

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/07/2015</b>
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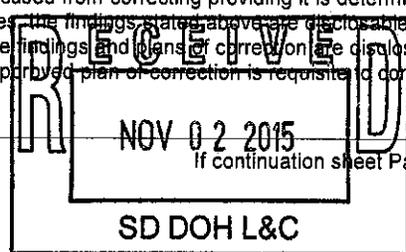
NAME OF PROVIDER OR SUPPLIER  <b>ABERDEEN HEALTH AND REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401</b>
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F 000	INITIAL COMMENTS  Surveyor: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 10/5/15 through 10/7/15. Aberdeen Health and Rehab was found not in compliance with the following requirements: F241, F252, F280, F281, F309, F314, F315, F323, F332, and F441.	F 000	*Addendums noted with an asterisk per 11/6/15 per telephone with facility administrator and nurse consultant. SC/SDDOH/EL	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, record review, interview, and pamphlet review, the provider failed to ensure privacy and dignity was maintained: *For one of five sampled residents (11) who required water, nutrition, and medications be delivered through a feeding tube by one of one registered nurse (RN) B. *For one of five sampled residents (11) during personal care by one of four certified nursing assistants (CNA) (E). Findings include:  1. Review of resident 11's medical record revealed: *An admission date of 8/9/12. *Diagnoses of coma (cannot be awakened, unable to move without assistance), pain, and	F 241	See next page	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Megan Kleinsasser</i>	TITLE <i>Exec Director</i>	(X6) DATE <i>10-30-15</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 241	<p>Continued From page 1</p> <p>esophageal reflux (unable to keep food in the stomach) with a feeding tube (tube inserted into the stomach for water, nutrition, and medication). *He was dependent upon staff to assist him with all of his activities of daily living that included grooming, bathing, dressing, toileting, and moving from place to place.</p> <p>Observation on 10/6/15 at 9:20 a.m. of registered nurse (RN) B with resident 11 revealed: *She had prepared to give the resident water through his feeding tube. *The resident had been: -Laying on his bed located by a large picture window. The window shades were open and faced a parking lot for visitors and staff to use. Across from the parking lot was a highway with traffic using it. -He was covered with a sheet and had no clothing on except an incontinent brief (disposable undergarment). -Unable to move any parts of his body without assistance. His arms were stiff, bent upwards, and resting on his chest. His fingers were curled to the inside of his palms. His legs were stiff and bent upwards towards his stomach. *RN B: -Pulled down the cover sheet to expose his upper body and feeding tube. -Administered the water through his feeding tube. *RN B had not closed the window shades during the above procedure.</p> <p>Observation on 10/6/15 at 11:00 a.m. of CNA E with resident 11 revealed: *She had prepared to assist the resident with personal care in his room including bed mobility and transferring out of bed. *The resident was:</p>	F 241	<p><i>See next page</i></p>	
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F 241	<p>Continued From page 2</p> <p>-Laying on his bed, the window shades were open, and he was laying underneath a sheet cover with just an incontinent brief on and no clothing.</p> <p>*She assisted him with personal care to his private area due to urine incontinence (loss of control).</p> <p>*Prior to assisting the resident with personal care and removing his sheet cover CNA E did not acknowledge him with her action. He laid completely uncovered and his body exposed in front of the large window.</p> <p>*During the resident's personal care:</p> <p>-She had not closed the shades on the window.</p> <p>-She then put a t-shirt and an incontinent brief on him.</p> <p>*Medication aide (MA) C assisted CNA E transfer him from the bed into his wheelchair (w/c).</p> <p>*CNA E left the room after he had been transferred into the w/c to get a clean cover sheet.</p> <p>*She left his door open to the hallways.</p> <p>*He was sitting in his w/c and facing the open door. During the entire time he sat with just an incontinent brief and t-shirt on.</p> <p>*Unidentified staff and residents had been observed going past his door during that time.</p> <p>Interview on 10/7/15 at 9:30 a.m. with the director of nursing confirmed RN B and CNA E should have closed the window shades. Resident 2 should have had his privacy ensured during any type of personal care. She agreed CNA E had not assisted the resident with personal care in a private and dignified manner.</p> <p>Review of the provider's undated Long-Term Care Facilities Resident's Bill of Rights pamphlet revealed "You have the right to privacy and</p>	F 241	<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.</p> <p>Without waiving the foregoing statement, the facility states with respect to:</p> <ol style="list-style-type: none"> <li>1. Resident #11's care plan has been reviewed/revise to reflect current needs. Staff assignment sheets have been reviewed/revise. Identified staff were re-educated to privacy/dignity concerns.</li> <li>2. Daily rounds by DNS and her designees will include observing for privacy and dignity needs being met including closing of window blinds, doors, privacy curtains, etc.</li> <li>3. By November 6<sup>th</sup>, 2015 staff will be re-educated regarding privacy &amp; dignity including window blinds, doors, curtains, etc by the DNS.</li> <li>4. The DNS and/or her designee will observe cares of 4 residents per week for 1 month then 2 residents per week for .2 months to ensure privacy and dignity is maintained during cares.*1 for resident 11 and other residents.</li> </ol> <p>SC/SDDOTTEL</p>	
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F 241	Continued From page 3 confidentiality in a long-term care facility. This includes your personal care."  The provider did not have a Privacy and Dignity policy when it had been requested during the survey.	F 241	5. The data collected will be presented to the Quality Assurance Quality Improvement Committee by the DNS. It will be reviewed/discussed and at this time the committee will make the decision/recommendation regarding follow up or changes.	11-6-15	
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT  The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.  This REQUIREMENT is not met as evidenced by: Surveyor: 16385 Based on observation, interview, and review of the resident's bill of rights pamphlet, the provider failed to maintain a clean environment and equipment: *For one sampled resident's (11) room. *For one randomly observed fan (Country Lane common area) near the nurses' station. Findings include:  1. Random observations from 10/5/15 through 10/7/15 of resident resident 11's room revealed: *A dried sticky liquid substance approximately six inches by twelve inches on the floor by the window side of resident 11's bed. *Two water bottles and dust on the floor between the night stand and the wall near the head of the bed. *The night stand stand had many spots of the same dried sticky liquid substance.	F 252	<i>Quarterly Sept 2016</i>  See next page		

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F 252	<p>Continued From page 4</p> <p>*The privacy curtain between the two residents was stained.</p> <p>*The wall next to the garbage can had a dark brown substance and several stains on it.</p> <p>*The resident's fan that was directed at him had a large amount of dust and lint on the front screen.</p> <p>Observation and interview on 10/7/15 at 10:30 a.m. with the housekeeping supervisor confirmed the above findings were dirty. She stated all residents' rooms should have been cleaned daily.</p> <p>2. Random observations from 10/5/15 through 10/7/15 of the wall fan in the Country Lane common area near the nurses' station revealed a large amount of dust and lint on the front screen.</p> <p>Observation and interview on 10/7/15 at 10:45 a.m. with the housekeeping supervisor confirmed the fan was dirty. She stated the fans should have been cleaned by housekeeping staff, and they must have missed cleaning that fan.</p> <p>Surveyor: 32355</p> <p>3. Interview on 10/7/15 at 10:00 a.m. with the social services designee revealed:</p> <p>*She would have assessed resident 11 only during his assessment period. That would have been once every three months.</p> <p>*Any other visits with the resident would have been after the staff identified issues she needed to check on.</p> <p>*She had been in his room on 10/5/15 when visiting with resident 11's roommate.</p> <p>*She had observed resident 11's side of the room at that time and had no current concerns.</p> <p>*The above observation was reviewed with her and she had not recognized any of those issues</p>	F 252	<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 with respect to:</p> <ol style="list-style-type: none"> <li>1. Resident #11's room has been deep cleaned including the fan and the privacy curtain was replaced. The identified fan on Country Lane has been cleaned.</li> <li>2. Room cleaning expectations was reviewed with Housekeeping Supervisor as well as the schedule. Cleaning of facility fans schedule was revised and frequency increased. Leadership team will be re-educated to room cleanliness and monitoring of rooms including equipment through daily work.</li> <li>3. Housekeeping will be re-educated to room cleaning expectations and cleaning of fans. A checklist will be used by staff identifying areas of completion.</li> <li>4. The supervisor and Administrator/designee will audit 4 rooms per week for 1 month and then 2 rooms per week for 2 months monitoring for completion of cleaning expectations.</li> </ol>	
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F 252	<p>Continued From page 5 on 10/5/15. *She agreed the above observation had not been considered a clean and home-like environment.</p> <p>Interview on 10/7/15 at 1:00 p.m. with the director of nursing revealed: *She had expected the social services designee to visit and assess resident 11 more than once every three months. *She agreed resident 11 required the staff to be an advocate for him. He could not voice any concerns on his own. He was dependent upon the staff to clean his room and take care of his personal items.</p> <p>Review of the provider's undated Long-Term Care Facilities Resident's Bill of Rights pamphlet revealed "You are entitled to quality of life. A facility must provide care and an environment that contributes to your quality of life including: a safe, clean, comfortable, and home-like environment."</p>	F 252	<p>5. The data collected will be presented to the Quality Assurance Quality Improvement Committee by the Housekeeping Supervisor. It will be reviewed/discussed and at this time the committee will make the decision/recommendation regarding follow up or changes.</p>	<p><i>Quality Improvement</i> <i>SCI 800011/1/16</i></p>
F 280 SS=E	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of</p>	F 280	<p><i>See next page</i></p>	<p><i>11-6-15</i></p>

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F 280	<p>Continued From page 6</p> <p>the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, and interview, the provider failed to ensure 4 of 16 sampled residents' (4, 7, 8, and 11) care plans were updated and revised to reflect their current care. Findings include:</p> <p>1. Review of resident 8's 8/27/15 revised care plan revealed: *Diagnosis benign (noncancerous) neoplasm (tumor) tongue. *He was independent after set-up with meals in the main dining room. *Required pureed diet with honey thick consistency liquids. *He would only drink the honey water- and refused the milk and juice. *He was currently eating mashed potatoes and hot cereal but was refusing other pureed foods. *He could be disconnected him from the feeding tube (tube inserted into the stomach for medications and nutrition) for thirty minutes three times a day for meals.</p> <p>Interview on 10/6/15 at 9:30 a.m. with the dietary manager regarding resident 8 revealed: *She had been in her position for about a year. She knew the dietary department had never set-up a meal tray for him.</p>	F 280	<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 with respect to:</p> <ol style="list-style-type: none"> <li>Resident #8, and #11's care plans have been reviewed/revise to reflect current individual needs and preferences. Resident #4 and #7 are discharged. *1 *2 *11 SC 10/16/15 Resident care plans will be reviewed/revise to reflect current individual needs and interventions including diet, repositioning frequency, adaptive equipment, specialty mattresses and interventions specific to their needs.</li> <li>By November 6<sup>th</sup>, 2015, clinical staff will be re-educated to updating of care plans to maintain accuracy and include individual needs related to needs, interventions, diet, repositioning frequency, adaptive equipment, specialty mattresses, etc by the DNS.</li> </ol>		

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F 280	<p>Continued From page 7</p> <p>*They did not offer him a meal tray if he did not come out to the dining room. *She was unsure why he never wanted to eat. *She knew he had signed a waiver to not have thickened liquids. Refer to F309, finding 1.</p> <p>Surveyor: 33488 2. Review of resident 7's care plan revealed it had no interventions on it related to his intravenous (IV) (into a vein) antibiotics causing nephrotoxicity (kidney failure), his Foley catheter (tube that drains urine from bladder) or his acute kidney failure. Refer to F281 findings 2 and 3.</p> <p>Surveyor: 32355 3. Observation on 10/6/15 at 7:40 a.m. of resident 4 revealed: *She had been: -Laying in her bed and positioned on her left side. -She had a pressure relieving boot only on her right foot. -Her left foot was laying directly on the mattress. -She was laying on a regular mattress with no air mattress overlay to assist with pressure relief. -She had a Foley catheter in place.</p> <p>Review of resident 4's medical records revealed: *An admission date of 5/14/15. *Diagnoses of obesity (over weight), pain, history of skin infections, high blood pressure, edema (swelling of the feet), and diabetes (uncontrollable blood sugar levels). *She had required assistance from the staff for transfers, bed mobility, dressing, and personal hygiene.</p>	F 280	<p>4. The DNS and/or her designee will audit three care plans per week for one month and then two care plans per week for two months for accuracy and that they reflect current needs.</p> <p>5. The data collected will be presented to the Quality Assurance Quality Improvement Committee by the DNS. It will be reviewed/discussed and at this time the committee will make the decision/recommendation regarding follow up or changes.</p> <p><i>Quality Improvement Committee</i></p>	11-6-15
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F 280	<p>Continued From page 8</p> <p>*She had a history of facility acquired pressure ulcers (wound) to both of her heels and coccyx (tailbone area).</p> <p>*She currently had a Stage II pressure ulcer to her coccyx and had been going to the wound clinic to assist with the healing of the ulcer.</p> <p>*On 8/13/15 there was a physician's order for a Foley catheter to assist with the healing of the coccyx pressure ulcer.</p> <p>Review of resident 4's 5/21/15 admission Minimum Data Set (MDS) assessment and 8/8/15 quarterly MDS assessment revealed:</p> <p>*She had been at risk for pressure ulcers.</p> <p>*She required pressure relieving devices for her bed and chair.</p> <p>*She did not require a turning and repositioning program.</p> <p>Review of resident 4's 8/14/15 care plan revealed:</p> <p>*Focus: "[Name] has an ADL [activities of daily living, assistance with bathing, eating, dressing, toileting, grooming] self care performance deficit r/t [related to] wounds and weakness."</p> <p>-Interventions: "Bed mobility: Requires ext [extensive] assist of two staff assistance to reposition and turn in bed." "Toilet use: Requires ext assist of one to two staff assistance to use toilet."</p> <p>*Focus: "[Name] had potential for pressure ulcer development r/t immobility."</p> <p>-Interventions: "8/14/15 air mattress on bed."</p> <p>*Focus: "Actual pressure areas to coccyx and to right heel."</p> <p>*No documentation to support:</p> <p>-What her turning and repositioning program consisted of and how often.</p> <p>-A placement of a Foley catheter on 8/13/15.</p>	F 280		
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F 280	<p>Continued From page 9</p> <p>-The use of pressure relieving boots for her feet.</p> <p>4. Random observations on 10/6/15 from 9:00 a.m. through 6:15 p.m. of resident 11 revealed: *When he was laying in bed he had been positioned on his left side. *He had a pressure relieving boot on his left foot but not his right. *There was an air mattress overlay on his bed underneath him. The air mattress overlay had not been plugged in and was flat. *From 2:30 p.m. through 6:15 p.m. he had: -Remained on his left side the entire time. The air mattress overlay continued to be unplugged. -A pressure relieving boot was on his left foot but not his right. His right foot rested directly on the mattress and was not floated (raised up so not touching the bed) to relieve pressure.</p> <p>Interview on 10/6/15 at 11:30 a.m. with certified nursing assistant (CNA) E revealed resident 11 to have been repositioned every two hours.</p> <p>Review of resident 11's medical record revealed: *An admission date of 8/9/12. *Diagnoses of coma (mental state of not being able to be awakened and cannot unable to move without assistance), pain, and esophageal reflux (unable to keep food in the stomach) with a feeding tube (tube inserted into the stomach for water, medication, and nutrition). *He was dependent upon staff to assist him with all of his activities of daily living. *He had a history of pressure ulcers (wound) to his left elbow. *His care plan had: -Identified he was to have been turned and repositioned in bed but did not state how often. -Failed to identify the use of pressure relieving</p>	F 280		
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F 280	<p>Continued From page 10 boots.</p> <p>Review of resident 11's undated nursing assistant care plan revealed: *He was to have been repositioned in bed every two to three hours. *His heels were to have been floated. *He was to have worn pressure relieving boots at all times.</p> <p>5. Interview on 10/7/15 at 9:30 a.m. with the director of nursing (DON) confirmed: *Both residents 4 and 11 had been at risk for skin breakdown. *The care plans were used by the staff to assist them with making sure all of the residents' needs were met. *Resident 4's and 11's care plans had not been reviewed and revised to reflect their current level of care. *The staff should have followed resident 4's care plan and placed an air mattress overlay on her bed. She had not been aware there was not one on her bed. *The staff should have followed resident 11's care plan and repositioned him every two to three hours. *She had not been aware resident 11's air mattress was unplugged. *Both of the residents were to have worn pressure relieving boots to their feet at all times. *The MDS assessment coordinator had been responsible to ensure the care plans reflected the resident's current level of care. *The interdisciplinary care team and nursing staff were to have assisted with the updating of the care plans.</p> <p>Review of the provider's August 2015 Completion</p>	F 280		
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F 280	Continued From page 11 of the RAI (Resident Assessment Instrument) manual for the Care Planning process revealed "The MDS [Minimum Data Set] assessments will be completed within the guidelines outlined in the RAI manual, and include the care planning process to lead to the development of a plan of care to address each residents functional status, strengths, weaknesses, and preferences which will be used to track improvements or declines in residents status."	F 280		
F 281 SS=G	<p><b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b></p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 A. Based on observation, interview, record review, medication review, and policy review, the provider failed to assess and provide appropriate interventions in a timely manner: *Prior to 1 of 1 randomly observed resident (12) being transported to the hospital for dialysis treatment (used for kidney failure). *Prior to and during the administration of antibiotics known to cause severe adverse events for 1 of 13 sampled residents (7). Findings include:</p> <p>1. Random observation on 10/6/15 at 9:40 a.m. of an unidentified transport person speaking with registered nurse (RN) A at the Arbor nurses station regarding resident 12 revealed: *The transporter remarked to RN A resident 12</p>	F 281	<i>See next page</i>	

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F 281	<p>Continued From page 12</p> <p>was about to be transported in her van and could not feel the oxygen (O2) coming out of the oxygen tank.</p> <p>*RNA asked the transport person if there was any O2 in the tank, and she replied "I don't know...No."</p> <p>*The transporter asked what she should do stating "Is it o.k. to transport her to Avera without oxygen? Will they hook her up there?"</p> <p>*RN A replied "Yeah, I'm sure they will."</p> <p>*The transporter proceeded to the exit doors, got in her van with resident 12, and drove off.</p> <p>*RNA had not assessed the resident for safety nor intervened prior to her leaving the facility.</p> <p>Interview with RNA immediately after the above situation with resident 12 revealed:</p> <p>*The resident was leaving for dialysis.</p> <p>*She replied "yes" when asked if the resident was to be on O2.</p> <p>*She did not know why she was on oxygen or how much; the resident was not one from her area so she was not sure.</p> <p>*When asked why she let the resident leave when she had no O2 and she replied they had none to send with her.</p> <p>-An unidentified maintenance man interjected into the conversation they had ordered four racks of oxygen, but none had arrived yet.</p> <p>*When asked why she had not assessed the resident for safety she replied "I should have."</p> <p>*She agreed the resident should not have been allowed to leave the facility without O2 and she should have assessed her immediately.</p> <p>Interview on 10/6/15 at 10:10 a.m. with the administrator and the director of nursing (DON) regarding the above situation revealed:</p> <p>*There was O2 available in the building.</p>	F 281	<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 with respect to:</p> <ol style="list-style-type: none"> <li>1. Resident #12, #11 and #17's care plans have been updated to reflect their current care needs. Resident #7 has been discharged. All residents who are on IV antibiotics are monitored per physician and/or pharmacist recommendations including standards for adverse effects. Identified staff A was re-educated and counseled. Identified Staff B and C were re-educated. Staff B maintains she gave correct amount of water and was misquoted in the 2567.</li> <li>2. Residents will be given medications per physician orders following the five rights of medication administration.</li> </ol> <p><i>*Medication administration audits will include proper time, signing of the MAR after the administration of the medication, feeding tube administration for residents</i></p>	
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F 281	<p>Continued From page 13</p> <p>*They would call Avera dialysis right away, notify them of the incident, and have an immediate assessment performed on the resident.</p> <p>Review of resident 12's medical record for revealed she had a diagnosis of chronic obstructive pulmonary disease (COPD, a disease process that makes it hard to breathe), anxiety, and had a physician's order for using 2 liters (L) of continuous oxygen to keep the O2 level in her blood at or above 91 percent (%).</p> <p>Interview on 10/7/15 at 9:10 a.m. with RN G via telephone from Avera St Luke's Dialysis regarding resident 12 and the above incident revealed: *She confirmed the resident had arrived at the facility without O2 and her tank had been empty. Her oxygen level in her blood upon arrival was 91%</p> <p>Interview on 10/7/15 at 9:40 a.m. with resident 12 revealed: *She had no oxygen on when transported to the hospital. *That caused her to worry, but she remained calm. *She denied being short of breath but stated she was tired upon arrival to Avera. *She had never been transported without oxygen before that time. *She stated someone from the facility had called ahead and alerted the dialysis staff about her lack of oxygen, and they took care of her right away. *She gets anxiety associated with her COPD.</p> <p>Review of the provider's February 3, 2012 Transfer Agreement between Avera St Luke's and and the facility revealed the facility was responsible for the resident's care until arriving at</p>	F 281	<p>3. Nursing staff will be re-educated by November 6<sup>th</sup>, 2015 on medication administration, oxygen therapy, and potential adverse side effects of medications, treatments, resident transfers within the facility including care items and equipment, assessing needs and status prior to transfer and working in collaboration with physician, pharmacist and nursing ensuring precautions and monitoring are in place when medications are ordered that have potential adverse effects. DNS/designee will provide the education.</p> <p>4. The Director of Nursing or her designee will audit three residents per week including care plan, medication administration, appropriate precautions &amp; monitoring when medications have significant potential adverse effects, necessary care items and equipment are in place.</p> <p>5. The data collected will be presented to the Quality Assurance Quality Improvement Committee by the DNS. It will be reviewed/discussed and at this time the committee will make the decision/recommendation regarding follow up or changes.</p>	11-6-15	

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F 281	<p>Continued From page 14</p> <p>Avera. Avera then assumed responsibility for the resident.</p> <p>Review of the provider's undated Use of Oxygen policy revealed:</p> <ul style="list-style-type: none"> <li>*Its purpose was to ensure each resident needing O2 would remain in a safe and secure environment.</li> <li>*O2 would be administered as ordered safely and efficiently.</li> <li>*Effectiveness of O2 administration would be monitored by nursing staff.</li> <li>*O2 tanks would be changed when empty or as needed.</li> </ul> <p>Review of the provider's undated Registered Nurse Job description revealed an RN was to:</p> <ul style="list-style-type: none"> <li>*Exhibit sound mature judgement.</li> <li>*Assess for effectiveness of medications being administered.</li> <li>*Participate in the development and implementation of an individualized care plan.</li> <li>*Utilize the interdisciplinary process to implement restorative nursing.</li> <li>*Update the resident's plan of care to reflect the resident's current status/needs.</li> <li>*Collect and record appropriate data.</li> </ul> <p>Interview on 10/7/15 at 1:25 p.m. with the assistant director of nursing (ADON) revealed:</p> <ul style="list-style-type: none"> <li>*It was her expectation RN A should not have let resident 12 leave the facility without oxygen on.</li> <li>*The resident should have had an immediate assessment for safety.</li> <li>*She agreed there was a potential for harm to have occurred to the resident.</li> </ul> <p>2. Observation and interview on 10/5/15 at 3:45 p.m. and again on 10/6/15 at 11:40 a.m. with</p>	F 281		
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F 281	Continued From page 15 resident 7 and his wife revealed: *He was admitted to the facility initially from the hospital on 9/4/15 for rehabilitation following a severe infection. *About a week after admission staff had notified her he would need to be sent to the emergency room (ER) to be evaluated for potential kidney damage caused by his antibiotics. *He returned to the facility after recovering from kidney failure and dehydration. *She felt her husband had declined physically from his initial hospitalization on 8/31/15. *He was thought to have swallowing difficulties in the hospital. He had had a hard time swallowing a pill with one medication pass while there. *He had no previous swallowing difficulties, and thickened liquids were ordered as a precautionary measure by the hospital. *The thickened water was lemon flavored which he disliked, and the milk had also been too thick for his liking. Therefore he would only drink a few sips. *She visited daily and had not witnessed staff offering liquids to him except during the daytime fresh water pass. *Staff would not regularly enter the room while she was there unless she pressed the call light or except when they passed fresh water. *She was concerned he was not drinking enough. *She pointed out his urine leg bag with dark brown urine in it. *She felt his discolored urine was from him not drinking enough and the kidney damage. *He admitted to not liking the taste or consistency of the water or milk and would often refuse to drink them. *He would normally drink "plenty" of water and milk prior to his admission. *On 10/6/15 his urine was dark yellow in color.	F 281			

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F 281	<p>Continued From page 16</p> <p>*His wife stated it looked better that day.</p> <p>Review of resident 7's medical record revealed: *He was originally admitted on 9/4/15 for rehabilitation and IV antibiotics. *During his stay from 9/4/15 to 9/12/15 he was receiving the IV antibiotics Gentamycin, Doxycycline, Vancomycin, and Levaquin. *He was also given Lasix, a diuretic (medication to flush fluid out of the body).</p> <p>RN A stated they used the nurses' drug reference material in Mosby's Nursing Drug Reference 2016 for the following medications. it contained the following information: *Gentamycin has a severe warning called a black box warning. That medication has been known to cause nephrotoxicity (kidney damage). *Doxycycline has been known to increase laboratory results that could be associated with decreased kidney function. *Vancomycin has a known side effect of nephrotoxicity. *Levaquin has a known side effect of crystaluria (crystal formation in the kidney found in the urine) that can lead to kidney irritation.</p> <p>Review of resident 7's nurses notes revealed: *Admission note on 9/4/15 documented his mouth, lips, and tongue were moist. *On 9/9/15 shortly after midnight his laboratory results for his vancomycin antibiotic was at a "critical high level of 28". (10-20 is therapeutic. any higher indicates potential nephrotoxicity per www.medscape.com.) *Later that same morning at 11:06 a.m. it was documented "no adverse effects noted from ab [antibiotics]." *On 9/11/15 his lips were dry and no adverse</p>	F 281		
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F 281	<p>Continued From page 17 reactions were noted.</p> <p>Documented in resident 12's nurses notes on 9/12/15 at 12:00 noon:                      *The provider had received a note from the pharmacy to hold (do not give) his Vancomycin and Gentamycin.                      *To contact the physician to determine the need to continue multiple IV antibiotics.                      *Updated the doctor that his kidney function laboratory test levels were elevated.                      *Received an order from the physician after notifying him of pharmacies concerns to send the resident to the ER for evaluation.                      *The resident was noted to have sore lips.</p> <p>On 9/12/15 at 4:12 the resident had been admitted to the hospital with acute kidney injury. On 9/18/15 at 3:20 p.m. the hospital had updated the facility on his condition stating the resident had aspirated (fluid went into lungs instead of stomach).                      The resident was re-admitted back to the facility on 9/22/15 after his acute kidney failure. He now had a urinary catheter upon admission.</p> <p>Review of the readily available nurses' drug reference material in Mosby's Nursing Drug Reference 2016, the nurses referenced for drug information and interventions revealed:                      *All four above listed antibiotics had adverse kidney effects listed including toxicity.                      *Nursing interventions should have included:                      -Keeping record of intake and output (I/O) of fluid.                      -Report decreased urine as kidney toxicity may occur or increased kidney laboratory results.                      -Ensure adequate intake of fluids (two liters per day).                      -Use caution in elderly patients.</p>	F 281		

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F 281	<p>Continued From page 18</p> <p>-The use of Lasix was contraindicated (advised against) while using Gentamycin as fluid depletion could make injury to the kidneys worse.</p> <p>Review of resident 7's care plan and physician's orders from 9/4/15 to 10/6/15 revealed: *No intervention for recording of intake and output, hydration (fluid intake) status, or kidney function. *No interventions related to signs or symptoms of adverse reactions from the IV antibiotics he was being given. *No mention of the resident's urinary catheter or interventions related to having one.</p> <p>Review of the 9/28/15 physician's progress note revealed resident 7 had been re-hospitalized on 9/12/15. The resident had acute kidney failure secondary to antibiotic toxicity and intravascular volume depletion (dehydration).</p> <p>Interview with the ADON on 10/6/15 at 8:30 a.m. regarding resident 7 and I/O recording revealed it was their policy to perform I/O only with a physician's order.</p> <p>Interviews with RN A on 10/6/15 at 11:00 a.m. and with RN F on 10/7/15 at 1:15 p.m. regarding I/O revealed unless there had been a physician's order to record or keep track of I/O they would not have performed that procedure.</p> <p>Review of the provider's undated Intake policy revealed: *The purpose was to determine adequate fluid balance of residents. *Intake was to be recorded if there was a physician's order, inadequate fluid intake of the resident, or evidence of dehydration, or if there</p>	F 281			

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F 281	<p>Continued From page 19</p> <p>were any fluid restrictions placed on the resident by the physician.</p> <p>Review of the provider's 2013 Medication administration policy revealed the nurse:</p> <ul style="list-style-type: none"> <li>*Should be knowledgeable of doses of medications, side effects, toxicities, and potential complications.</li> <li>*Should assess for physician's rationale for ordering treatment, laboratory test results, and appropriateness of treatment.</li> <li>*Should document the response to the procedure including any adverse or desired results of the medication.</li> </ul> <p>Review of the provider's undated Registered Nurse Job description revealed an RN was to:</p> <ul style="list-style-type: none"> <li>*Exhibit sound mature judgement.</li> <li>*Assess for effectiveness of medications being administered.</li> <li>*Participate in the development and implementation of an individualized care plan.</li> <li>*Update the resident's plan of care to reflect the resident's current status/needs.</li> <li>*Collect and record appropriate data.</li> </ul> <p>Interview, record review, and policy review on 10/7/15 with the ADON regarding resident 7's hydration and acute kidney failure revealed she:</p> <ul style="list-style-type: none"> <li>*Agreed they did not perform any I/O unless ordered by a physician.</li> <li>*Agreed all IV medications given after his first admission to the facility had side effects of kidney problems to include nephrotoxicity.</li> <li>*Was unsure if the resident's hydration status or multiple medication use was the cause of his acute kidney failure. She could not say it had not played a significant role in his diagnosis of acute kidney failure.</li> </ul>	F 281		

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F 281	<p>Continued From page 20</p> <p>*Had no process in place as a guideline or assessment for residents who received potentially toxic medications or monitoring of their hydration status while receiving those medications.</p> <p>*Agreed they had no interventions in place prior to and after his acute kidney failure to monitor his kidney function on the care plan.</p> <p>*Could not say staff had used critical thinking or assessed the resident for complications regarding the use of the IV medications he had received.</p> <p>*Had expectations staff would use critical thinking and assess for potential adverse effects from the IV medications to avoid possible complications from therapy.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, page 372, 394, and 1186 revealed:</p> <p>*Nurses were to apply the nursing process and use a critical thinking approach to care.</p> <p>***During the assessment process thoroughly assess each patient [resident] and critically analyze findings to ensure you make patient-centered clinical decisions required for safe nursing care."</p> <p>***Continually evaluate the patient's safety..."</p> <p>***Successful critical thinking requires a synthesis [blend] of knowledge, experience, information gathered from patients, critical thinking attitudes, and intellectual and professional standards."</p> <p>Surveyor: 32355</p> <p>B. Based on observation, record review, interview, and policy review, the provider failed to ensure:</p> <p>*Physicians' orders were followed for 4 of 22 medication pass observations for two randomly observed residents (11 and 17) by registered</p>	F 281		

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F 281	<p>Continued From page 21</p> <p>nurse (RN) (B) and medication aide (MA) (C). *One of two medication aides (C) had not signed off the medications as already given prior to administering them. Findings include:</p> <p>1a. Observation on 10/6/15 at 9:20 a.m. of RN B with resident 11 revealed: *She prepared to administer water to the resident through his feeding tube (tube inserted into the stomach for medication and nutrition). *She filled a plastic container with an unknown amount of water. *She retrieved a 60 cubic centimeter (cc) syringe and filled it with water. *She administered that 60 cc of water through the resident's feeding tube. *She got a 60 cc syringe with water and administered it to the resident again. *She had administered a total of 120 cc of water to the resident. *She replaced her supplies, washed her hands, and left the room.</p> <p>Interview on 10/6/15 with RN B at the time of the above observation revealed: *The nursing staff were to have administered water to the resident through his feeding tube every four hours. *She had not been sure of the exact amount of water the resident was to have been administered every four hours. She would have to check the physician's orders. *She had been sure that was an appropriate amount of water to have administered. *She was not observed of checking the physician's orders to ensure she had given the amount of water ordered. She returned to her normal duties as charge nurse.</p>	F 281		

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F 281	<p>Continued From page 22</p> <p>Review of resident 11's 9/17/15 physician's orders revealed he was to have had 175 cc of free water every four hours through his feeding tube. He had only received 120 cc of water during the above observation.</p> <p>b. Observation on 10/6/15 at 11:05 a.m. of RN B with resident 11 revealed she had disconnected his feeding tube. That had been done so the staff could assist him with personal care and getting him out of his bed.</p> <p>Interview on 10/6/15 with RN B at the time of the above observation revealed she was not sure how long his tube feeding could be disconnected from his nutritional source. She had stated "He needs this though, its good for him to get out of bed."</p> <p>Observation on 10/6/15 from 11:05 a.m. through 2:35 p.m. of resident 11 revealed he had been in his wheelchair (w/c) and sitting in the community room listening to music. During that entire time his tube feeding had been disconnected from his nutritional source.</p> <p>Review of resident 11's 9/17/15 physician's orders revealed he was to have had Jevity 1.2 Caloric liquid (nutritional supplement) through his feeding tube twenty-four hours per day running at 70 cc per hour.</p> <p>c. Observation on 10/6/15 at 12:15 p.m. of resident 17 revealed: *He had been sitting at the dining room table in his w/c. *He had started to eat his noon meal. *MA C administered his noon medications to him</p>	F 281		
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F 281	<p>Continued From page 23 that included his omeprazole (stomach medication).</p> <p>Review of resident 17's September 2015 medication administration record revealed the omeprazole was scheduled every day at 11:00 a.m.</p> <p>Interview at the above time with MA C regarding resident 17 revealed she knew the omeprazole should have been given thirty minutes prior to eating. She had been running late with his medications.</p> <p>d. Observation and interview on 10/6/15 at 5:00 p.m. with RN B revealed:                      *She prepared to administer resident 11 his omeprazole through his feeding tube. The medication was in liquid form and had been stored in a refrigerator in the medication room.                      *She poured the exact amount of the medication to be administered into a medication cup. Review of the label attached to the medication bottle revealed an expiration date of 9/24/15.                      *RN B had not been aware the medication was expired.                      *She had been unable to locate another bottle of omeprazole. She stated "Well I have a problem with giving expired medications, so he will have to wait until it comes from pharmacy which will be later tonight."                      *She sent a fax to the pharmacy requesting another bottle of omeprazole for the resident.                      *She returned to her normal duties as charge nurse.                      *She was not observed notifying the physician of the unavailability of the medication for administration.</p>	F 281			

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F 281	<p>Continued From page 24</p> <p>2. Random observations on 10/6/15 of MA C during medication administration revealed: *She had been observed administering medications to several unidentified residents. *She had signed off the medications as given prior to administering them to the residents.</p> <p>Interview on 10/6/15 at 12:20 p.m. with MA C regarding the above observations revealed she had been shown to sign-off the medications prior to administering them by the provider's nurse educator. She confirmed her MA course had instructed her to always sign the medications as given after administering them.</p> <p>3. Interview on 10/7/15 at 9:30 a.m. with the director of nursing regarding the above observations revealed: *She would have expected RN B and MA C to have followed the physicians' orders for residents 11 and 17. *The nurses had been responsible for ordering any liquid medication in a timely manner to ensure the availability of the medication. *She confirmed medications were to have been signed off as given after they had been administered.</p> <p>Review of the provider's January 2005 Medication Administration General Guidelines policy and procedures revealed: **"Medications are administered as prescribed in accordance with good nursing principles and practices and only be persons legally authorized to do so." **"Medications are administered in accordance with written orders of the attending prescriber." **"Medications are administered within 60 minutes of scheduled time, except before or after meal</p>	F 281			

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F 281	Continued From page 25 orders, which are administered precisely as ordered." **"Medication expiration dates will be monitored to ensure outdated medications are not administered to residents." **"Outdated medication will be immediately withdrawn from stock and discard according to the facility's policy on medication destruction."	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, and interview, the provider failed to ensure the physical, mental, and psychosocial needs were met for one of one sampled resident (8) by: *Following the care plan for individualized activities of daily living (ADL, assistance with bathing, eating, dressing, toileting, and grooming). *Appropriate assessment and documentation of	F 309	<i>See next page</i>	

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F 309	<p>Continued From page 26</p> <p>the resident's refusal of care.</p> <p>*Appropriate assessment, notification, and documentation of mental health services for his refusal of care.</p> <p>*Completing complete nursing assessments for pain.</p> <p>Findings include:</p> <p>1. Review of resident 8's medical record revealed:</p> <p>*A 1/18/08 admission date.</p> <p>*Diagnoses: Benign (noncancerous) neoplasm (tumor) tongue, depression, and anxiety.</p> <p>Observation of resident 8 from 10/4/15 at 4:00 p.m. through 10/7/15 at 10:00 a.m. revealed he:</p> <p>*Was in bed and wore only a disposable brief.</p> <p>*Had no clothes on.</p> <p>*Often had the sheet covering him pushed off to the side.</p> <p>*Had no lights on his room, and the blinds in the room were closed.</p> <p>*Had a curtain drawn between the entrance to his room and the hallway.</p> <p>*Ate no food by mouth.</p> <p>*Took a few sips of water from a cup with a straw that was on his nightstand.</p> <p>*Had a gastrostomy feeding tube (tube inserted directly into the stomach for nutrition and medication).</p> <p>*Received the tube feeding Osmolite continuously at 60 milliliters (ml) an hour.</p> <p>Review of resident 8's 8/27/15 revised care plan revealed:</p> <p>**Chooses to spend a considerable amount of time in his room and in bed."</p> <p>**Offer to assist but honor request if he denies."</p> <p>**Prefers to be in a dark room with the lights off</p>	F 309	<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 with respect to:</p> <ol style="list-style-type: none"> <li>1. Resident #8's care plan has been reviewed/revised. Resident #8 was seen by Northeastern Mental Health on October 23<sup>rd</sup>, 2015 per schedule. Physician will again be notified of resident's complaint of headache. Resident #8 continues to refuse to accept a visit from the Ombudsman.</li> <li>2. Residents will be reviewed to identify any having behaviors of continued refusal of cares. If identified, their individual needs will be reassessed including Ombudsman services if indicated.</li> <li>3. By November 6<sup>th</sup>, 2015 Clinical staff including Social Services will be re-educated regarding assessment and use of care plan, assessment and documentation when an individual refuses cares on a regular basis, necessary notification and documentation with ongoing refusals and mental health services.</li> </ol>		

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F 309	<p>Continued From page 27 and the blinds closed."                  ***Prefers to wear his hospital gown when in bed."                  ***Feeds self independently after set-up when eating food for pleasure in the dining room. Requires total assistance with tube feedings."                  ***Has not left his room for months except for showers and appointments."                  ***Refuses bathing often."                  ***May disconnect from tube feeding for thirty minutes three times a day for meals."                  ***If refuses treatment/intervention, confer with him to determine why and alternative methods to gain compliance and document."                  ***Observe/document/report to medical practitioner as needed signs and symptoms of psychotropic [mood and behavior altering medications] complications: decline in mood or behavior, social isolation, withdrawal, decline in ADL, loss of appetite, and nausea and vomiting."                  ***Ask if he is having any pain when providing cares. If so, have him rate his pain on a scale of 0-10 [0 being no pain and 10 being severe pain]. Document. Follow-up with effectiveness."                  ***Has scheduled pain medication and as needed [PRN] medication orders for breakthrough pain."                  ***Total assistance of one for bowel and bladder incontinence [no control]."</p> <p>Review of resident 8's 9/16/15 through 10/6/15 ADL documentation by the certified nursing assistants revealed "not applicable" was documented for:                  *Dressing: Twelve times. There was refused by one time.                  *Transferring: Sixty-eight times. There was refused by five times.                  *Bathing: Three times.                  *Eating: Thirty-four times.</p>	F 309	<p>4. The DNS and/or her designee will 3 residents per week for 1 month and then 2 residents per week for 2 month for assessment, care plan, documentation and notification of regular refusals and mental health services.</p> <p>5. The data collected will be presented to the Quality Assurance Quality Improvement Committee by the DNS. It will be reviewed/discussed and at this time the committee will make the decision/recommendation regarding follow up or changes.</p>	11-6-15
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*QUALITY  
10/13/2015*

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F 309	<p>Continued From page 28</p> <p>Review of resident 8's 9/16/15 through 10/6/15 behavior documentation sheet revealed he refused care on 10/4/15 and 10/6/15.</p> <p>Review of resident 8's 6/10/15 through 9/2/15 care conference summary notes revealed: *6/10/15: "Has not come out for any meals. Continues tube feedings. Does not attend any activities and does not even like 1:1's [individualized one-on-one activities in his room]. Likes to be in bed with lights out. Declined to attend care conference today. Denied any concerns." *9/2/15: "Says he calls staff but takes awhile for them to come. Does not go out to dining room to eat anymore. Activities does 1:1's. Likes to stay in room with lights out. Does not like to wear clothes."</p> <p>Review of resident 8's 6/18/15 through 8/20/15 physician's orders revealed: *6/18/15: "Nursing report feeding tube clogs a lot. Chronic headache and leg pain. No change in orders." *7/23/15: "Feeding tube replaced yesterday. Patient [resident] states he has a headache all the time. No change in orders." *8/20/15: "Nursing report patient has been vomiting today. Patient states stomach hurts." An x-ray was done of his abdomen with no abnormal findings.</p> <p>Review of resident 8's 5/29/15 mental health certified nurse practitioner notes revealed: *No new orders. *See in four months. *There was no documentation a follow-up visit had been completed in September 2015.</p>	F 309			

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F 309	<p>Continued From page 29</p> <p>Review of resident 8's 8/20/15 through 8/26/15 social service designee progress notes revealed: *8/20/15: "Total severity score for depression indicates 5-9 mild depression." *8/26/15: "Brief interview for mental status (BIMs) score of 13. [Indicates intact memory]. Does have a diagnosis of major depressive disorder with use of Lexapro [antidepressant]. No behaviors or rejection of care."</p> <p>Review of resident 8's 8/20/15 through 9/22/15 nursing progress notes revealed: *8/20/15: -"Able to communicate verbally with a rational response. Able to deal with stress/frustrations with moderate ability to cope, may become agitated." -"Mood indicators present: Has difficulty falling or staying asleep or sleeping too much. Feels tired or has little or no energy. No adverse mood or behaviors noted. Behaviors are not severe enough to pose a risk to the individual or others." *8/21/15: -"Had a pain assessment completed. Is able to communicate pain verbally. History of pain noted to leg and back pain. Medication used to alleviate pain is Duragesic patch [topical narcotic pain medication] and neurontin [chronic pain medication]. Hydrocodone [narcotic pain medication as needed]." -"The resident is currently having pain and has experienced pain in the past five days." -"Does complain of pain to his legs, back and stomach. Prefers to stay in his room in his bed with the lights off. Pain intensity is 7 [on a 1-10 scale with 1 being little pain and 10 being severe pain]." -"Does get up in his recliner at times with much encouragement from staff."</p>	F 309		

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F 309	<p>Continued From page 30</p> <p>*9/13/15: -"Resident yelled for help and was found sitting on floor next to bed bleeding from back of head." -"Small laceration [cut] approximately one-half inch length bleeding large amount." -"To hospital for one staple to the back of the head where laceration was."</p> <p>*9/15/15: -"He received a hi/lo bed today and is in the lowest position when he is in it." -"He does not like to get out of bed or come out of his room. He does reposition self."</p> <p>Interview on 10/6/15 at 10:30 a.m. with resident 8 revealed he: *Felt the nursing staff were giving him the wrong medication for his headache. *Felt the hydrocodone helped his headache, but the Tylenol did not. *Was not sure what medications the nurses were giving him, as they mixed them in applesauce and gave them to him to swallow. *Did not want to get up out of bed, because he always was in pain with a headache. His headache was usually about a 9 on a 0 to 10 pain scale. The hydrocodone when the nurses would give it to him relieved his pain to about a 7. *Did not feel like eating, because he was always full. The staff never asked him anymore if he wanted to go to the dining room.</p> <p>Review of resident 8's 8/4/15 through 9/30/15 as needed (PRN) medication record revealed: *Hydrocodone was documented as administered twenty-one times. *His documented pain rating of his headache was usually 7 to 9 on a 0 to 10 pain rating. *There was documentation of little relief to effective.</p>	F 309			

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F 309	<p>Continued From page 31</p> <p>*There was no further documentation what had been done to relieve his pain when the hydrocodone had been not effective.</p> <p>Interview on 10/6/15 at 2:00 p.m. with the social service designee regarding resident 8 revealed:</p> <p>*She was not sure why he did not want to eat anything by mouth. He used to like to eat lots of mashed potatoes and bread.</p> <p>*She thought he was asking for cartons of milk, and the staff were giving them to him but not documenting it.</p> <p>*The adult undergarment was his choice; he did not want to be toileted or use the urinal.</p> <p>*She knew it was care planned for him to wear a gown in bed, but he often took it off.</p> <p>*She knew it had been awhile since his mental health physician had seen him, but they followed him regularly. She knew the staff had informed the doctor of his resistance with his ADLs, but they had not consistently documented they had.</p> <p>*He had been seen by the mental health certified nurse practitioner 5/29/15. She knew there was an order for him to be seen in four months, but that had not occurred. She thought the doctor had just reviewed his medications but had not seen him.</p> <p>*She visited with him when she did her quarterly assessments. She would sometimes answer his call light if it was on. Usually all he wanted was for his fan to be moved or something for a headache.</p> <p>*She had not thought to involve the ombudsman (social service advocate).</p> <p>*Most of the staff just knew he was resistant with his care and would not let them do anything for him.</p> <p>*She knew he would get upset with staff who did get him up to shower or make him get out of bed for an appointment.</p>	F 309			

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F 309	Continued From page 32 *His feeding tube had been plugging up more frequently and he had needed to go to the hospital for that.  Interview on 10/6/15 at 3:30 p.m. with the activity director regarding resident 8 revealed: *She thought it had been the last year he had refused to come out of his room, get dressed, or make any attempt to eat. *He was usually receptive at times if she stopped in the room and visited with him. *She thought maybe he had just given up.  Interview on 10/7/15 at 10:30 a.m. with the DON regarding resident 8 revealed: *If the CNAs documented "not applicable" for a particular ADL, either the ADL was not done or the resident had refused. *The CNAs should have been documenting on a consistent basis if he was refusing cares. *The CNAs should still have been offering every shift to assist him with dressing, transferring out of bed, and going to the dining room to eat.	F 309			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced	F 314	<i>See next page</i>		

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F 314	Continued From page 33 by: Surveyor: 33488  Surveyor: 32355 Based on observation, record review, interview, and guideline review, the provider failed to: *Ensure two of three sampled residents (4 and 11) who required staff assistance with their activities of daily living (ADL, assistance with grooming, bathing, toileting, eating, and dressing) remained free from facility acquired pressure ulcers (injury to skin usually from pressure and frequently over a bony area). *Appropriately assess 1 of 1 sampled resident (7) with new onset buttock (bottom) pain who was at risk for pressure ulcer (injury to skin from pressure) development. Findings include:  1. Review of resident 11's medical record revealed: *An 8/9/12 admission date. *Diagnoses of coma (mental state of not being able to be awakened and unable to move without assistance), pain, and esophageal reflux (unable to keep food in the stomach) with a feeding tube (tube inserted into the stomach for medication and nutrition). *He was dependent upon staff to assist him with all of his activities of daily living. *He had a history of pressure ulcers (wound) to his left elbow. *His care plan had: -Identified he was to have been turned and repositioned in bed but did not state how often. -Failed to identify the use of pressure relieving boots.  Review of resident 11's undated nursing assistant	F 314	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 with respect to:  1. Resident #11's care plan has been reviewed/revised and reflects the current needs and preferences. Resident #4 and #7 have been discharged.  2. All residents continue to receive a comprehensive skin assessment upon admission, quarterly, with a significant change and annually. Residents were reviewed to assure all devices were in place.  3. By November 6 <sup>th</sup> , 2015 all nurses will be re-educated to pressure ulcer prevention, assessment and re-assessment, monitoring and treatment of pressure ulcers by the DNS or her designee.  4. The DNS or her designee will audit 2 residents per week for 1 month and then 1 resident per week for 2 month for prevention, assessment, reassessment, monitoring, and treatment of pressure ulcers.  <i>to include resident 11. SC/SDDOH/EL</i>		

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F 314	<p>Continued From page 34 care plan revealed: *He was to have been repositioned in bed every two to three hours. *His heels were to have been floated (raised up). *He was to have worn pressure relieving boots at all times.</p> <p>Observation on 10/5/15 at 3:45 p.m. of resident 4 revealed: *She had been in her room sitting in her wheelchair (w/c). *She had been alert but confused and was unable to answer any questions. *She had a blue pressure relieving boot on her right foot. The left foot had nothing on it and was resting on the w/c's foot pedal. *Her bed contained a regular mattress with no air mattress overlay (for pressure relief) on top of it.</p> <p>Observation on 10/6/15 at 7:40 a.m. of resident 4 revealed she: *Had been laying in her bed and positioned on her left side. *Had a pressure relieving boot only on her right foot. *Had her left foot laying directly on the mattress. *Had been laying on a regular mattress with no air mattress overlay to assist with pressure relief from the bed. *She had a Foley catheter (tube inserted into the bladder to drain urine) in place.</p> <p>Review of resident 4's medical records revealed: *An admission date of 5/14/15. *She had a rash to her abdomen and lower back on admission. No other skin issues had been identified at that time. *Diagnoses were obesity (over weight), pain, history of skin infections, high blood pressure,</p>	F 314	<p>5. The data collected will be presented to the Quality Assurance Quality Improvement Committee by the DNS. It will be reviewed/discussed and at this time the committee will make the decision/recommendation regarding follow up or changes.</p> <p><i>Quality Improvement Committee</i></p>		

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F 314	<p>Continued From page 35</p> <p>edema (swelling of the feet), and diabetes (abnormal blood sugar).</p> <p>*She had required assistance from the staff for transfers, bed mobility (repositioning), dressing, and personal hygiene.</p> <p>*On 6/1/15 a blister (fluid under skin) had been identified to her right heel.</p> <p>*On 9/11/15 a Stage I (one) pressure ulcer had been identified to her left heel.</p> <p>*She currently had a Stage II (two) pressure ulcer to her coccyx and had been going to the wound clinic to assist with the healing of the ulcer. The pressure ulcer had been identified on 6/10/15.</p> <p>*On 8/13/15 a physician's order for a Foley catheter to assist with the healing of that pressure ulcer.</p> <p>Review of resident 4's admission Braden Scale assessment (special type) revealed a score of eighteen indicating she was at moderate risk for developing pressure ulcers.</p> <p>Review of resident 4's 5/21/15 admission Minimum Data Set (MDS) and 8/8/15 quarterly MDS assessments revealed she:</p> <p>*Had been at risk for developing pressure ulcers.</p> <p>*Had required pressure relieving devices for her bed and chair.</p> <p>*Had not required a turning and repositioning program.</p> <p>Review of resident 4's 8/14/15 care plan revealed:</p> <p>*Focus: "[Name] has an ADL self care performance deficit r/t [related to] wounds and weakness."</p> <p>-Interventions: "Bed mobility: Requires ext [extensive] assist of two staff assistance to reposition and turn in bed."</p>	F 314			

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F 314	<p>Continued From page 36</p> <p>*Focus: "[Name] had potential for pressure ulcer development r/t immobility." -Interventions: "8/14/15 air mattress on bed." *No documentation to support: -What her turning and repositioning program consisted of and how often she required assistance. -The use of pressure relieving boots for her feet. *The staff failed to ensure the air mattress had been on the resident's bed as directed by the care plan.</p> <p>2. Random observations on 10/6/15 from 9:00 a.m. through 6:15 p.m. of resident 11 revealed: *When he was laying in bed he had been positioned on his left side. *He had a pressure relieving boot on his left foot but not on his right foot. *There had been an air mattress overlay (relieves pressure from mattress) on his bed. The air mattress overlay had not been plugged in and was flat. *From 2:30 p.m. through 6:15 p.m. he had: -Remained on his left side the entire time. The air mattress overlay continued to be unplugged. -A pressure relieving boot was on his left foot but not his right. His right foot rested directly on the mattress and was not floated (raised up) to relieve pressure.</p> <p>Interview on 10/6/15 at 11:30 a.m. with certified nursing assistant (CNA) E revealed resident 11 was to have been repositioned every two hours. She had been assigned to take care of him that day.</p> <p>Review of resident 11's 5/19/15, 6/11/15, and 9/11/15 Braden Scale assessment revealed a score of nine indicating he was at a very high risk</p>	F 314			

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F 314	Continued From page 37 for developing pressure ulcers.  3. Interview on 10/7/15 at 9:30 a.m. with the director of nursing (DON) confirmed: *Both residents 4 and 11: -Had been at risk for skin breakdown, -Had received pressure ulcers after being admitted to their facility and while receiving care here. *The care plans were used by the staff to assist them with making sure all of the residents' needs were met. *The nursing assistant care plans were used daily by the CNAs to guide them in taking care of the residents. *Residents 4 and 11's care plans had not been reviewed and revised to reflect their current levels of care. *The staff should have followed resident 4's care plan and placed an air mattress overlay on her bed. She had not been aware there was not one on her bed. *The staff should have followed resident 11's care plan and repositioned him every two to three hours. *She had not been aware resident 11's air mattress was unplugged. *Both of the residents were to have worn pressure relieving boots to their feet at all times. *The MDS assessment coordinator had been responsible to ensure the care plans reflected the residents' current level of care. She had been responsible for the updating of the nursing assistant care plans. *The interdisciplinary care team and nursing staff were to have assisted with the updating of the care plans.  Surveyor 33488	F 314			

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F 314	<p>Continued From page 38</p> <p>4. Observation and interview on 10/5/15 at 3:45 p.m. with resident 7 and his wife revealed: *He was originally admitted to the facility from the hospital on 9/4/15 for rehabilitation following a severe infection. *His wife stated he was complaining of a sore bottom and was concerned about "bed sores" (pressure ulcer). *Staff would not regularly enter the room while she was there unless she put the call light on. *He was seated in his recliner but would transfer to his wheelchair for going out on the unit. *He would lay down in the early evening for bed.</p> <p>Random observations on 10/6/15 from 8:00 a.m. through 4:45 p.m. revealed resident 7 was seated either in his wheelchair or his recliner.</p> <p>Review of resident 7's medical record revealed: *His 9/4/15 comprehensive skin and positioning evaluation revealed he was at high risk for skin breakdown. He was marked as completely immobile under the mobility portion. *Interventions listed on the above assessment were to: -Reposition per individual needs. -Encourage position changes. -Encourage rest periods. -Attempt to reposition off affected area. -Pressure redistribution support surface on his bed. *His 9/10/15 comprehensive skin and positioning evaluation revealed he was at high risk for skin breakdown. He was marked as very limited under the mobility portion. *Interventions listed on the above assessment were to: -Encourage rest periods. -Pressure redistribution support surface on his</p>	F 314			

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F 314	<p>Continued From page 39</p> <p>bed.</p> <p>-Pressure redistribution support surface on his chair.</p> <p>*His 9/29/15 comprehensive skin and positioning evaluation revealed he was at moderate risk for skin breakdown. He was marked as very limited under the mobility portion.</p> <p>-Encourage rest periods.</p> <p>-Pressure redistribution support surface on his bed.</p> <p>-Pressure redistribution support surface on his chair.</p> <p>Review of resident 7's current care plan revealed:</p> <p>*No mention of how often he should be have been repositioned.</p> <p>*No mention of how often he should be laid down for rest periods.</p> <p>*No mention of a pressure relieving device in his recliner.</p> <p>Observation and interview on 10/6/15 at 4:45 p.m. with RN A while performing a skin assessment of resident 7's buttock (bottom) area revealed:</p> <p>*A Stage I (one) (a reddened area) pressure ulcer on his left upper buttock measuring 5.5 centimeters (cm) by 0.5 cm.</p> <p>*RN A had not seen that pressure ulcer on his buttock prior to now nor was aware of any concerns.</p> <p>*She agreed that was caused by prolonged pressure to the buttock.</p> <p>*The Minimum Data Set (MDS) assessment coordinator would be responsible for determining the repositioning schedule for each resident.</p> <p>Review of resident 7's medical record revealed:</p> <p>*His 9/4/15 discharge summary from the hospital</p>	F 314			

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F 314	<p>Continued From page 40</p> <p>revealed he had a reddened area on his coccyx (lower back and buttock area). *Nurses notes from that same day revealed "reddened area to coccyx."</p> <p>Interview on 10/6/15 at 5:20 p.m. with the ADON, MDS coordinator for the Arbor wing, and the nurse consultant regarding resident 7's pressure ulcer revealed: *The facility's standard of care for repositioning was for it to be done every two hours. *Staff did not record repositioning on residents. *The MDS coordinator was told about the resident's pain on his buttock by therapy that morning as he had refused therapy at that time. She had advised RN A about the resident's pain. *The ADON was unsure why a nursing assessment was not done in a timely manner if it had been reported to RN A earlier that day. *It was the ADON's expectation a nursing assessment should have been completed in a timely manner when a resident complained of new onset buttock pain.</p> <p>Review of the provider's September 2010 Guidelines for Pressure Ulcer Prevention Guidelines revealed: *Components of Program: -"Comprehensive evaluation of the resident's clinical condition and pressure ulcer risk factors at admission and as required throughout the resident's stay." -"Recognition of any risk factors identified on the comprehensive assessment." -"Evaluation of the individual risk factors and determination, based on clinical judgement, selection of interventions to stabilize, reduce or remove the underlying risk factors identified on the assessment(s)."</p>	F 314			

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F 314	Continued From page 41 -"Monitor the effects of the interventions and modify the interventions when indicated." -"Re-assessment of the individual's pressure ulcer risk factors as required." -"Education program includes pressure ulcer prevention, the assessment and treatment of pressure ulcers, lower extremity ulcers and other skin conditions."	F 314			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on observation, record review, and interview, the provider failed to ensure documentation by the medical provider for the reason of the continued use of a Foley catheter (a tube to drain urine from the bladder) for one of one sampled resident (2). Findings include:  1. Observation on 10/7/15 at 8:00 a.m. of resident 2 revealed she had a indwelling Foley catheter.  Review of resident 2's medical record revealed: *She had a Foley catheter on admission on	F 315	See next page	11-6-15	

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NAME OF PROVIDER OR SUPPLIER  <b>ABERDEEN HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401</b>		
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F 315	<p>Continued From page 42 4/23/15. *A 5/22/15 physician's order to discontinue the Foley catheter. -The catheter was removed on 5/23/15. *She was hospitalized in June 2015 and had surgery. *She was readmitted on 6/29/15 with a Foley catheter. *A 6/29/15 physician's order for the catheter to be changed monthly. *A follow-up appointment with the urologist was scheduled for 8/3/15 at 3:00 p.m. *She was treated with antibiotics for a urinary tract infection on 8/10/15.</p> <p>Review of resident 2's physician's progress notes revealed: *The continued use of the catheter was not addressed. *No current diagnoses pertaining to her urinary function.</p> <p>Review of resident 2's 9/9/15 care plan revealed: *It addressed catheter care and tasks related to the device. *It did not address a timeline for reassessment of the necessity of the catheter.</p> <p>Interview on 10/7/15 at 1:10 p.m. and at 1:45 p.m. with the assistant director of nursing regarding resident 2 revealed: *The follow-up appointment with the urologist had been marked on the unit calendar but was scribbled out. *She placed a call to the urologist's office regarding the follow-up appointment and was told it was canceled on 7/22/15. -There was no information available why the appointment was canceled and by whom.</p>	F 315	<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> <ol style="list-style-type: none"> <li>1. Resident #2's care plan was reviewed/revise and reflects current urinary status.</li> <li>2. All medical records have been reviewed for documentation for use of a catheter and diagnosis. <i>*including resident #2.</i></li> <li>3. Licensed staff will be re-educated by November 6, 2015 regarding need for documentation and diagnosis from physician to support use of the catheter <i>SC1SD00H1EL</i></li> <li>4. The DNS or her designee will audit 2 resident records with catheters a week for one month and then one resident per week for two months for documentation of catheter use and diagnosis.</li> </ol>		

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

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F 315	Continued From page 43 *She stated she thought the resident had a history of urinary retention. *It was her expectation the use of the catheter would have been re-evaluated and its use justified. -Acknowledged she could find no documentation regarding the above issue.  Interview on 10/7/15 at 2:10 p.m. with registered nurse F revealed: *She would look at the reason a catheter was ordered and address with the physician if there were any concerns about it. *There was no documentation in the medical record that any staff member had communicated a concern with the physician.  Policies concerning the evaluation of a urinary catheter were requested during interviews with the assistant director of nursing, however none were received by the end of the survey.  Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, MO, 2013, p. 1061, revealed indications for long-term catheterization might include, "...severe urinary retention with recurrent episodes of urinary tract infection; skin rashes, ulcers, or wounds irritated by contact with urine; and terminal illness when bed linen changes are painful for the patient."	F 315	5. The data collected will be presented to the Quality Assurance Quality Improvement Committee by the DNS. It will be reviewed/discussed and at this time the committee will make the decision/recommendation regarding follow up or changes.	11-6-15	
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	F 323	See next page		

*Quality Improvement Committee*

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F 323	Continued From page 44 prevent accidents.  This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, and interview, the provider failed to properly supervise and implement interventions to prevent one of one sampled resident's (14) elopement (leaving the building without staff knowledge). Findings include:  1. Review of resident 14's 4/10/15 nursing progress notes revealed: *5:50 p.m., Admitted to the facility from an acute care hospital after a surgical procedure. *7:15 p.m., "Resident was ambulating [walking] in hallway on own with no assistive device [walker or wheelchair] and exited the facility through A wing west door. Was redirected inside by three staff. Director of nursing [DON] informed of same at 7:40 p.m."  Review of resident 14's 4/11/15 nursing progress notes revealed: *6:25 a.m., "Noted from previous note that this registered nurse [RN] attempted to redirect resident before he went outside and he proceeded to go out the door after saying I don't pay you guys all this money for you to tell me I can't go outside. I want to smoke. Attempted to apply Wanderguard [bracelet on body that sounds an alarm when the resident attempts to exit the building] time two and would not make door alarm sound. Passed along to day shift." *3:03 p.m., "Went to room at 11:10 a.m. to check	F 323	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:  1. Resident #14 has been discharged. 2. All residents are assessed upon admission, quarterly and with any change of condition for their risk of elopement. Staff were re-educated at the time of the incident. 3. Clinical staff will be educated by November 6 <sup>th</sup> , 2015 to review the procedure for a resident away without staff knowledge, appropriate unit placement, use of Wanderguards and other devices. Education will be provided by the DNS or her designee. 4. The DNS or her designee will audit 2 residents per week for 1 month and then 1 resident per week for two months for accurate completion of elopement assessments, care plan, placement and use of devices.		

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F 323	<p>Continued From page 45</p> <p>on resident and noted he was not in room. Called a code green and facility and grounds searched and could not find him. Was on phone to police when he returned on his own with out resistance. Was last seen one hour before was missing. Returned at 11:40 a.m. Was cold and tired. Says he was going to the casino down the road. Order received from doctor to admit to Birchwood [secured unit in the facility]. Very tired on return and slept in his bed most of the evening. Refused lunch. Cooperative with cares. At time of return temperature was 92.0 degrees [normal 98.6]. His temperature increased to 97.4 degrees in one-half hour."</p> <p>Review of resident 14's 4/11/15 investigation report by the DON revealed:                      **Resident stated he was on his way to the casino down the road to go gambling. He said he got tired and sat on the side of the road to rest. He stated a man in a car pulled up along side him and asked him if he needed a lift anywhere. The man gave him a ride and dropped him off at the front door. He always goes to the casino to gamble and did not realize that he needed to let anyone known when he was leaving."                      *Wanderguard was placed on resident and staff started performing thirty minute checks for his whereabouts as well. He was moved to Birchwood.                      *He had walked through the main therapy entrance doors. That entrance was not alarmed or locked from 6:00 a.m. to 6:00 p.m. due to therapy staff in there conducting therapy and monitoring the entrance.                      *That door had a Wanderguard alarming system on it, but the resident did not have a Wanderguard on at that time due to his intact cognition (memory was okay).</p>	F 323	<p>5. The data collected will be presented to the Quality Assurance Quality Improvement Committee by the DNS. It will be reviewed/discussed and at this time the committee will make the decision/recommendation regarding follow up or changes.</p> <p><i>Quality Improvement System</i></p>	11-6-15	

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F 323	Continued From page 46 *There was no documentation if the therapy staff had seen him exit the building.  Interview on 10/7/15 at 10:15 a.m. with the DON regarding resident 14 revealed: *The Wanderguard that had been attempted twice on 4/11/15 had not functioned when the nurse tried to put it on him. *There were other Wanderguards in the facility that should have been put on him when the night shift had relayed the information to the day shift on 4/11/15 prior to his elopement. *He had not been put in the secured memory care unit on 4/10/15 as his cognition appeared okay. *He had a history of elopements at a previous facility, but that information had not been shared with them on his admission.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, record review, interview, and policy review, the provider failed to ensure medications were administered with less than 5 percent (%) medication error rate. The provider's medication error rate was 5.9% for 2 of 34 observed medications administered by two of three staff to two randomly observed residents (11 and 17). Findings include:	F 332	<i>See next page</i>	

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F 332	<p>Continued From page 47</p> <p>1. Observation on 10/6/15 at 12:15 p.m. of resident 17 revealed: *He had been sitting at the dining room table in his wheelchair (w/c). *He had started to eat his noon meal. *Medication aide (MA) C administered his noon medications to him that included his omeprazole (stomach medication).</p> <p>Review of resident 17's September 2015 medication administration record revealed the omeprazole was scheduled every day at 11:00 a.m.</p> <p>Interview at the above time with MA C regarding resident 17 revealed she knew the omeprazole should have been given thirty minutes prior to eating. She stated "I am running late with his medications."</p> <p>2. Observation and interview on 10/6/15 at 5:00 p.m. with registered nurse (RN) B revealed: *She prepared to administer resident 11 his omeprazole through his feeding tube. The medication was in liquid form and had been stored in a refrigerator in the medication room. *She poured the exact amount of the medication to be administered into a medication cup. Review of the label attached to the medication bottle revealed an expiration date of 9/24/15. *RN B had not been aware the medication was expired. *She had been unable to locate another bottle of omeprazole. She stated "Well I have a problem with giving expired medications, so he will have to wait until it comes from pharmacy which will be later tonight." *She sent a fax to the pharmacy requesting another bottle of omeprazole for the resident.</p>	F 332	<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> <ol style="list-style-type: none"> <li>1. Resident # 11 and #17 have their Omeprazole administered per physician orders.</li> <li>2. Medications were checked for expiration dates.</li> <li>3. Licensed staff and med techs will be re-educated by November 6<sup>th</sup>, 2015 specifically to administering Omeprazole 30 minutes before meals per physician orders. In addition, procedure for checking for expired medication will be reviewed/revised.</li> <li>4. The DNS or her designee will audit 2 staff per week for three months for Medication administration including the five rights, signing of medications given, expiration dates and adherence to physician orders.</li> </ol>	
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*Observation of medication administration for resident 11 and resident 17. Audits will include SC/SPO/HE*

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F 332	Continued From page 48 *She returned to her normal duties as charge nurse. *She was not observed notifying the physician of the unavailability of the medication for administration.  Review of the provider's January 2005 Medication Administration General Guidelines policy and procedures revealed: **"Medications are administered as prescribed in accordance with good nursing principles and practices and only be persons legally authorized to do so." **"Medications are administered in accordance with written orders of the attending prescriber." **"Medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered precisely as ordered." **"Medication expiration dates will be monitored to ensure outdated medications are not administered to residents." **"Outdated medication will be immediately withdrawn from stock and discard according to the facility's policy on medication destruction."  Review of the provider's 7/6/15 (pharmacy name) Long-term Care Pharmacy policy revealed "Medications that are not tablets/capsules: These medications will need to be refill/order on demand. Examples of these would be: liquids."	F 332	5. The data collected will be presented to the Quality Assurance Quality Improvement Committee by the DNS* <sup>1</sup> It will be reviewed/discussed and at this time the committee will make the decision/recommendation regarding follow up or changes.		
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	F 441	See next page	11-6-15	

*Quality Improvement*

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F 441	<p>Continued From page 49 of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, record review, interview, and policy review, the provider failed to ensure sanitary conditions were maintained for:</p>	F 441	<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 with respect to:</p> <ol style="list-style-type: none"> <li>The identified concentrator filters were changed. The identified feeding tube equipment was cleaned. Identified staff E, C, D, and A were re-educated.</li> <li>All concentrators were cleaned, filters checked and replaced if indicated. All feeding tube equipment was cleaned. Schedule for cleaning feeding tube equipment was reviewed with Housekeeping Supervisor.</li> <li>Clinical staff will be re-educated by November 6<sup>th</sup>, 2015 regarding proper hand washing, gloving, disinfecting of glucometers, cleaning of O2 concentrators and replacement of filters and resident medical equipment including feeding tube pumps by the DNS.</li> </ol>		

*for resident 11. SC/SPROTH/EL*

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F 441	<p>Continued From page 50</p> <p>*One of five sampled residents (11) who received personal care by one of five certified nursing assistants (CNA) (E).</p> <p>*Five of five randomly observed in-use oxygen concentrator filters in resident rooms 146, 149, 157, and 160.</p> <p>*One of two sampled residents (11) tube feeding equipment.</p> <p>*The set-up process of blood sugar testing for three randomly observed residents by two of two medication aides (MA) (C and D).</p> <p>*The process of disinfecting blood glucose glucometers (device for testing blood sugar levels) by one of one observed registered nurse (RN) (A).</p> <p>Findings include:</p> <p>1. Observation on 10/6/15 at 11:00 a.m. of CNA E during personal care for resident 11 revealed:</p> <p>*He had been laying in his bed resting. He shared a room with another resident.</p> <p>*He only had on an incontinent brief (loss of bladder/bowel control) and was covered with a sheet.</p> <p>*CNA E had washed her hands and put on clean gloves.</p> <p>*With those clean gloves on she:</p> <p>-Opened the bedside table drawer and retrieved a package of disposable wipes.</p> <p>-Removed the sheet off the resident and removed his soiled incontinent brief.</p> <p>-Opened the package of disposable wipes and cleansed the resident's perineal (private area) area.</p> <p>*With those soiled gloves she:</p> <p>-Closed the opening on the disposable wipes package.</p> <p>-Opened the drawer on the bedside table and placed the package inside.</p>	F 441	<p>4. The Housekeeping supervisor and/or her designee will audit three resident rooms per week for one month and then two resident rooms per week for two months for clean concentrators, filters and feeding tube equipment. DNS or her designee will monitor three staff per week for handwashing, glove use and care and maintenance of blood glucose meters including set-up process for testing disinfecting of meter between use and storage.</p> <p>5. The data collected will be presented to the Quality Assurance Quality Improvement Committee</p> <p>by the DNS.*<sup>1</sup> It will be reviewed/discussed and at this time the committee will make the decision/recommendation regarding follow up or changes.</p>	11-6-15

*Quality Improvement Committee*

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F 441	<p>Continued From page 51</p> <p>*Removed her gloves and without washing or sanitizing her hands put on clean gloves, finished dressing the resident, and assisted him into his wheelchair.</p> <p>*Removed her gloves and again without washing or sanitizing her hands put on another clean pair of gloves.</p> <p>*With those gloves on she:</p> <ul style="list-style-type: none"> <li>-Turned on the water faucet by touching the handles on the faucet.</li> <li>-Retrieved a clean washcloth and wet it.</li> <li>-Turned the water faucet off by again touching the handles on the faucet.</li> <li>-Washed the resident's face.</li> <li>-Placed the soiled washcloth directly on top of two unmarked electric razors on the sink countertop.</li> </ul> <p>*Removed her gloves and sanitized her hands. That had been the only time CNA E was observed washing or sanitizing her hands after having performed perineal care on resident 11.</p> <p>Interview on 10/7/15 at 9:40 a.m. with the director of nursing (DON) confirmed the above care had been performed by the CNA in an unsanitary manner. She would have expected the CNA to have removed her gloves and washed or sanitized her hands after performing a task that had soiled her gloves and hands. She agreed the process above and the washcloth laid on top of the electric razors had created the potential of cross-contamination of bacteria to be transmitted from one resident to another.</p> <p>Review of the provider's January 2010 Glove Techniques (non-sterile) (PPE [personal protective equipment]) policy and procedure revealed:</p> <p>*Policy: -"Wear clean non-sterile gloves when touching</p>	F 441			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/07/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>ABERDEEN HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401</b>	
(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	<p>Continued From page 52</p> <p>blood, body fluids, secretions, excretions, other potentially infectious materials, and contaminated items." -"Change gloves between tasks and procedures on the same resident after contact with material than [that] may contain a high-concentration of microorganisms." -"Always wash hands after removing gloves."</p> <p>2. Random observations on 10/5/15 and 10/6/15 of resident rooms 146, 149, 157, and 160 revealed: *One or two oxygen concentrators inside of those rooms. *The oxygen concentrator filters were dirty with gray colored lint.</p> <p>Interview on 10/7/15 at 9:40 a.m. with the DON revealed the night shift staff were to have cleaned the oxygen concentrator filters. She had not specified how often they were to have cleaned the oxygen concentrator filters.</p> <p>Review of the provider's undated General Responsibilities Per Shift document revealed no documentation to support the staff had been responsible for cleaning the oxygen concentrator filters.</p> <p>3. Random observation on 10/6/15 and 10/7/15 of resident 11's tube feeding equipment revealed: *The legs on the tube feeding pole had a hard, dried tan colored substance on them. The substance appeared to be tube feeding formula. *On the top of the tube feeding pole there were multiple strips of torn off tape attached to it. Those tape strips had dark gray/black colored areas on them. *The tube feeding pump was covered with dust</p>	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/07/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>ABERDEEN HEALTH AND REHAB</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401</b>		
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F 441	<p>Continued From page 53 and a white sticky substance. The sticky substance appeared to be tube feeding formula.</p> <p>Review of resident 11's 9/17/15 physician's orders revealed "Clean feeding pump [wipe down] every day shift every Tues [Tuesday], Sat [Saturday] for feeding tube."</p> <p>Interview and observation on 10/7/15 at 9:25 a.m. with the DON confirmed the tube feeding pump and pole were dirty. She would have expected the housekeeping department to clean the equipment.</p> <p>4. Observation on 10/6/15 at 8:15 a.m. of MA D revealed: *She had prepared to check the blood sugar a resident. *She retrieved a tub of disinfectant Sani-cloth wipes and a plastic container with blood sugar testing supplies. *She entered the resident's room and placed the above supplies directly on top of the resident's table of newspapers (protective covering to prevent cross-contamination of bacteria) without a barrier. *After she had completed checking the resident's blood sugar she left the room with those supplies. *She placed those supplies inside the bottom drawer of the medication cart.</p> <p>Observation on 10/6/15 from 11:25 a.m. through 11:35 a.m. of MA C revealed: *She had prepared to check several unidentified resident's blood sugar levels. *She had retrieved the tub of disinfectant Sani-cloth wipes and the container with the blood sugar testing supplies. *She entered the resident's room and placed</p>	F 441		

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F 441	<p>Continued From page 54</p> <p>those items directly on top of the sink counter-top without a barrier between them.</p> <p>*After she had completed checking the resident's blood sugar she retrieved those supplies and entered another resident's room.</p> <p>*She placed those supplies directly on top of the resident's bed covers without a barrier between them.</p> <p>*After she had completed checking blood sugars she placed those supplies inside the bottom drawer of the medication cart.</p> <p>Interview on 10/7/15 at 2:20 p.m. with the DON confirmed the above MAs should have placed barriers underneath the blood sugar testing supplies. She agreed there had been potential of cross-contamination of bacteria to be transmitted from one resident to another.</p> <p>Surveyor: 35625</p> <p>5. Observation and interview on 10/6/15 at 12:30 p.m. with RN A completing a blood glucose check on resident 18 revealed she:</p> <p>*Wiped the glucometer off with a wet "sani-wipe" cloth after its use.</p> <p>-It was allowed to air dry prior to it being set down on a surface.</p> <p>-The surface was wet less than one minute.</p> <p>*Stated that was the facility practice for cleaning the glucometer.</p> <p>Review of the sani-wipe manufacturer's instructions revealed a two minute contact time was needed to destroy the identified organisms (germs).</p> <p>Review of the staff training records revealed:</p> <p>*On 7/22/15 the nursing staff including RN A had</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER  <b>ABERDEEN HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401</b>		
(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 55 been educated on the use of glucometers. *The education detailed the cleaning of the glucometer with the sani-wipe but did not include reading the label for information regarding the contact time.  Interview on 10/7/15 at 1:45 p.m. with the assistant director of nursing regarding the use of the sani-wipe revealed she was: *Unaware the contact time was two minutes. *Unable to state an expectation for staff due to being unaware of the contact time but verbalized she would investigate that issue.	F 441			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/06/2015</b>
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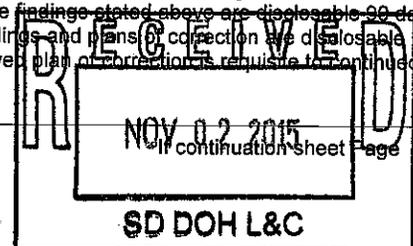
NAME OF PROVIDER OR SUPPLIER  <b>ABERDEEN HEALTH AND REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401</b>
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K 000	INITIAL COMMENTS  Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 10/6/15. Aberdeen Health and Rehab was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.  The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiency identified at K069 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 069 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD  Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96  This STANDARD is not met as evidenced by: Surveyor: 32334 Based on document review and interview, the provider failed to ensure the commercial kitchen fire protection system was maintained in accordance with NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Findings Include:  1. Observation at 11:30 a.m. on 10/6/15 in the dietary kitchen area revealed a commercial kitchen hood with fire suppression system installed. Further observation revealed an old fire extinguishing system was also installed in that hood tied into the building fire sprinkler system. The old system should have been removed when the newer Amerex wet chemical fire suppression	K 069	See next page	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Melissa Klein</i>	TITLE <i>Exec Director</i>	(X8) DATE <i>10-30-15</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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NAME OF PROVIDER OR SUPPLIER  <b>ABERDEEN HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401</b>		
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K 069	Continued From page 1 was installed. The older water based sprinkler system might jeopardize the functionality of the wet chemical fire suppression system. Any abandoned pipe from that previous sprinkler system shall be removed from within the hood, plenum, and exhaust duct.  Interview with the maintenance director at the time of the above observation confirmed that condition. He indicated that old sprinkler system was tied into the water based building fire sprinkler system. He was not sure why that system was not removed when the newer wet chemical fire suppression system was installed.	K 069	<ol style="list-style-type: none"> <li>1. The 4 sprinkler heads have been removed and capped off by Western States as of October 28<sup>th</sup>, 2015.</li> <li>2. The Maintenance Supervisor or his designee will audit the building every 2 weeks to ensure the fire sprinklers are located correctly throughout the building.</li> <li>3. This has been added to the preventative maintenance checklist. The Maintenance Supervisor is responsible for this area of compliance.</li> <li>4. The data collected will be presented to the Quality Assurance Quality Improvement Committee by the Maintenance Director. It will be reviewed/discussed and at this time the committee will make the decision/recommendation regarding follow up or changes.</li> </ol>	11-6-15	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10587</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/07/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ABERDEEN HEALTH AND REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 N HWY 281 ABERDEEN, SD 57401</b>
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S 000	<p>Initial Comments</p> <p>Surveyor: 32334 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 10/5/15 through 10/7/15. Aberdeen Health and Rehab was found in compliance.</p>	S 000		

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

*Megan Kleinsasser*

TITLE

*Eye Director*

(X6) DATE

*10-30-15*

STATE FORM

6899

EWSY11

If continuation sheet 1 of 1

