care items.	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, interview, record review, and policy review, the provider failed to ensure two of three sampled residents (3 and 6) who were dependent on staff had received hydration between meals. Findings include: 1. Random observation on 1/14/14 from 8:00 a.m. through 6:30 p.m. and 1/15/14 from 7:45 a.m. through 5:45 p.m. of resident 3's room revealed:	F 327	Resident 3 and 6's care plans and medical records were reviewed to ensure the resident was receiving sufficient fluid intake to maintain proper hydration and health. All other residents' care plans and medical records were reviewed to ensure they were all receiving sufficient fluid intake to maintain proper hydration and health. The Director of Nursing and interdisciplinary team reviewed and revised the policies and procedures of resident hydration to ensure adequate fluid hydration between meals for those residents dependent upon staff.	

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F 327	<p>Continued From page 21</p> <p>*A Styrofoam cup of honey thick liquid on the counter across the room, out of the residents reach, with the lid on securely, and labeled "(resident name) and 1/13/14 pm."</p> <p>*On that same day at 10:15 a.m. an observation revealed a Styrofoam cup of nectar thick liquid labeled "(resident name [not resident 3]) a.m. 1/14", on the counter across the room, out of resident reach, and with the lid securely on. This was an incorrect consistency as it was not resident 3's drink.</p> <p>*Again on that same day at 2:10 p.m. a Styrofoam cup of honey thick liquid had been sitting on the counter across the room labeled with "resident 3's name 1/14 p.m." with the lid securely in place and out of reach of the resident. This surveyor marked the level of fluid on the Styrofoam cup.</p> <p>*Final observation on 1/15/14 at 8:45 a.m. revealed the same Styrofoam cup labeled with "resident's name 1/14 p.m." and with no change noted in the fluid level.</p> <p>Review of resident 3's medical record revealed: *She had eight urinary tract infections from 1/22/13 through 11/19/13. *She had a history of skin breakdown. *The undated care plan revealed a problem of "Constipation" with an intervention of "Encourage to drink all fluids at meals and additional liquids between meals when care is given." *Review of her 11/11/13 Minimum Data Set (MDS) revealed she had been totally dependent upon staff for eating. She had limitations (difficulty moving) in both arms with her range of motion (movement).</p> <p>2. Random observation on 1/14/14 from 8:00 a.m. through 6:30 p.m. and on 1/15/14 from 7:45</p>	F 327	<p>Director of Nursing and interdisciplinary team will present education to all staff that may assist with the hydration needs of residents.</p> <p>The Director of Nursing or designee will audit the hydration charts for every resident once a week for four weeks and once a month for two more months to ensure that each resident has sufficient fluid intake to maintain proper hydration and health.</p> <p>The Director of Nursing or designee will present the findings of the audits at the monthly QAPI meetings with further follow-up as recommended by the committee.</p>	3/6/14

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NAME OF PROVIDER OR SUPPLIER AURORA-BRULE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383	
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F 327	Continued From page 22 a.m. through 5:45 p.m. in resident 6's room revealed: *The resident was sitting in her recliner, and her lips were dry and cracked. *She had no water glass in her room. *Random observations throughout 1/14/14 until 6:30 p.m. revealed no water glass present in her room. *Observation on 1/15/14 at 8:45 a.m. revealed a water glass had been placed on the counter across the room but not within the resident's reach. Review of resident 6's medical records revealed resident 3's 11/20/13 MDS revealed she had been totally dependent upon staff for eating and her arms range of motion had impairment (difficulty) limitations on both sides. 3. Interview on 1/15/14 at 9:00 a.m. with the director of nursing (DON) stated she expected residents to have been offered water with each encounter with care. If that had been occurring it would have caused a change in the fluid level within the cup. On 1/15/14 at 9:00 a.m. interview with the DON confirmed the provider did not have a hydration policy.	F 327		
F 329 SS=G	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	F 329	Resident 4 and 9's drug regimen was reviewed to ensure that it was free from unnecessary drugs such as antipsychotics unless a proper diagnosis and documentation was necessary for the administration of an antipsychotic in which gradual dose reductions and behavioral interventions were used in an effort to discontinue these drugs.	

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F 329	Continued From page 23 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Preceptor: 25107 Based on observation, interview, record review, and policy review, the provider failed to: *Have appropriate documented physician indications and facility documentation for the continued use of antipsychotic medication for two of four sampled residents (4 and 9). *Have appropriate written physician indications and provider documentation for the continued use of duplicated antipsychotic medications for one of one sampled residents (9). *The social services designee (SSD) had not notified nursing staff or the physician of displayed signs and symptoms of tardive dyskinesia (involuntary thrusting of the tongue in and out, and tremors in the arms and facial muscles) and	F 329	All other residents' drug regimens were reviewed to ensure that they were free from unnecessary drugs such as antipsychotics unless a proper diagnosis and documentation was necessary for the administration of an antipsychotic in which gradual dose reductions and behavioral interventions were used in an effort to discontinue these drugs. The Director of Nursing, Medical Director, Social Services Designee, Pharmacist Consultant, and interdisciplinary team reviewed and revised the policies and procedures about the resident receipt of antipsychotic medications and the documentation of appropriate indications for use or continued use, the appropriate monitoring for side effects, and reporting of signs and symptoms of tardive dyskinesia and other ill effects. The Director of Nursing will present education to all staff that may assist with the provisions of antipsychotic use. The Director of Nursing or designee will audit the drug regimens for every resident once a week for one month and once a month for two more months to ensure that they are free from unnecessary drugs or that a proper diagnosis and documentation is necessary for the administration of an antipsychotic in which gradual dose reductions and behavioral interventions will be used in an effort to discontinue these drugs.	

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F 329	<p>Continued From page 24 seen by social services. *Ensure appropriate nursing assessment, documentation, and intervention for one of one sampled resident (9) displaying signs and symptoms of tardive dyskinesia. *The physician had not been notified of a significant change of one of one sampled resident (9) in relation to side effects of antipsychotic medication. Findings include:</p> <p>1. Observation on 1/15/14 at 8:00 a.m. in the dining room revealed resident 9 had been thrusting his tongue in and out. He had tremors in his left hand.</p> <p>Observation, interview, and medical record review on 01/15/14 from 8:35 a.m. to 9:00 a.m. with the director of nursing (DON) and SSD regarding resident 9 revealed: *The DON had agreed through her observation during the above timeframe he had shown signs and symptoms of tardive dyskinesia. That had been the first time she had observed those signs and symptoms exhibited by the resident. *The SSD stated she had noted tongue thrusting and tremors to his left hand on 12/19/13 during her quarterly assessment. *The SSD had not notified nursing staff or the physician of her above observations. *Nursing staff had marked "negative" on the treatment record of their daily monitoring for side effects of his antipsychotic medication (a medication used to treat various mental disorders.) *The DON did not know why the resident's symptoms had been recorded by nursing staff as negative. She was not sure if the nurses had known what the side effects of antipsychotic</p>	F 329	The Director of Nursing or designee will present the findings of the audits at the monthly QAPI meetings with further follow-up as recommended by the committee	3/6/14

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F 329	<p>Continued From page 25 medication were.</p> <p>*She would have expected that nursing staff should have properly assessed the resident, had identified and documented the side effects of his antipsychotic medication properly, and intervened on his behalf by notifying the physician.</p> <p>*A nurse's note dated 3/14/13 had been faxed to the physician requesting an explanation for the continued use of resident 9's antipsychotic medication eight days after he was re-admitted to the facility.</p> <p>*There had been no documented response by the physician or nursing staff regarding that request in the resident's medical record.</p> <p>Review of the provider's 12/9/13 Antipsychotic Medication Policy revealed: *There was no process in place for reporting the side effects of antipsychotic medication to the provider. *There should have been an assessment made by nursing staff using the AIMs (abnormal involuntary movement) scale for side effects of antipsychotic medication during his quarterly assessment in December 2013.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing 8th Ed., St Louis, MO, 2013, pages 357-358 and 565, stated: *Appropriate assessments are made by nurses and that communication is an essential part in the documentation process between health care workers. *Nurses would make a telephone report when a significant change or changes in a resident's condition occurs. *Nurses are responsible for evaluating the effects of medications and their side effects on the</p>	F 329			

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F 329	Continued From page 26 resident's ongoing health status. Surveyor: 25107 2. Medical record review and interview on 1/15/14 at 9:25 a.m. with the DON in regards to resident 4 revealed: *Nurses notes: -2/28/13 4:00 p.m. to 5:00 p.m. resident yells, swears, and swing at staff and other residents. Resident tries to exit building per door #1 into employee lounge and into dining room. Resident and other residents kept safe. 5:00 p.m. power of attorney (POA) was called and speaks to resident on phone for ten minutes. Resident throws phone receiver on counter top and leaves area; staff picks up phone and speaks to the POA. POA to visit in a few minutes." -3/1/13 at 8:00 a.m. "Mitchell clinic here - Blood drawn." -3/1/13 at 3:00 p.m. "orders received for Seroquel, POA advised." *3/1/13 at 3:00 p.m. a physician telephone order for Seroquel 12.5 milligrams per oral twice daily. "Up to see on rounds next week." -3/2/13 at 1:30 p.m. "kitchen informs this nurse that this is the third meal that resident has refused." *3/6/13 physician progress notes stating resident 4 "[resident name] has been somewhat combative at times and we have started Seroquel. We wanted to document the beneficial effect that this has had for her." *3/25/13 a faxed physician notification requesting a diagnosis for the use of Seroquel. The diagnosis written on the sheet was depression. Noted by the facility on 3/26/13 and signed by the physician on 3/26/13. *7/3/13 physician progress notes:	F 329		

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F 329	<p>Continued From page 27</p> <p>-Assessment "Alzheimer's dementia with some psychotic features."</p> <p>-Plan: "Will continue her Seroquel. This certainly is necessary especially in lite of the some psychotic ideas addressed today. Will continue the rest of her meds (medication) and orders."</p> <p>*7/11/13 pharmacist consultation report: -Comment: (Resident name) was started on Seroquel 12.5 milligram (mg) twice daily on 3/1/13, as she was yelling, hitting, throwing items at staff and other residents. As you are aware, updated documentation regarding the response and ongoing need of psychotropic medications is required to help the facility comply with regulations. She is also taking Celexa 20 mg daily for depression.</p> <p>-Recommendation: Please consider a gradual dose reduction, perhaps decreasing to 12.5 mg daily, while concurrently monitoring for re-emergence of target and/or withdrawal symptoms. If therapy is to continue at the current dose, please provide rationale describing a dose reduction as clinically contraindicated.</p> <p>-No physician's response was noted."</p> <p>*At the bottom of the 7/11/13 pharmacist consultation report was a hand written note dated 7/22/13 stating "not sent to MD- Please see 7/3/13 dictation" signed by a registered nurse.</p> <p>*11/12/13 pharmacist consultation report: -Comment: "(Resident name) was started on Seroquel 12.5 mg twice daily on 3/1/13, as she was yelling, hitting, throwing items at staff and other residents. As you are aware, updated documentation regarding the response and ongoing need of psychotropic medications is required to help the facility comply with regulations. She is also taking Celexa 20 mg daily for depression."</p> <p>-Recommendation: "Please consider a gradual</p>	F 329			

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F 329	Continued From page 28 dose reduction, perhaps decreasing to 12.5 mg daily, while concurrently monitoring for re-emergence of target and/or withdrawal symptoms. If therapy is to continue at the current dose, please provide rationale describing a dose reduction as clinically contraindicated." -Physician's Response: "I decline the recommendation above because gradual dose reduction (GDR) is clinically contraindicated for this individual. The resident's target symptoms returned or worsened after the most recent GDR attempt within the facility and a GDR attempt at this time is likely to impair this individual's function or increase distressed behavior as documented below. Please provide patient specific rationale describing why GDR attempt is likely to impair function or increase behavior in this individual: 'Reduction attempt will likely cause increase in agitation'. Signed and dated by the physician on 11/26/13." *She was familiar with resident 4 and some of the behaviors resident 4 had exhibited such as hitting, swearing, and trying to leave the facility. *There should have been more documentation on 2/28/13 in regards to resident 4's behavior and the visit from the POA. It was not clear what happened after the POA had visited or if the POA had visited. *There was no documentation in the nurse's notes on 3/1/13 to document how or why the order for Seroquel was obtained, who asked for the order, or that the physician was contacted. *The 3/1/13 telephone physician order should have also indicated the appropriate diagnosis to support the need for Seroquel and did not provide a clear rationale for the use of Seroquel. *The diagnosis of depression obtained on 3/25/13 on the faxed physician notification was not an appropriate diagnosis for the use of Seroquel and	F 329			

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F 329	<p>Continued From page 29</p> <p>was not accurate with the physician notes on 3/6/13 stating the resident was combative.</p> <p>*The 7/11/13 pharmacist consultation report should have been sent, so the physician could have responded regardless of the physician's progress note on 7/3/13.</p> <p>*She agreed resident 4 had not had a gradual dose reduction since 3/1/12 when the medication was started.</p> <p>*The rationale provided by the physician on the 11/12/13 pharmacist consultation report stating a reduction would likely cause an increase in agitation did not provide adequate documentation to prove the continued use of Seroquel was effective.</p> <p>*She questioned whether the Seroquel was effective for resident 4, because without a gradual dose reduction they could not measure the effectiveness of the Seroquel.</p> <p>*Resident 4 continued to exhibit the behaviors of hitting, swearing, and trying to leave the facility. Those behaviors were mostly associated with smoking.</p> <p>*She could not provide documentation the use of Seroquel had provided a beneficial effect for resident 4.</p> <p>3. Review of the provider's 12/9/13 psychotropic medication policy revealed: **"Aurora Brule Nursing Home recognizes that antipsychotics benefit only some residents and can be associated with side effects and risks. Therefore, when antipsychotic medications are used in our facility, the facility will make every effort to comply with state and federal regulations related to the use of psychopharmacological medications in our facility. This is to include regular review for continued need, appropriate dosage, side effects, risks and/or benefits".</p>	F 329		

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F 329	Continued From page 30 **Aurora Brule Nursing Home supports the goal of determining the underlying cause of the behavioral symptoms, so that appropriate treatment may be initiated and utilized to meet the needs of the individual resident." **Efforts to reduce dosage or to discontinue use of antipsychotics will be ongoing, as appropriate, for the clinical situation. Use will be reviewed at care conference, and recommendations for Gradual Dose Reduction (GDR) will be given to physician, unless clinically contraindicated." **If a resident is admitted to ABNH (Aurora Brule Nursing Home) and is currently on an antipsychotic medication, or anyone resident who is currently on an antipsychotic prior to the implementation of this policy, nursing will do an AIMS (abnormal involuntary movement scale) assessment, obtain consent, and determine the need to continue the medication."	F 329		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	The infection control program was reviewed to ensure that it is designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The Germicidal Foaming cleaner used on the shower chair in the 200 wing shower room was observed to ensure that the cleaner was being used appropriately ensuring the manufacturer's guidelines for use are followed. The Germicidal Foaming cleaner used on all other shower chairs were observed to ensure that the cleaner was being used appropriately ensuring the manufacturer's guidelines for use are followed.	

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F 441	<p>Continued From page 31</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Preceptor: 25107 Based on observation, interview, label review, cleaning log review, and policy review, the provider failed to: *Follow manufacturer's guidelines for minimum contact time of a disinfectant cleaner for three of three bath areas. *Ensure one of one bath area EZ-stand lifts (mechanical equipment used to transfer an individual from one surface to another) were cleaned according to the provider's policy and procedure. *Prevent contamination of all peri-care items stored with toileting wipes. *Maintain policies and procedures to ensure</p>	F 441	<p>The E-Z stand lift located on the 200 wing was observed to ensure that it was clean and sanitary as to prevent contamination or cross-contamination of resident care items.</p> <p>All other E-Z stand lifts were observed to ensure that they were clean and sanitized as to prevent contamination or cross-contamination of resident care items.</p> <p>The resident's shared bathroom of 110 and 112 was observed to ensure that all personal care items were stored separately as to prevent contamination or cross-contamination of resident care items.</p> <p>All other resident bathrooms were observed to ensure that all personal care items were stored separately as to prevent contamination or cross-contamination of resident care items.</p> <p>The bathtub in the 300 wing was observed to ensure it had been cleaned according to facility policies and procedures as to prevent the spread of infections or diseases.</p> <p>All other bathing areas were observed to ensure they had been cleaned according to facility</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) COMPLETION DATE	
F 441	Continued From page 32 consistent infection control practices throughout the facility. Findings include: 1. Interview and label review on 1/14/14 at 2:22 p.m. with certified nursing assistant (CNA) C in the bathing areas located in the 200 wing revealed: *She had used Germicidal Foaming Cleaner to clean and disinfect the shower chair between residents. *She stated she sprayed the shower chair with the above cleaner and let it sit for five to ten minutes prior to rinsing with water. *The Germicidal Foaming Cleaner was as phenol disinfectant and required minimum contact time of ten minutes prior to rinsing. *She had been unaware of the exact minimum contact time. Interview on 1/14/14 at 5:40 p.m. with CNA D in the bathing area located in the 200 wing revealed: *She had used Germicidal Foaming Cleaner to clean and disinfect the shower chair between residents. *She stated she sprayed the shower chair with the above cleaner and let it sit for "five minutes or so." *She had been unaware of the exact minimum contact time of ten minutes. Interview on 1/15/14 at 10:30 a.m. with CNA B in the 300 hallway regarding the cleaning of the shower chairs revealed: *She had used Germicidal Foaming Cleaner to clean and disinfect the shower chair between residents. *She stated she sprayed the shower chair with the above cleaner and let it sit for five to seven	F 441	<p>policies and procedures as to prevent the spread of infections or diseases.</p> <p>The Administrator, Director of Nursing, and interdisciplinary team reviewed and revised the policies and procedures of the infection control program so that they include a designated person responsible for the oversight to receive proper education and is provided adequate time to perform oversight of the program, the assurance of manufacturer's guidelines for cleaning use are followed, the assurance of staff following established facility policies and procedures, and the assurance that staff are aware of appropriate procedures to prevent contamination or cross-contamination of resident care items.</p> <p>The Director of Nursing will present education to all staff on Infection Control.</p> <p>The Director of Nursing ^{*infection control nurse} or designee will ^{TW/SCDH/KJ} audit the infection control program for once a week for one month and once a month for two more months to ensure that the infection control program has been maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>The Director of Nursing ^{*infection control nurse} or designee will ^{TW/SCDH/KJ} present the findings of the audits at the monthly QAPI meetings with further follow-up as recommended by the committee.</p>	3/6/14	

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F 441	<p>Continued From page 33 minutes prior to rinsing. *She had been unaware of the exact minimum contact time of ten minutes.</p> <p>2. Observation and interview on 1/14/14 at 5:40 p.m. with CNA D in the bathing area located in the 200 wing revealed: *An EZ-stand lift used by residents, had a moderate amount of white/grey debris located around the toe area of the foot rest (photo 2). *She was not sure when the lift had last been cleaned. *She agreed it was in need of cleaning. *She thought the lifts were cleaned weekly on Sundays.</p> <p>Review of the provider's 6/19/13 Mechanical Lift and Stand Aid Cleaning policy revealed: *The lifts would be cleaned after every shift and as needed when soiled. *The CNAs were responsible to clean the lifts at the end of their shift.</p> <p>3. Random observations on 1/14/14 from 07:50 a.m. to 6:30 p.m. revealed: *Packages of toileting wipes were combined with private area care barrier creams and personal hand lotion in a wall mounted file storage bin in multiple residents' bathrooms. *In the shared resident's bathroom of rooms 110 and 112, there was a package of toileting wipes with a thumbprint-sized brown stain on the outside of the package. It had been stored with a latex glove in a wall mounted file storage bin with a latex glove (photo 3 and 4).</p> <p>4. Observation on 1/14/14 at 3:10 p.m. in the bathing area located in the 300 wing revealed: *The facility's only bathtub was wet and had a</p>	F 441			

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F 441	<p>Continued From page 34</p> <p>non-skid mat in the bottom. *It appeared to have been recently used. *Removal of the mat revealed the bathtub and the mat had a small amount of loose debris on them. *The mat had left a stain pattern in the bottom of the tub (photo 5).</p> <p>Interview on 1/14/14 at 3:15 p.m. with CNA C and D in regards to the cleaning of the bathtub revealed: *Neither CNA knew when the bathtub was last used or cleaned. *CNA C thought the aide on the night shift cleaned the bathtub. *CNA D had not worked on that wing and was not aware of the cleaning procedure for the bathtub.</p> <p>Interview on 1/15/14 at 10:30 a.m. with CNA B in regards to the cleaning of the bathtub revealed: *Only one resident used the tub that she was aware of. That resident bathed independently and on her own schedule. *She was unsure who cleaned the tub after the resident had finished bathing. *She "doubted anyone cleaned it."</p> <p>5. Interview and record review on 1/15/14 at 12:58 p.m. with the DON revealed she: *Agreed CNAs should have been following the minimum contact time listed on the Germicidal Foaming Cleaner. *Agreed creams and lotions should not have been kept in the same container with toileting wipes, because toileting wipes could become contaminated like those found in the shared bathroom for residents' rooms 110 and 112. *Was unaware the staff had been storing those supplies together in the bins. *Thought the CNAs had been cleaning the lifts</p>	F 441		

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F 441	<p>Continued From page 35</p> <p>weekly and were documenting it on the lift cleaning log.</p> <p>*Had reviewed the lift cleaning log and there had been no documentation of any weekly cleaning since September 2013.</p> <p>*Was not aware of the provider's policy that stated the lifts should have been cleaned at the end of each shift and when visibly soiled.</p> <p>*Was not aware staff had not been cleaning the bathtub after each use.</p> <p>*Agreed it should have been cleaned after each use. She stated the resident was to notify staff when she had bathed so staff could clean the tub.</p> <p>Interview and cleaning log review on 1/15/14 at 1:15 p.m. with the infection control coordinator revealed she:</p> <p>*Had been a registered nurse for two years.</p> <p>*Had been the acting infectious disease coordinator for only four months.</p> <p>*Had not received additional training yet but had watched an instructional DVD on infection control.</p> <p>*Had no dedicated time to work on infection control and only worked on it while performing her other duties.</p> <p>*Agreed creams and lotions should not have been kept in the same container with toileting wipes, because toileting wipes could become contaminated like those found in the shared bathroom for resident's rooms 110 and 112.</p> <p>*She was unaware the staff had been storing those supplies together in the bins.</p> <p>*Thought the CNAs had been cleaning the lifts weekly.</p> <p>*Was not aware there had been no documentation of weekly cleaning of the lifts since September 2013.</p> <p>*Had not been aware of the facilities policy that stated the lifts were to be cleaned at the end of</p>	F 441		

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F 441	Continued From page 36 each shift by the CNAs. *Had watched the CNAs perform cleaning of the bathing facilities. *Had not paid attention to how long the Germicidal Foaming Cleaner stayed on the shower chairs before rinsing. *Was not aware of the minimum contact time for that cleaner. *Agreed staff should have followed the manufacturer's instructions for minimum contact time. *Was not aware staff had not been cleaning the bathtub after each use and agreed it should have been cleaned after use.	F 441		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520	QAPI program was reviewed to ensure that the committee is meeting at least quarterly and that it is identifying issues with respect to which quality assessment and assurance activities are necessary and develops and implements appropriate plans of action to correct identified quality deficiencies. Administrator, Medical Director, Director of Nursing, Social Services Designee, and interdisciplinary team reviewed and revised the QAPI programs policies and procedures so that they include the responsibility of all staff members, definite designated committee members, at minimum quarterly meetings to identify issues, the ongoing identification of quality assessment and assurance activities, the development and implementation of plans of action to correct identified concerns, QAPI documents available for review, and the review of root cause analysis for reoccurring problems.	

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F 520	<p>Continued From page 37</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, record review, interview, and policy review, the provider failed to ensure an effective quality assurance (QA) program had been maintained to identify concerns, and to develop and implement corrective action. Findings include:</p> <p>1. Review of the previous survey on 12/12/12 revealed the following deficiencies had been cited: F241, F253, F279, F281, F323, F431, F441, F456, F465, and F466.</p> <p>During the current survey the following deficiencies had been cited and/or recited (*): F248, F279*, F280, F281*, F314, F323*, F327, F329, F441*, and F520.</p> <p>Interview on 1/15/14 at 1:15 p.m. with the social service designee who was also the head of the QA program revealed: *Each department did not have specific areas to address during the QA meetings. *They had no measurable goals or interventions. *They had no corrective plans to address areas of concern identified at QA meetings. *Their meetings had been reactive and not proactive. *She agreed the current process had been ineffective, and she had planned on implementing a new process. *She agreed the current Quality Assurance Plan</p>	F 520	<p>Administrator, Director of Nursing, and Social Services Designee will present education to all staff on the QAPI program</p> <p>The Administrator or designee will audit the QAPI program once a month for three month to ensure that a quality assurance program is being maintained.</p> <p>The Administrator or designee will present the findings of the audit at the monthly QAPI meetings with further follow-up as recommended by the committee.</p>	3/6/14	

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F 520	Continued From page 38 had been outdated. Review of the provider's undated Quality Assurance Plan revealed: **Aurora-Brule Nursing Home is a 77 bed Intermediate Care Nursing Facility." **Develops and implements appropriate plans of action to correctly identify deficiencies."	F 520			

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K 000	<p><i>Addendums noted with an asterisk per 2/18/14 telephone to facility administrator. CH/S000H/JJ</i></p> <p>Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 1/15/14. Aurora-Brule Nursing Home was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K019, K038, K046, and K051 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:	
K 019 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Vision panels in corridor walls or doors are fixed window assemblies in approved frames. (In fully sprinklered buildings, there are no restrictions in the area and fire resistance of glass and frames.) 19.3.6.2.3, 19.3.6.3.8, 19.3.6.5</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain the smoke tight rating of corridor wall assemblies for one randomly observed area (the sliding glass window for the kitchen to the dining room). Findings include:</p>	K 019	<p>The kitchen glass window was observed to ensure that vision panels are smoke-tight, fixed window assemblies in approved frames.</p> <p>All other vision panels in corridor walls or doors were observed to ensure that the vision panels are smoke-tight, fixed window assemblies in approved frames.</p> <p>The Administrator and Maintenance Director assessed the kitchen sliding glass window, took it out and replaced it with a fixed window.</p> <p>The Administrator and Maintenance Director assessed and ensured the Kitchen's fire alarm system was equipped with smoke detection that is connected to the facility's fire alarm system.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 2-12-14
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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.

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K 019	Continued From page 1 1. Observation at 1:45 p.m. on 1/15/14 revealed a 24 inch tall by 30 inch wide opening with two sliding glass windows in the wall between the kitchen and the dining room. Vision panels in corridor walls or doors must be fixed window assemblies in approved frames. The sliding glass windows were not smoketight and were not equipped with rollup doors. The kitchen was not equipped with smoke detection connected to the facility fire alarm system. The building was completely sprinklered. Interview with the administrator at the time of the observations confirmed those findings. She stated the window could be changed to a fixed vision panel assembly.	K 019	All other areas were observed to ensure that they were equipped with smoke detection connected to the facility fire alarm system. Administrator and Maintenance Director will present education to all staff on fire safety. The Maintenance Director or designee will audit the facilities fire alarm system once a month to ensure that all areas are equipped with smoke detection connected to the facility fire alarm system. The Maintenance Director or designee will present the findings of the audits at the monthly QAPI meetings with further follow-up as recommended by the committee.	
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 18087 A. Based on observation, testing, and interview, the provider failed to ensure four of ten exits were readily accessible at all times (main entrance, west exit from the 200 wing, the east lobby corridor, and the north exit from the 300 wing). Findings include: 1. Observation beginning at 10:30 a.m. on 1/15/14 revealed four of the ten marked building exits were each equipped with a magnetic door lock. The door would lock when a resident with a	K 038	The main entrance, West exit from the 200 wing, the east lobby corridor, and the north exit from the 300 wing were observed to ensure that the exits are delayed egress and readily accessible at all times in accordance with life safety code standards. All other exit doors were observed to ensure that the exits are delayed egress and readily accessible at all times in accordance with life safety code standards. The east exit at the beauty shop, the north exit from the 300 wing, and the west exit from the chapel were observed to ensure that there was a paved path of exit discharge to the public way.	3/6/14

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K 038	<p>Continued From page 2</p> <p>wander management device came too close to the exit. Testing of the west exit from the 200 wing with a Watchmate wander management device revealed the locked door was not a delayed egress-type magnetic lock. A keypad was mounted adjacent to the door that would unlock the magnet (Locknetics brand).</p> <p>Interview with the maintenance supervisor at 10:45 a.m. on 1/15/14 revealed the magnetic door locks (Locknetics brand) were not the delayed egress type. He indicated the doors locked when a wander management device came in close proximity to the lock. It was not determined if the magnetically locked doors would unlock when the fire alarm was activated.</p> <p>B. Based on observation and interview, the provider failed to construct a paved path of exit discharge to the public way at three exits (east exit at the beauty shop, the north exit from the 300 wing, and the west exit from the chapel). Findings include:</p> <p>1. Observation from 10:30 a.m. to 2:30 p.m. on 1/15/14 revealed the following exits were not paved to the public way: *The east exit at the beauty shop (approximately 75 feet to the public way). *The north exit from the 300 wing (approximately 125 feet to the public way). *The west exit from the chapel (approximately 125 feet to the public way).</p> <p>Interview with the administrator at 3:00 p.m. confirmed those findings. She stated the provider had recently obtained bids to pave the noted exits to the public way.</p>	K 038	<p>All other exits were observed to ensure that there was a paved path of exit discharge to the public way</p> <p>The Maintenance Director will ensure that all exit doors are delayed egress and readily accessible at all times and poured concrete so that all exits have a paved path of exit discharge to the public way in accordance with life safety code standards</p> <p>The Maintenance Director or designee will audit monthly all exit doors and their pathways to ensure that they are readily accessible with an exit discharge to the public way.</p> <p>The Maintenance Director or designee will present the findings of the audits at the monthly QAPI meetings with further follow-up as recommended by the committee.</p>	3/6/14

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K 046 K 046 SS=D	Continued From page 3 NFFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to install a remote stop button for the generator. Findings include: 1. Observation at 11:00 a.m. on 1/15/14 revealed there was not an emergency stop button installed for the generator. Interview with the maintenance supervisor at the time of the observation revealed he was unaware of the remote stop requirement for the generator.	K 046 K 046	Generator was reviewed to ensure that there was a remote stop button installed so that there is emergency lighting of at least 1 1/2 hour duration provided to the facility. The Maintenance Director observed and installed a remote stop button on the generator so that there is emergency lighting of at least 1 1/2 hour duration provided to the facility. The Maintenance Director or designee will audit the generator to make sure the remote stop button is in working order every month for 3 months. The Maintenance Director or designee will present the findings of the audits at the monthly QAPI meetings with further follow-up as recommended by the committee.	3/6/14
K 051 SS=E	NFFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4,	K 051	The Kitchen hood fire suppression system was observed to ensure that it tied into the building's fire alarm system. All other fire suppression systems were observed to ensure that it tied into the building's fire alarm system. Maintenance Director observed and ^{* will have} the kitchen hood fire suppression system ^{* tied} into the building's fire alarm system. _____ ^{CH/SPAAH/JJ} _____ * A new record of completion form will be submitted per NFPA 72 when this work is done by the contractor CH/SPAAH/JJ	

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

PRINTED: 01/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A107	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2014
NAME OF PROVIDER OR SUPPLIER AURORA-BRULE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383	
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K 051	Continued From page 4 9.6 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on record review and interview, the provider failed to tie the kitchen hood fire suppression system into the fire alarm system. Findings include: 1. Record review revealed the 9/11/13 six-month inspection of the kitchen hood fire suppression system noted it was not tied into the building's fire alarm system. Interview with the administrator at 3:00 p.m. on 1/15/14 revealed she was unaware of the required installation.	K 051	The Maintenance Director or designee will audit the kitchen hood fire suppression system once a month for three months to ensure that the kitchen hood fire suppression system ties into the buildings fire alarm system. The Maintenance Director or designee will present the findings of the audits at the monthly QAPI meetings with further follow-up as recommended by the committee.	3/6/14

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10709	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2014
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NAME OF PROVIDER OR SUPPLIER AURORA-BRULE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 408 S. JOHNSTON ST WHITE LAKE, S.D., SD 57383
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S 000	Initial Comments <i>Addendums noted with an asterisk per 2/24/14 telephone to facility administrator. TN/5000H/JJ</i> Surveyor: 25107 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 1/14/14 through 1/15/14. Aurora-Brule Nursing Home was found not in compliance with the following requirement(s): S166, S206, and S361.	S 000	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state law. Without waiving the foregoing statement, the facility states that with respect to:	
S 166	44:04:02:17(1-10) OCCUPANT PROTECTION The facility must take at least the following precautions: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents; (3) Provide a call system for each...resident bed and in all toilet rooms and bathing facilities routinely used by...residents. The call system must be capable of being easily activated by the...resident and must register at a station serving the unit; (4) Provide handrails firmly attached to the walls on both sides of all resident corridors in nursing facilities; (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors in nursing facilities. Other exterior doors must be locked or alarmed. The alarm must be audible at a designated nurses' station and may not automatically silence when the door is closed;	S 166	The exit door located by room 300 was <i>* repaired</i> <i>TN/5000H/JJ</i> to ensure that the door could be opened and closed properly. All other exit doors were observed to ensure that they could be opened and closed properly. The facility will develop a preventative maintenance program to include ongoing and routine maintenance checks of all exit doors and their alarm system, exit doors and their ability to open and close properly, grab bars in toilet rooms and resident bathing areas, call light system, handrails in corridors, electrical equipment, clothes dryers, and light fixtures. <i>*(See addendum on page 2 of 7)</i> <i>TN/5000H/JJ</i> The Maintenance Director reviewed and revised the policies and procedures of the preventative maintenance program so that it includes ongoing and routine maintenance checks of grab bars in toilet rooms and resident bathing areas, call light system, handrails in corridors, electrical equipment, alarm systems on exit doors, clothes dryers, and light fixtures.	

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

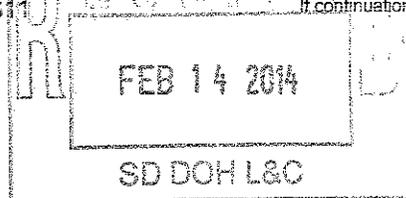
[Handwritten Signature]

TITLE

Administrator

(X6) DATE

2-12-14



SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10709	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2014
NAME OF PROVIDER OR SUPPLIER AURORA-BRULE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 408 S. JOHNSTON ST WHITE LAKE, S.D., SD 57383		
(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
S 166	Continued From Page 1 (7) Portable space heaters and portable halogen lamps may not be used in a facility; (8) Household-type electric blankets or heating pads may not be used in a facility; (9) Any light fixture located over a...resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof lamp; and (10) Any clothes dryer must have a galvanized metal vent pipe for exhaust. This Rule is not met as evidenced by: Surveyor: 25107 Based on interview and observation, the provider failed to have a written and scheduled preventative maintenance plan. Findings include: 1. Interview on 1/14/14 at 3:00 p.m. with the head of maintenance revealed: *He did not have a written or scheduled preventative maintenance plan. *The only items that were maintained were items that had been identified by previous surveys from the Department of Health as deficient practices. Those deficient practices had included items such as Wandergaurd and door alarms which were checked weekly by the nursing staff. *Items such as hand rails were checked monthly but were not documented when checked. *Call light buttons were also not on a maintenance plan, but he thought they were periodically tested by the nursing staff. There was no documentation to support the call lights were being tested. *His maintenance plan was to repair items on work orders as they were reported to him by	S 166	The Maintenance Director or designee will audit all preventative maintenance checks to ensure that routine and ongoing maintenance checks of all exit doors and their alarm systems, exit doors and their ability to open and close properly, grab bars in toilet rooms and resident bathing areas, call light systems, handrails in corridors, electrical equipment, clothes dryers, and light fixtures are made. These audits will be conducted weekly for four weeks and twice a month for two more month and quarterly thereafter. The Maintenance Director or designee will present the findings of the audits at the monthly QAPI meetings with further follow-up as recommended by the committee. *The operation of the entire facility will be reviewed and a written preventative maintenance plan will be developed to cover the routine maintenance and cleaning of the entire facility and the equipment within it. TN/SDDOH/JJ	3/6/14

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10709	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2014
NAME OF PROVIDER OR SUPPLIER AURORA-BRULE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 408 S. JOHNSTON ST WHITE LAKE, S.D., SD 57383		
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S 166	Continued From Page 2 facility staff. 2. Observation and interview on 1/14/14 at 3:01 p.m. of the exit door located by resident room 300 with the head of maintenance revealed: *The exit door would not open without using abnormal force. *The door was dragging on the sill plate and would not close and latch into the frame unless it was pulled shut. After being pulled shut and latched the door would not easily open. *The head of maintenance was not aware the door was not opening and closing properly. *He did not have the door on a preventative maintenance schedule as he did not have a written or scheduled preventative maintenance plan.	S 166		
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	S 206	The orientation and education program was reviewed to ensure that all required subjects were being covered annually. *The training had been provided by the education coordinator but those records were not presented at the time of the survey. TN/SDDOH/JJ	

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S 206	Continued From Page 3 (10) Dining assistance, nutritional risks , and hydration needs of...residents. ...Additional personnel education shall be based on facility identified needs. This Rule is not met as evidenced by: Surveyor: 26180 Based on staff inservice record review and interview, the provider failed to ensure all staff were trained annually on four of the ten required inservices (Fire prevention, Emergency procedures, Restraints, Incidents and diseases subject to mandatory reporting). Findings include: Review of the provider's 2013 training on 1/15/14 at 1:45 p.m. with the director of nursing revealed: *There had been no inservices on the following required subjects in the past year: -Fire prevention. -Emergency procedures. -Restraints. -Incidents and diseases subject to mandatory reporting. *The DON confirmed that was accurate. *The DON confirmed these inservices should have occurred annually.	S 206	The facility will review and revise the orientation and in-service program so that they include annually all of the required subjects of fire prevention and response, emergency procedures and preparedness, infection control and prevention, accident prevention and safety procedures, proper use of restraints, resident rights, confidentiality of resident information, incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms, car of residents with unique needs, and dining assistance, nutritional risks, and hydration needs of residents. The Administrator or designee will audit the orientation and in-service program monthly to ensure that all required topics are covered annually The Administrator or designee will present the findings of the audits at the monthly QAPI meetings with further follow-up as recommended by the committee.	3/6/14
S 361	44:04:13:02 Resident rooms A...resident room must meet the following requirements: (1) A maximum room capacity not exceeding two...residents; (2) A minimum area, exclusive of toilet rooms,	S 361	Rooms 301, 303, 304, 306, and 311 were observed to ensure that they were within 150 feet of a nursing desk that is manned by a staff person.	

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S 361	Continued From Page 4 closets, lockers, wardrobes, or vestibules, of 120 square feet (10.8 square meters) in one-bed rooms and 200 square feet (18.58 square meters) in two-bed rooms; (3) Each bed in two-bed rooms must have cubicle curtains or equivalent built-in devices for full visual privacy that allow access to the toilet room and corridor without entering the roommates space...; (4) Have a window whose sill is not higher than 3 feet (0.91 meters) above the floor. The floor must be above grade; (5) Have a call button at each bed for nurses' calling stations; (6) Have a toilet room and lavatory...Resident toilet rooms must be directly accessible for each...resident without going through the general corridor. In remodeling projects, one toilet room with handsinks in...resident rooms may service two...resident rooms, but not more than four beds. For new construction, toilet rooms may not be shared between...resident rooms. The lavatory may be omitted from the toilet room if one is provided in each...resident room. The minimum dimensions of any room containing only a water closet are 3 feet by feet (0.91 meters by 1.83 meters). All new construction of toilet rooms must be accessibility standards required in section 44:04:13:01; (7) Have a locker or closet for each...resident; and (8) Have each...resident room door located not more than 150 feet (45.72 meters) from the nurse's station. Modifications of the requirements listed in subdivisions (1) to (8), inclusive, of this section may be approved for special care rooms by the department after receipt of a written request.	S 361	All other rooms were observed to ensure that they were within 150 feet of a nursing desk that is manned by a staff person. The Administrator and Director of Nursing observed the Flair Hall nurses station and relocated the East and Flair Hall CNA's to that nurses station to ensure that there was sufficient [REDACTED] [REDACTED] *staff to man all nurse stations to ensure the requirement is met. TN/SDDOH/JJ The Administrator or designee will audit weekly for one month and once a month [REDACTED] [REDACTED] *during staff scheduling to ensure there is sufficient staff at each nurse station. TN/SDDOH/JJ *The administrator or designee will present the findings of the audits at the monthly QAPI meetings with further follow-up as recommended by the committee. TN/SDDOH/JJ	3/6/14

SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 361	Continued From Page 5 This Rule is not met as evidenced by: Surveyor: 26180 Based on observation and interview, the provider failed to ensure five of nine occupied resident rooms (301, 303, 304, 306 and 311) on the 300 wing were within 150 feet of a nursing desk that was manned by a staff person. Findings include: 1. Random observation from 1/14/14 through 1/15/14 revealed: *The main nursing desk: -Was in excess of 150 feet from rooms 301, 303, 304, 306, and 311. -Did not allow for direct visual observation of any part of the 300 wing. *The nursing desk at the entry to the 300 wing revealed there was not a staff person stationed at that desk. *Observation of the main nursing desk at the junction of the 100 and 200 wings revealed there was a camera monitor of the 300 wing. -There was usually not a staff person at that desk to observe the monitor of the 300 wing rooms. -Rooms listed above could not be seen unless you were on the 300 wing or sat directly at the monitor of the 300 wing. Interview on 1/15/14 at 1:30 p.m. with the administrator revealed: *Her understanding was that during a previous licensure survey there had been a deficiency identified relating to the nursing station on the 300 wing not being used by the nursing staff. -To correct that deficiency they had put the	S 361		

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S 361	Continued From Page 6 camera and monitor in, so they could see what was happening in the 300 wing hallway. *She agreed the monitor of the 300 wing was not being consistently observed. Interview on 1/15/14 at 2:00 p.m. with the director of nursing revealed: *There were not staff stationed at the 300 wing nursing desk. *She confirmed the 300 wing nursing station had not had staff assigned to it.	S 361		