



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

PRINTED: 09/17/2015  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>435032</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>09/10/2015</b> |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CUSTER REGIONAL SENIOR CARE</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1065 MONTGOMERY ST<br/>CUSTER, SD 57730</b>   |                      |   |
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| F 275  | Continued From page 1<br>No annual assessment had been completed within 366 days from the last comprehensive assessment.<br><br>Review of the 8/12/15 Facility Resident Census/Status Report from the Department of Social Services (DSS) revealed the next MDS assessment due had been a quarterly assessment.<br><br>Review of the 8/12/15, 8/19/15, 8/26/15, and 9/2/15 Facility Resident Census/Status Reports from DSS revealed no annual assessments were due for any of the residents of the facility.<br><br>Review of the MDS 3.0 version 1.12, page 2-15, revealed an annual comprehensive assessment reference date was to have been completed by the last comprehensive assessment date plus 366 calendar days.<br><br>Interview on 9/10/15 at 5:00 p.m. with the administrator, director of nursing, and MDS nurse confirmed:<br>*The annual assessment had not been completed as the RAI manual directed.<br>*There had been no system to verify completion of the MDS assessments compared to the report from Department of Social Services (DSS). | F 275   | 1) Annual MDS will be completed on the resident #8 ARD 9/23/15<br>2) DON, Administrator and MDS coordinator developed for the IDT to reference a policy to ensure annual, quarterly, and significant change in MDS are completed timely.<br>3) IDT team inserviced regarding policy on 9/21/15. Team members unavailable will be in-serviced by 10/15/15<br>4) DON or Designee to audit 10% of residents monthly x6 months to ensure system of documentation matches the MDS schedule and report findings to Risk Process Improvement team monthly ongoing.<br><br>*Addendum*-<br>IDT (Interdisciplinary Team) definition- team comprised of but not limited to the Social Service Designee, Ops Manager for Food and Nutrition or designee, Activities Director or designee, C.N.A Supervisor, and MDS Coordinator.<br><br>Risk Process Improvement team is a group of team members that report to QAPI (Quality Assurance Process Improvement) monthly. Our goal is to collect data, discuss findings and interventions for improvement of care for the residents.<br>QAPI team oversees the Risk Process Improvement progress and is a reporting/evaluating committee that involves the Medical Director quarterly to assist with any changes in programs if needed. | 10/15/15             |   |
| F 278<br>SS=E  | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  | F 278   |   |                      |   |

*VS*  
*10/13/15*

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| F 278  | <p>Continued From page 2</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Surveyor: 32355</p> <p>Surveyor: 32572<br/>Based on observation, interview, record review, and policy review, the provider failed to ensure the Minimum Data Set (MDS) assessment had been completed accurately for five of ten sampled residents (2, 4, 5, 6, and 7). Findings include:</p> <p>1. Random observations from 10:00 a.m. through 5:00 p.m. on 9/9/15 and 8:00 a.m. through 5:00 p.m. on 9/10/15 of resident 2 revealed he had</p> | F 278   | <p>MDS corrected for all named residents: #4, 5&amp;, and 6.<br/>Assessment for restraint vs. enabling use for resident # 2 completed by therapy for use of positioning strap. Policy revised collaboratively with Administrator, DON and MDS Coordinator on 9/17/15 regarding restraint use vs. enabling use, motorized conveyance and evaluation of devices.<br/>IDT educated on accuracy of MDS coding. Members unavailable will be educated upon return by 10/15/15.<br/>DON or Designee will audit MDS of 10% residents weekly x1 month then monthly x 6 months to ensure accuracy of coding and report finding to Risk Team monthly.<br/>DON or Designee will audit 10% charts monthly to ensure evaluations are complete for potential restraint use and report to monthly Risk Team meeting.</p> <p>*ADDENDUM*-MDS' for resident #7 reviewed for accuracy. Data revealed no documentation of pressure wounds noted until 8/9/15. Initial care plan unable to correct. Skin reassessed and care plan updated with current information as of 9/22/15.<br/>All audits will be reported by DON or Designee to Risk monthly.*</p> | 10/15/15<br><br><i>VS</i><br><i>10/13/15</i> |

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| F 278  | <p>Continued From page 3</p> <p>been sitting in a motorized wheelchair (w/c) with a seatbelt secured around his upper thighs.</p> <p>Review of resident 2's medical record revealed:<br/>*An admission date of 1/30/12.<br/>*MDS assessments done on 12/23/14 and 6/17/15 had not been coded for restraint use.<br/>*No assessment to determine restrictive versus enabling use had been completed.</p> <p>Interview on 9/10/15 at 8:10 a.m. with the director of nursing confirmed the seat belt resident 2 used was considered a restraint and no assessments had been completed.</p> <p>2. Review of resident 4's medical record revealed:<br/>*A 12/8/13 emergency department note signed by the physician stating his diagnosis was schizoaffective (chronic mental illness) disorder.<br/>*MDS assessments of 5/13/15 and 7/29/15 had not been coded for a diagnosis of schizoaffective disorder.</p> <p>Review of resident 4's September 2015 medication administration record (MAR) revealed he received Seroquel XR (mood altering drug) 200 milligrams (mg) everyday at bedtime. The MAR indicated he had been receiving that medication for depression.</p> <p>Review of resident 4's 4/8/15 pharmacist Medication Regime Review (medication review) had not addressed an appropriate diagnosis for the Seroquel.</p> <p>Review of resident 4's 8/6/15 signed physician's orders confirmed he had been receiving that medication for depression.</p> | F 278   |   |   |

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| F 278 | <p>Continued From page 4</p> <p>Review of the provider's undated Antipsychotic Drug Therapy policy revealed "Antipsychotics should not be used for one or more of the following is/are the only indication...depression."</p> <p>Surveyor: 32355<br/>3. Review of resident 5's medical record revealed:<br/>*An admission date of 8/24/15.<br/>*Diagnoses of cellulitis (infection of tissue) and a history of urinary tract infections (UTI).<br/>*She had been admitted to the hospital on 8/19/15 for sepsis (infection in the blood).</p> <p>Review of resident 5's 8/19/15 history and physical revealed:<br/>*Diagnosis of sepsis with a negative urinalysis for UTI.<br/>**"Impression: Recent sepsis. The patient is on day fourteen of antibiotics. I was told that four more days were indicated with the Clindamycin."</p> <p>Review of resident 5's 8/21/15 urine culture revealed she had an active yeast infection.</p> <p>Review of resident 5's 8/24/15 discharge summary from the hospital revealed "Final diagnostic assessment of Cellulitis of the right leg with sepsis."</p> <p>Review of resident 5's 8/24/15 patient transfer record revealed a diagnosis of "Cellulitis of the lower right leg."</p> <p>Review of resident 5's 7/2/15 and 8/31/15 MDS assessments revealed they had been inaccurately coded to reflect a diagnosis of UTI. The diagnosis of cellulitis and sepsis had been</p> | F 278 |  |  |
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| F 278  | <p>Continued From page 5 coded.</p> <p>Surveyor: 32572<br/>4. Review of resident 6's 6/2/15 Braden Scale Assessment revealed she had been at "Low risk" for pressure ulcers (skin breakdown).</p> <p>Review of resident 6's MDS assessments from 6/9/15, 6/30/15, and 7/28/15 revealed she had been coded all of them at a high risk for pressure ulcers.</p> <p>Interview on 9/10/15 at 5:00 p.m. with the administrator, director of nursing, and MDS nurse confirmed the Braden assessment was one of the resource documents used for coding the MDS.</p> <p>Surveyor: 32355<br/>5. Review of resident 7's 6/1/15 and 9/9/15 Braden Scale Assessment revealed she had been at low risk for developing pressure ulcers.</p> <p>Review of resident 7's 6/1/15 Admission Summary revealed "Does not have wound on coccyx with duoderm (protective dressing) removed and not reapplied."</p> <p>Review of resident 7's 6/1/15 Nursing Admission Assessment revealed "Buttock/coccyx has dried excoriation (break in skin surface), duoderm removed."</p> <p>Review of resident 7's initial comprehensive 6/10/15 care plan revealed a focus area of "Impaired skin integrity as evidenced by sacral (bony area of buttock) pressure sore [ulcer]."</p> <p>Review of resident 7's Skin Integrity Assessments revealed on:</p> | F 278   |   |                      |   |

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| F 278  | Continued From page 6<br>*6/13/15 a pressure ulcer on her right buttock.<br>*7/27/15 a pressure ulcer on her right and left buttocks.<br><br>Review of resident 7's 6/8/15, 6/29/15, and 7/27/15 MDS assessments revealed no coding for pressure ulcers.<br><br>Interview on 9/10/15 at 5:00 p.m. with the administrator, director of nursing, and MDS nurse confirmed the above MDS assessments had not been accurately coded.<br><br>The provider did not have a policy and procedure for accurate completion of the MDS assessments.   | F 278   |   |   |
| F 280<br>SS=D  | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>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.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. | F 280   |   |   |

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| F 280  | <p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Surveyor: 32355</p> <p>Surveyor: 32572<br/>Based on observation, interview, record review, and policy review, the provider failed to ensure the care plans reflected the current status for three of ten sampled residents (2, 3, and 6). Findings include:</p> <p>1. Random observations from 10:00 a.m. through 5:00 p.m. on 9/9/15 and 8:00 a.m. through 5:00 p.m. on 9/10/15 of resident 2 revealed he had been sitting in a motorized wheelchair (w/c) with a seatbelt around his upper thighs.</p> <p>Review of resident 2's revised 1/13/14 care plan revealed no documentation of seatbelt use.</p> <p>Surveyor 32355</p> <p>2. Random observations of resident 3 from 9/9/15 through 9/10/15 revealed he had a Foley catheter (tube inserted into the bladder to drain urine).</p> <p>Review of resident 3's 9/8/15 physician's orders revealed he had a diagnoses of urine retention. The physician ordered a Foley catheter to be inserted into his bladder.</p> <p>Review of resident 3's revised 8/18/15 care plan revealed:<br/>*A focus area of "Urinary incontinence [loss of control] on occasion."<br/>*No documentation to direct the staff on how to care for his Foley catheter.</p> | F 280   | <p>1) Care Plan updated on resident #2 regarding strap use for positioning.<br/>2) Resident #3 care plan was updated during survey process – resident no longer in facility.<br/>3) Resident #6 care plan updated for ADL status and balance concern.<br/>4) Comprehensive care plan policy updated by Administrator, DON and MDS Coordinator on 9/17/15. IDT Team educated 9/21/15. Unavailable members will be educated upon return by 10/15/15.<br/>5) Audits of care plans of 10% of residents weekly x one month then monthly x 12 months for accuracy by DON or Designee and report findings to the Risk Team-ongoing</p> <p>*ADDENDUM*- LPN's and RN's are responsible to update the care plan on an ongoing basis to reflect the resident's current cares and needs. IDT will review the care plan during team meetings with the family quarterly and with significant changes for further updates.<br/>All audits will be reported to the Risk team monthly on an ongoing basis.</p> | 10/15/15<br><br><i>VS</i><br><i>10/13/15</i>        |

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| F 280  | <p>Continued From page 8</p> <p>*The care plan had not been updated to support the recent Foley catheter placement and care.</p> <p>Surveyor 32572</p> <p>3. Review of resident 6's initiated 6/15/15 care plan revealed no documentation on how to care for her for the following:</p> <ul style="list-style-type: none"> <li>*Bed mobility (how to reposition herself).</li> <li>*Transfers (moving from one place to another).</li> <li>*Bathing.</li> <li>*Eating.</li> <li>*Locomotion (how she moved throughout the facility).</li> <li>*Dressing.</li> <li>*Toilet use.</li> <li>*Personal hygiene.</li> </ul> <p>Review of her 7/28/15 Minimum Data Set (MDS) assessment revealed:</p> <ul style="list-style-type: none"> <li>*She needed supervision with set-up assistance from staff members for the following: <ul style="list-style-type: none"> <li>-Bed mobility.</li> <li>-Transfers.</li> <li>-Walking in her room.</li> <li>-Locomotion on and off the unit.</li> <li>-Eating.</li> <li>-Dressing.</li> <li>-Toilet use.</li> </ul> </li> <li>*That MDS also indicated: <ul style="list-style-type: none"> <li>-She had been "not steady, but able to stabilize without human assistance."</li> <li>-She had "impairment on both sides" of her arms.</li> <li>-She used a walker to aid with walking.</li> </ul> </li> </ul> <p>Interview on 9/10/15 at 5:00 p.m. with the administrator, director of nursing, and the MDS nurse confirmed care plans should have reflected the current status of the resident.</p> | F 280   |   |   |

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| F 280  | Continued From page 9<br>Review of the provider's 1/10/15 Comprehensive Care Plan policy revealed:<br>*"The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS."<br>**"Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change."  | F 280   |   |   |
| F 281<br>SS=E  | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 32355<br><br>Surveyor: 32572<br>Based on observation, interview, record review, and policy review, the provider failed to ensure nursing professional standards had been maintained for four of ten sampled residents (3, 6, 7, and 9) in the following areas:<br>*Elements needed for a complete physician's order.<br>*Completion of nursing assessments.<br>*Completion of Care Area Assessments (CAA).<br>*Completion of the care plan.<br>Findings include:<br><br>Surveyor 32355<br>1. Random observations of resident 3 from 9/9/15 through 9/10/15 revealed he had a Foley catheter (tube inserted into the bladder to drain urine).<br><br>Review of resident 3's 9/8/15 fax request sent at | F 281   |   |   |

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| F 281  | <p>Continued From page 10</p> <p>2:55 p.m. by the charge nurse to his primary physician revealed:<br/>**Per nursing staff - [resident name] is not incontinent [unable to control urine], but voids small amounts. He was just toileted - seemed unable to void, straining on toilet - nurse did a bladder scan [device to check for urine retention] - revealed greater than 999 milliliters in bladder."<br/>**Granddaughter who happened to be here states that several years ago he was doing self cath [catherization] due to urinary retention."</p> <p>Review of resident 3's 9/8/15 physician's orders revealed:<br/>*An order stating "Foley cath."<br/>*The order failed to:<br/>-State the size of the catheter to be inserted.<br/>-Identify a diagnosis to support the reason for a Foley catheter.<br/>-Provide a discontinuation date for the Foley catheter.<br/>-Identify how long the catheter was to have been in place.<br/>-State the time that order was received and who received the order.</p> <p>Review of resident 3's from 9/7/15 through 9/8/15 progress notes revealed:<br/>*On 9/7/15 he had fallen and was sent to the hospital emergency room (ER) for treatment.<br/>*On 9/8/15:<br/>-At 1:40 a.m. he had returned from the ER.<br/>-At 9:26 a.m. he required the use of oxygen at 2 liters per minute for low oxygen levels in his blood.<br/>-At 12:15 p.m. he received allergy medication.<br/>-At 8:40 p.m. "Resident has a 18 french Foley inserted that is draining to gravity. He tolerated the procedure well. He had 1,400 cubic</p> | F 281   | <ol style="list-style-type: none"> <li>1) No immediate corrective action taken to #3 orders as he no longer resides in facility.</li> <li>2) Resident #6 new Braden score completed. Care plan updated regarding ADL status, balance concerns and Pressure ulcer Risk. Previous MDS' corrected.</li> <li>3) Resident #7 skin re-assessed and care plan updated with current data as of 9/22/15</li> <li>4) Resident #9- No immediate corrective action taken- no longer resides at the facility.</li> <li>5) Policy for RAI Process created by DON, MDS Coordinator and Administrator on 9/17/15. Available IDT educated on 9/21/15. Unavailable members to be educated upon return to facility by 10/15/15.</li> <li>6) Other policies revised include care planning Comprehensive and IDT, Resident evaluation and Re-evaluation, Physician Orders, Wound Discovery, Monitoring, Staging, Care and Documentation, Foley catheter care, Care of urinary drainage bags, Pericare, Hand washing/sanitizing and PPE. Nursing staff will be educated 9/29/15 regarding care planning</li> </ol> |   |

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

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| F 281  | <p>Continued From page 11<br/>centimeters when the Foley was inserted."<br/>*No documentation to support:<br/>-He had been having trouble with voiding.<br/>-The physician had been notified of his problems with voiding.<br/>-The physician had ordered an 18 French Foley catheter to be inserted for urinary retention.<br/>-The physician had been contacted regarding the incomplete physician's order received above.</p> <p>Interview on 9/10/15 at 5:00 p.m. with the director of nursing (DON), administrator, and Minimum Data Set (MDS) assessment nurse confirmed:<br/>*The physician's orders on 9/8/15 had been incomplete.<br/>*The staff members who received physician's orders were responsible for the accuracy and completeness of them.<br/>*The nursing documentation was incomplete and should have identified:<br/>-The resident's difficulties with voiding.<br/>-The physician had been notified, and the orders received.</p> <p>Review of the provider's undated Elements of a Physician Order policy revealed:<br/>**Any order must include the following:<br/>-Resident name.<br/>-Date of order.<br/>-Specific medication/treatment.<br/>-Name of physician giving the order.<br/>-Strength of medication.<br/>-Dosage.<br/>-Time or frequency of administration.<br/>-Route.<br/>-Quantity or duration [length] or therapy.<br/>-Diagnosis or indication for use."</p> <p>The provider did not have a policy and procedure</p> | F 281   | <p>process and accuracy assessments – resident evaluations and reevaluation, physician orders, wound care and pressure ulcer risk. Any staff members unavailable will be educated upon availability or by 10/15/15.<br/>DON or Designee to audit 10% of Physician orders taken by staff monthly x 6 months for accuracy, diagnosis and complete information.<br/>DON or Designee to audit 10% of comprehensive MDS weekly x one month then monthly x 6 months for completion of CAA and accuracy.<br/>DON or Designee to audit 10% care plans weekly x one month then monthly x 12 months for accuracy of current status.<br/>All audit findings will be report to the Risk Team.</p> <p>*ADDENDUM*- All audit finding will be reported to the Risk Team by the DON or Designee monthly on an ongoing basis. Nursing staff responsible for updating the care plans to include LPN's and RN's.</p> | 10/15/15<br><br><i>VS</i><br><i>10/13/15</i>        |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 281  | <p>Continued From page 12 in place for nursing documentation.</p> <p>Surveyor 32572<br/>2. Review of resident 6's medical record revealed:<br/>*A 6/2/15 Braden Scale for Predicting Pressure Sore Risk assessment had not been totally completed.<br/>*Review of the 6/9/15 Minimum Data Set (MDS) CAA revealed:<br/>-Activities of daily living (ADL; assistance with bathing, eating, dressing, toileting, and grooming), urinary incontinence and indwelling catheter, falls, dental care, pressure ulcer (injury to skin usually from pressure and frequently over a bony area), and pain CAAs had triggered (needed to be addressed).<br/>--Those CAA worksheets had not been completed.<br/>--Those worksheets had been signed by the MDS coordinator.</p> <p>Surveyor 32355<br/>3. Review of resident 7's medical record revealed:<br/>*An admission date of 6/1/15.<br/>*Diagnoses of muscle weakness, difficulty in walking, and osteoarthritis (inflammation of the joints).<br/>*The hospital had documented her skin was intact (no problems or open areas) upon discharge to the facility.</p> <p>Review of resident 7's 6/1/15 admission assessment revealed she had dried open areas to her buttock and coccyx (tailbone). A protective dressing had been removed. There was no documentation to support the size or stage (how deep the tissue was open) of the wounds.</p> | F 281   |   |   |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 281  | <p>Continued From page 13</p> <p>Review of resident 7's care plan revealed:<br/>*A focus area that had been initiated on her admission, 6/1/15. It stated "I have impaired skin integrity related to [r/t] episodes of incontinence [loss of bladder control] and decreased mobility - as evidenced by sacral [coccyx area] pressure sore."<br/>*A goal stated "My pressure area will resolve without complications by the next review."<br/>*Interventions were to direct the staff on how to care for her pressure sore and prevent further breakdown.</p> <p>Review of resident 7's 6/13/15 nursing progress note documentation revealed "Skin assessment done this am with new open areas found on right inner buttock. Areas measured and treatment initiated. Has wounds in same area prior to coming to this facility."</p> <p>Review of resident 7's Licensed Nurse Weekly Skin assessments from 6/13/15 through 8/28/15 revealed:<br/>*There was documentation of open areas on both of her buttocks.<br/>*On 7/11/15 there was documentation of a pressure ulcer to her sacral area (tailbone).<br/>*No documentation:<br/>-To support the type of wounds the nursing staff had identified and assessed.<br/>-To identify the stage of that pressure ulcer identified on 7/11/15.</p> <p>Review of resident 7's 6/1/15 and 9/9/15 Braden Scale Assessments (special type of skin assessment) revealed she had been at low risk for developing pressure ulcers.</p> | F 281   |   |   |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 281  | <p>Continued From page 14</p> <p>4. Review of resident 9's medical record revealed:</p> <ul style="list-style-type: none"> <li>*An admission date of 3/12/15.</li> <li>*Diagnoses of urine retention, depression (sadness), and muscle weakness.</li> <li>*His admission nursing assessment revealed "No open areas [in the skin] noted."</li> </ul> <p>Review of resident 9's care plan revealed a focus area for "Pressure ulcer on coccyx treated with a dressing." That focus area had been created four days after the resident's admission and was not revised until 8/25/15.</p> <p>Review of resident 9's weekly Skin Assessment records revealed:</p> <ul style="list-style-type: none"> <li>*On 3/13/15 he had been admitted with a skin tear to his right buttock.</li> <li>*No weekly skin assessments had been completed after 3/13/15 until 7/5/15.</li> <li>* On 7/5/15 was the first documentation to support his care plan for a pressure ulcer to his coccyx.</li> <li>-It had failed to identify the stage of the wound.</li> <li>*On 7/12/15 the wound to his coccyx was documented as a stage II (shallow open area).</li> <li>*On 7/25/15 that wound was documented as a stage I (intact skin with different color than the surrounding skin).</li> <li>*On 7/26/15 the pressure ulcer had been documented as a stage II.</li> <li>*On 8/2/15 and on 8/9/15 the pressure ulcer had been documented as a stage I.</li> <li>*On 8/16/16 and on 8/19/15 the pressure ulcer staging was "N/A [not available]."</li> <li>*8/23/15, 8/30/15, and 8/31/15 the pressure ulcer was documented as a deep tissue injury [blistered, mushy area, painful, or purple in color]."</li> </ul> | F 281   |   |                      |   |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 281  | <p>Continued From page 15</p> <p>Interview on 9/10/15 at 5:00 p.m. with the administrator, DON, and MDS nurse confirmed:<br/>*The expectation had been all documents would have been complete.<br/>*The weekly skin assessments were not complete and failed to accurately stage the pressure ulcers.<br/>*The documentation and identification of the wounds was not supported in the care plans.<br/>*The CAA process had not been documented within the medical record.</p> <p>Review of the provider's 6/18/15 Pressure Ulcer Risk Assessment/Intervention policy revealed:<br/>**"Residents will be assessed for the risk of pressure ulcers upon admission and ongoing throughout their stay by nursing personnel. The assessment information will be utilized to identify preventative interventions."<br/>*Failed to identify a procedure to assist the staff on accurately staging a pressure ulcer.</p> <p>When the MDS policy was requested the provider revealed they did not have one. They used the (Resident Assessment Instrument) RAI manual as the policy.</p> <p>Review of the MDS 3.0 RAI manual, Version 1.12 revealed:<br/>*On page 1 through 6, "Care Area Assessment (CAA) process. This process is designed to assist the assessor to systematically interpret the information recorded on the MDS."<br/>*On page V-5, "Facility staff are to use the RAI triggering mechanism to determine which areas require review and additional assessment."<br/>-"For each triggered care area, use the CAA process and current standard of practice,</p> | F 281   |   |                      |   |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 281  | Continued From page 16<br>evidence-based or expert-endorsed clinical guidelines and resources to conduct further assessment of the care areas."<br>-"Document relevant assessment information regarding the resident's status."  | F 281   |   |   |
| F 323<br>SS=E  | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 32355<br><br>Surveyor: 32572<br>Based on observation and interview, the provider failed to ensure safety of the portable oxygen cylinders had been maintained in a secure manner on the 100 hallway. There had been residents, visitors, and staff walking by those unsecured cylinders. Findings include:<br><br>1. Random observations from 10:00 a.m. through 5:00 p.m. on 9/9/15 and from 8:00 a.m. through 5:00 p.m. on 9/10/15 revealed portable oxygen cylinders sitting on the floor in the 100 hallway.<br><br>During that time there were residents who walked independently with assistive devices (walkers and canes) and residents who moved independently in wheelchairs in that hallway. | F 323   | 1) Oxygen tanks (liquid) immediately removed from hallways and placed off the floor to be secured to the w/c or walker of the residents.<br>2) Administrator, DON, MDS Coordinator and Maintenance. Supervisor created policy for O2 safety and storage.<br>3) Education provided to staff (at all staff meeting) on 9/22/15 regarding O2 safety and storage.<br>4) Ongoing education to be given to new (oncoming) staff with facility orientation.<br>5) Safety audits to individual Oxygen tanks in hall during rounding 3 to 5 times weekly for one month then monthly x 12 months by nursing staff or designee. Findings reported to Risk team monthly.<br><br>*ADDENDUM*- Oxygen safety audits were added to the Nurse Rounding form for each shift. LPN's and RN's assigned to the shift are responsible to complete the form and address the concerns immediately upon finding. The nurse rounding forms will be turned into the DON or designee weekly for review. The DON or designee will report the negative findings to the Risk Team monthly. | 10/15/15<br><br>VS<br>10/13/15                      |

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| F 323  | Continued From page 17<br><br>On 9/10/15 a portable oxygen cylinder that was not secured to anything sat on the floor outside of resident room 103 from 11:35 a.m. through 5:00 p.m. Numerous residents, visitors and staff walked by that cylinder.<br><br>Interview on 9/10/15 at 5:00 p.m. with the administrator, director of nursing, and the MDS coordinator confirmed the portable oxygen cylinders in the hallway were safety risks for residents. They also confirmed the provider did not have an oxygen safety policy.   | F 323   |   |                      |   |
| F 356<br>SS=D  | 483.30(e) POSTED NURSE STAFFING INFORMATION<br><br>The facility must post the following information on a daily basis:<br>o Facility name.<br>o The current date.<br>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>- Registered nurses.<br>- Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>- Certified nurse aides.<br>o Resident census.<br><br>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:<br>o Clear and readable format.<br>o In a prominent place readily accessible to residents and visitors.<br><br>The facility must, upon oral or written request, | F 356   |   |                      |   |

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| F 356  | <p>Continued From page 18<br/>make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Surveyor: 32355</p> <p>Surveyor: 32572<br/>Based on observation, record review, policy review, and interview, the provider failed to ensure the twenty-four hour nursing staff information was posted, maintained, and reflected the actual staffing that was on duty to provide the basic care needs to all seventy-three residents. Findings include:</p> <p>Surveyor 32355<br/>1. Observation on 9/9/15 at 8:00 a.m. by the nurses' station revealed:<br/>*There was a white board attached to the wall with the nursing staff available for that day.<br/>*The board had not provided the current resident census.<br/>*The documentation on the board revealed there should have been three registered nurses (RN) and no licensed practical nursing (LPN) working from 5:30 a.m. to 2:00 p.m.</p> <p>Observation on 9/9/15 at 1:00 p.m. of the white board revealed there should have been one RN and three LPNs currently working in the facility.</p> <p>The White board had not included the director of</p> | F 356   | <p>1) Direct care Staffing Policy revised in collaboration with Administrator, DON, MDS Coordinator. Direct care staffing form updated.</p> <p>2) Education will be provided to nurses 9/29/15. Education to new (oncoming) staff will be provided upon facility orientation.</p> <p>3) White board taken down after education.</p> <p>4) Residents to be educated during resident council of new process of staff documentation and location by Social Services x 3 months.</p> <p>5) Random audits of staffing sheets to be completed 3 to 5 times weekly then monthly x 12 months by DON to ensure accuracy of information available.</p> <p>Audit results will be shared by the DON with the Risk meeting monthly.</p> | 10/15/15             |   |

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| F 356  | <p>Continued From page 19 nursing (DON), Minimum Data Set (MDS) assessment coordinator, and the resident admitting nurse.</p> <p>Surveyor 32572<br/>Interview on 9/9/15 at 11:30 a.m. with LPN A confirmed there were LPNs working that day. She had been scheduled 10:00 a.m. until 10:00 p.m. There had been an LPN working from 5:30 a.m. to 6:00 p.m. that day. The night nurse also scheduled for that day had been an LPN.</p> <p>Surveyor 32355<br/>Review of the provider's 4/8/15 through 9/13/15 daily staffing sheets revealed:<br/>*There had been no staffing sheets available to review:<br/>-For every Friday, Saturday, and Sunday.<br/>-Prior to 4/8/15.</p> <p>Interview on 9/9/15 at 1:30 p.m. with the health unit coordinator B revealed:<br/>*The white board had been what the provider used to inform the residents and visitors of their current staffing for that day.<br/>*She would have:<br/>-Updated the board Monday through Thursday. Another health unit coordinator would have been responsible for updating the board on Friday.<br/>-Completed the daily staffing sheets Monday through Thursday.<br/>*She would not have updated the white board or staffing sheets with any staff changes made that day.<br/>*She was not sure who would have been responsible for the updating of the white board and staffing sheets on the weekends.<br/>*She agreed the white board and staffing sheets should have been updated with any staff changes</p> | F 356   |   |                      |   |

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

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| F 356  | Continued From page 20<br>made during the day. She could not guarantee that had occurred.<br><br>Surveyor 32572<br>Interview on 9/10/15 at 5:00 p.m. with the administrator, director of nursing, and MDS coordinator confirmed the following:<br>*The white board at the nurses station had not been kept current.<br>*The white board did not get changed when change of staffing occurred.<br>*The permanent staffing sheets had not been maintained for eighteen months.<br>*The permanent staffing sheets did not reflect changes in staffing.<br><br>Review of the provider's 5/1/03 Staffing Plan policy revealed "Charge nurse is responsible for completing the appropriated paper work when a staff member does not report to duty or reports to duty late." | F 356   |   |                      |   |
| F 441<br>SS=D  | <b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b><br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective   | F 441   |   |                      |   |

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| F 441  | <p>Continued From page 21 actions related to infections.</p> <p>(b) Preventing Spread of Infection<br/>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br/>(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.<br/>(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<br/>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:<br/>Surveyor: 32572<br/>Based on observation, interview, and policy review, the provider failed to ensure infection control measures were maintained for personal cares for one of two observations for sampled resident (3).<br/>Findings include:</p> <p>Surveyor: 32355<br/>1. Observation on 9/9/15 at 1:12 p.m. of certified nursing assistant (CNA) C during personal care for resident 3 revealed:<br/>*The resident had been sitting in his wheelchair (w/c) in his room with his Foley catheter (tube that</p> | F 441   | <p>1) No immediate corrective action could be taken for residents #3 as he no longer resides in facility.<br/>2) Pericare, Foley catheter care, and care of urinary drainage bag policies revised by DON and MDS coordinator.<br/>3) Education provided to C.N.A- C and all staff regarding hand washing and PPE on 9/22/15.<br/>4) Further education to direct care staff for catheter care, catheter bag care and pericare will be provided on 9/29/15 and new (oncoming) staff upon facility orientation.<br/>5) Pericare and hand washing audits to be completed by CNA Supervisor or designee on 3 to 5 staff per week x one month to include all shifts then 10 staff per month x 12 months.<br/>Findings reported to the Risk Team monthly.</p> | 10/15/15  |

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| F 441  | <p>Continued From page 22</p> <p>removes urine from the bladder) hanging from the bottom of his w/c.</p> <p>*CNA C assisted the resident into the bathroom.</p> <p>*She had:</p> <ul style="list-style-type: none"> <li>-Assisted the resident to stand-up and pulled down his soiled clothes and incontinent (loss of urine and, or bladder control) brief. Those items had been soiled with bowel movement.</li> <li>-Assisted him to sit down on the toilet.</li> <li>-Removed her soiled gloves, sanitized (cleaned) her hands, and put on a clean pair of gloves.</li> </ul> <p>*With those clean pair of gloves she had:</p> <ul style="list-style-type: none"> <li>-Turned on the faucet water by touching the dirty surfaces of the handles.</li> <li>-Opened a cabinet drawer and got a clean incontinent brief.</li> <li>-Got a clean pair of pants from his closet.</li> <li>-Put the Foley catheter drainage bag through his clean pants and laid the drainage bag directly on the floor with no barrier. That drainage bag remained directly on the floor during the entire personal care process.</li> <li>-Got clean washing towels from a rack by the sink.</li> <li>-Moistened those clean washing towels with the water.</li> <li>-Turned the water off by touching the dirty surfaces of the faucet handles.</li> <li>-Assisted the resident to stand-up.</li> <li>-Cleansed the resident's BM soiled bottom first.</li> </ul> <p>*Without changing those BM soiled gloves and sanitizing her hands she had:</p> <ul style="list-style-type: none"> <li>-Cleansed his front perineal area (private area) that included the insertion site of the Foley catheter.</li> <li>-Pulled up the resident's pants and assisted him to sit down in the w/c.</li> </ul> <p>Interview on 9/10/15 at 5:10 p.m. with the DON</p> | F 441   |   |                      |   |

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| F 441  | <p>Continued From page 23</p> <p>confirmed the above technique for personal and Foley catheter care had not been done in a sanitary (clean) manner. That had created the potential for bacteria and germs to enter that closed system, spread to the resident's bladder, and cause a urinary tract infection.</p> <p>Review of the provider's 10/20/06 Foley Catheter Care policy revealed:<br/>*"Indwelling catheter, or Foley catheter plus drainage bag is a 'closed system,' which means no openings from bladder to the drainage bag. It is important to keep this equipment clean so that bacteria and germs do not enter this system causing infection."<br/>*"Do not allow the drainage bag to rest on the floor."</p> <p>Review of the provider's 1/10/15 Hand Hygiene policy revealed "Indications for hand hygiene, When moving from a contaminated body site to a clean body site during patient/resident care."</p> | F 441   |   |                      |   |