

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435078	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2015
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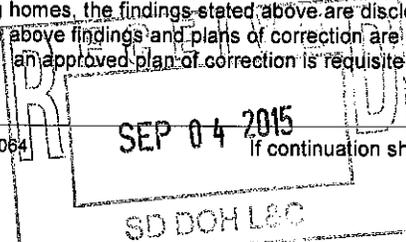
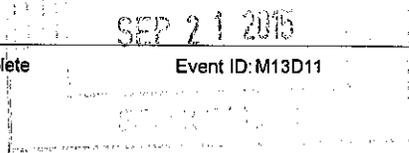
NAME OF PROVIDER OR SUPPLIER avera eureka health care center	STREET ADDRESS, CITY, STATE, ZIP CODE 202 J AVENUE POST OFFICE BOX 40 EUREKA, SD 57437
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F 000	INITIAL COMMENTS	F 000		
F 167 SS=B	<p>Surveyor: 22452 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/10/15 through 8/12/15. Avera Eureka Health Care Center was found not in compliance with the following requirements: F167, F176, F280, F281, F314, F318, F323, F325, F371, F425, and F441.</p> <p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation and interview, the provider failed to ensure the resident council and the residents were made aware of the most current survey results that had taken place on 6/11/14. Findings include:</p> <p>1. Observation from 8/10/15 at 4:30 p.m. through 8/11/15 at 6:00 p.m. revealed the survey results from 6/11/14 were not posted in the facility.</p> <p>Interview on 8/11/15 at 11:30 a.m. with the</p>	F 167	<p>Administrator posted survey results once she was made aware they were missing from the bulletin board on 8/12/15. Residents were informed at a previous Resident Council meeting on 5/1/15 that the survey results were posted for their own or family review and they could take the results any time and review them. Residents will be reminded at each Resident Council meeting where the survey results are posted and that they or family members can review the results at any time but if they take the results that they please return them to the bulletin board. Continued.....</p>	8/12/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Carmen Weber</i>	TITLE <i>Administrator</i>	(X6) DATE <i>9-2-15</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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 167	Continued From page 1 director of nursing regarding the survey results revealed: *They were usually posted on a bulletin board in the activity room next to the dining room. *The survey results were not posted on the bulletin board. *She was unaware where the survey results were. *She knew they had been hanging on the bulletin board not too long ago. During a resident group meeting on 8/11/15 beginning at 3:00 p.m. revealed eight of eight residents were not aware where the survey results were posted.	F 167	Administrator will check the bulletin board 1 x week for 6 months to make sure a copy of the survey results are posted and available to residents and/or family members. Administrator will report the findings to the Quality Assurance Performance Improvement committee in October 2015, January 2016 and April 2016.	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, interview, record review, and policy review, the provider failed to ensure one of two sampled residents (5) who self-administered medications had: *A physician's order for the medication to be self-administered. *Monitoring of the medication for expiration dates. Findings include: 1. Observation on 8/11/15 at 3:00 p.m. revealed a medication bottle of Orasol (for mouth pain) a	F 176	Expired med was removed from resident's room. Education was provided to all nursing staff at an in-service on 8/31/15 to check and monitor for any meds that may be kept in a resident's room. Education to all residents and family members will be put in the next facility newsletter regarding self (continued...)	9/25/15

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F 176	Continued From page 2 January 2013 expiration date in the resident's top dresser drawer. Review of the resident's medical record (both electronic and paper) revealed no physician's order to self-administer that medication. Interview on 8/12/15 at 2:10 p.m. with the director of nursing confirmed resident 5 did not have a physician's order for the above medication to be self-administered. She confirmed the provider's policy had not been followed. Review of the provider's November 2014 revised Self-Administration of Medication After Set Up policy revealed: ***Physician/Health Care Provider Involvement: -Physician order [is] necessary for each resident to self administer." ***Ongoing Evaluation: -The charge nurse is responsible for observation that the person had independently consumed their medications and for assuring the residents ongoing ability to self administer their own medications as well as the safety of other residents in the immediate area."	F 176	administration of medications and that nursing staff must be made aware of any medications brought into the facility from home. Staff will then follow self-administration of medications policy to determine safety. If a resident desires to self-administer medication, the Interdisciplinary Team will assess at care conference for safety and make the final determination. Director of Nursing will monitor residents who self-administer meds to ensure that there is a physician order allowing the self-administration of meds 1 x month and will report findings to the Quality Assurance Performance Improvement Committee quarterly for 1 year. <i>Weekly checks of self-administered medications will continue as has been done in the past by charge nurses. On a monthly basis, Director of Nursing will ensure that appropriate orders exist for all residents deemed appropriate for self-administration of medication.</i> 9-16-15 CW		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an	F 280			

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F 280	<p>Continued From page 3</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, interview, record review, and policy review, the provider failed to update and revise care plans for 7 of 12 sampled residents (1, 2, 3, 4, 5, 6, and 8) to reflect their current status. Findings include:</p> <p>1. Observation on 8/11/15 at 8:35 a.m. of resident 3 revealed she was in her room sitting in her lift chair (type of recliner with a mechanical lift in it) eating breakfast.</p> <p>Observation and interview on 8/11/15 at 10:17 a.m. with registered nurse (RN) A during resident 3's personal care revealed: *The resident had been in the bathroom. *She was able to walk herself to and from the bathroom with her walker. *RN A assisted her with personal care and checked the placement of the duoderm (type of dressing) patches on her buttocks. *The area around the patches appeared to be dark purple in color. *RN A stated the resident had pressure ulcers</p>	F 280	<p>Care plans for resident's 1, 2, 3, 4, 5, 6 and 8 will be updated with current information. Care plans will be updated by charge nurse on an as needed basis and formally every 90 days in conjunction with MDS assessment by MDS nurse, Director of Nursing and charge nurse. The care planning policy was revised to reflect the plan to keep care plans current and was reviewed at a nursing in-service on 8/31/15.</p> <p>Interdisciplinary team will review care plans every 90 days in conjunction with the MDS assessment to ensure the care plan is accurate and up to date to reflect the needs of the individual resident. Director of Nursing will report the findings to the Quality (continued....)</p> <p><i>Residents' care plans will be updated by charge nurses as changes occur. 9-14-15 CW</i></p>	9/25/15

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F 280	<p>Continued From page 4</p> <p>(injured area of skin caused by too much pressure) on both of her buttocks. The duoderm patches were the current treatment for those areas.</p> <p>*She stated the resident liked to sit in her chair a lot which did not help the healing of the pressure ulcers.</p> <p>*The staff had just changed her chair back to a facility lift chair the previous evening. The resident had not been sitting up as well in the other one.</p> <p>Review of resident 3's medical record revealed:</p> <p>*She had fallen on 12/19/14, 7/14/15, 7/16/15, and 7/30/15.</p> <p>*Pressure ulcers to her both buttocks had initially started on 3/8/15. Those areas had:</p> <ul style="list-style-type: none"> -Healed on 5/10/15. -Re-opened on 5/14/15. -Healed on 6/19/15. -Re-opened on 7/20/15. <p>Review of resident 3's care plan revealed:</p> <p>*On 5/14/15 a handwritten entry she had stage 2 (open area to the top layer of skin) pressure ulcers to both buttocks.</p> <p>*A goal was for those pressure ulcers to be healed by September 2015.</p> <p>*Intervention for those areas was:</p> <ul style="list-style-type: none"> -To apply Mepilex (specific type of dressing) to buttocks and secure with a tegaderm (type of clear plastic dressing). -Assess weekly. -Avoid pressure. <p>*There was no mention of:</p> <ul style="list-style-type: none"> -The current treatment for a duoderm dressing to the pressure ulcers. -She liked to spend a lot of time in her chair. -Other interventions for pressure ulcer care or prevention. 	F 280	<p>Assurance Performance Improvement Committee quarterly for 1 year.</p>		

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F 280	<p>Continued From page 5</p> <p>*There was no specific area for falls or interventions for the prevention of falls.</p> <p>Interview on 8/12/15 at 10:20 a.m. with licensed practical nurse K revealed: *Charge nurses should know what was on the residents care plans but they would not revise them. *The Minimum Data Set (MDS) nurses primarily made changes on the care plans.</p> <p>Interview on 8/12/15 at 1:30 p.m. with the director of nursing (DON) confirmed resident 3's care plan had not been updated related to her pressure ulcers or her history of falls.</p> <p>2. Observation on 8/11/15 at 11:50 a.m. of resident 1 revealed she walked independently with a cane.</p> <p>Observation on 8/11/15 at 1:05 p.m. revealed resident 1 had assistance bars on both sides towards the head of her bed.</p> <p>Review of resident 1's care plan with the target date of 9/30/15 revealed: *She had impaired function and required the assistance of one staff for moving around with a cane. *There was no mention of assistance bars on the bed.</p> <p>Interview on 8/11/15 at 1:30 p.m. with the DON confirmed resident 1 no longer required one staff assistance with walking. She confirmed her care plan had not been updated to reflect her current status.</p> <p>3. Review of resident 4's medical record</p>	F 280			

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F 280	<p>Continued From page 6 revealed:</p> <p>*He had his right fifth toe amputated (removed) on 5/29/15.</p> <p>*He had fallen on 9/28/14, 5/19/15, 7/5/15, and 7/19/15.</p> <p>-The fall on 5/19/15 had resulted in rib fractures.</p> <p>Review of resident 4's care plan with a last reviewed date of 6/2/15 revealed:</p> <p>*He had an active problem of a pressure ulcer to his right fifth toe that had started on 3/27/15.</p> <p>*The area for falls had included:</p> <p>-A history of falls with the last date of 5/19/15.</p> <p>-No mention of the 7/5/15 and 7/19/15 falls.</p> <p>-No mention of the rib fractures from the 5/19/15 fall.</p> <p>Interview on 8/12/15 at 1:30 p.m. with the DON confirmed resident 4's care plan had not been updated. It did not address his right fifth toe amputation and his recent falls.</p> <p>Surveyor: 22452</p> <p>4. Review of resident 6's 5/5/15 initial wandering assessment guide revealed:</p> <p>*To the question "Is the resident resistance to being placed in a long-term care facility there was documentation voiced dissatisfaction."</p> <p>***She has attempted to elope three times since her admission on 4/1/15. All three occurred 9:00 p.m. to 6:00 a.m."</p> <p>***The Wanderguard [bracelet on the resident that alarms when attempts to exit an alarmed door] device was placed on her walker and she became angry with it being placed on her ankle."</p> <p>Review of resident 6's 4/20/15 care plan revealed:</p> <p>***Consider Wanderguard to prevent wandering."</p>	F 280			

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F 280	<p>Continued From page 7</p> <p>*There were no other interventions documented for her wandering behavior.</p> <p>*There was no documentation the Wanderguard bracelet was attempted on her ankle and on her walker on 5/5/15 and removed due to the resident's refusal.</p> <p>Refer to F323, finding B1.</p> <p>Surveyor: 32572</p> <p>5. Observation on 8/10/15 at 3:45 p.m. revealed resident 2 had assistance bars at the head of the bed on both sides.</p> <p>Observation on 8/12/15 at 9:20 a.m. revealed certified nursing assistant (CNA) D emptying the small leg drainage bag [the small drainage bag is attached to a catheter (tube that drains the bladder) and attached to the leg of the resident]. Which is not a closed urinary system.</p> <p>Review of the 7/6/15 Minimum Data Set (MDS) Summary form revealed: ""Handrails [assistance bars] X [times] two to bed to assist with bed mobility/repositioning." ""Staff empties drainage bag twice a day." It did not indicate if that was the large urine collection bag or the small leg bag.</p> <p>Review of resident 2's 5/14/14 care plan revealed: *No mention of the use of assist rails. *The catheter was to have been maintained as a closed system. Not to be changing to a small leg bag.</p> <p>6. Observation on 8/10/15 at 3:45 p.m. revealed resident 5 had assistance bars at the head of the bed on both sides.</p> <p>Review of the 6/22/15 MDS Summary Form for</p>	F 280		

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F 280	<p>Continued From page 8</p> <p>resident 5 revealed "Handrails [assist bars] X [times] two to bed to assist with bed mobility."</p> <p>Review of resident 5's 5/8/14 care plan revealed: *No mention of the use of assistance rails. *The target areas: risk for falls, impaired nutritional status both had target dates (when the areas would be reviewed or resolved) of 8/11/14.</p> <p>7. Observation and record review on 8/10/15 at 3:45 p.m. revealed resident 8 had assistance bars at the head of the bed on both sides.</p> <p>Review of the 5/25/15 MDS Summary form for resident 8 revealed: *"Handrails [assistance bars] X [times] two for transferring in and out of bed and positioning."</p> <p>Review of resident 8's 12/9/14 care plan revealed: *No mention of the use of assist rails. *The target areas of impaired ADL (activity of daily living) did not have a target date.</p> <p>Surveyor: 35237</p> <p>8. Interview on 8/12/15 at 1:30 p.m. with the DON revealed: *Care plans should have been updated for residents related to changes in their care. *Charge nurses could have updated residents' care plans but generally did not. *Typically the MDS assessment nurses updated the care plans.</p> <p>Surveyor: 32572</p> <p>Review of the provider's June 2012 revised Care Planning and Total Plan of Care policy revealed "The care plan will be updated as needed by nursing staff or any member of the</p>	F 280			

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F 280	Continued From page 9 interdisciplinary team."	F 280			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, interview, and policy review, the provider failed to ensure physician's orders were followed for the calculation of insulin for one of one sampled resident (1). Findings include: 1. Review of resident 1's 7/15/15 physician's orders revealed she: *Had her blood sugar checked three times a day before meals. *Received sliding scale (amount of insulin determined by the blood sugar readings) Humulin R insulin before meals depending what her blood sugar readings were. *Was to receive the following doses of Humulin R insulin according to blood sugar levels of: -Less than 180, none. -181 to 220, 4 units. -221 to 260, 6 units. -261 to 300, 8 units. -301 to 350, 10 units. -Greater than 351, 12 units. Observation on 8/11/15 at 10:45 a.m. of resident 1 revealed registered nurse (RN) A: *Checked the resident's blood sugar (level) using a Glucometer (device that measures the amount	F 281	Pharmacist consultant review done and recommendations given for management of Diabetes mellitus to work toward eliminating sliding scale insulin. Medical Director reviewed and noted downward trend of blood sugar and will reevaluate. Education for all nursing staff at an in-service on 8/31/15 to review the 8 rights of medication administration for every med pass (Nursing 2012 Drug Handbook) and a poster of the 8 rights was laminated and put on each medication cart. An e-mail communication was sent to all nurses from the Director of Nursing with safety guidelines for nursing skills (Potter and Griffin 2013) for (continued....)	9/9/15	

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F 281	<p>Continued From page 10 of sugar in the blood). The blood sugar reading was 344 milligrams per deciliter (mg/dl). *Drew up 17 units of Humulin R insulin into a syringe to administer to her. (According to her medication administration record she should have received 10 units of Humulin R insulin for a blood sugar of 344 mg/dl. *After questioning by the surveyor stated she was going to dispose of the syringe that contained the 17 units of insulin. *Drew up 10 units of Humulin R and administered it to the resident.</p> <p>Interview on 7/15/15 at that time with RN A following the above observation revealed she was unaware why she had drawn up the 17 units of Humulin R in the syringe. She should have drawn up 10 units of Humulin R insulin to administer to the resident.</p> <p>Review of resident 1's 7/15/15 physician's orders revealed she: *Had her blood sugar checked three times a day before meals. *Received sliding scale (amount of insulin determined by the blood sugar readings) Humulin R insulin before meals depending what her blood sugar readings were. *Was to receive the following doses of Humulin R insulin according to the following blood sugars: -Less than 180, none. -181 to 220, 4 units. -221 to 260, 6 units. -261 to 300, 8 units. -301 to 350, 10 units. -Greater than 351, 12 units.</p> <p>Review of the provider's May 2013 Administration of Medication policy revealed:</p>	F 281	<p>each nurse to review. Director of Nursing will follow-up with the Medical Director and consultant pharmacist to work toward eliminating of sliding scale insulin by 9/9/15. Ongoing education will occur for nursing staff on medication administration safety at monthly department meetings. Director of Nursing will report Medication safety education topics to Quality Assurance Performance Improvement committee quarterly for 1 year.</p> <p><i>Resident 1 was reassessed for the need for sliding scale insulin and as a result, the sliding scale insulin has been discontinued. All resident medications are evaluated monthly by a consultant pharmacist. If any resident is on a sliding scale insulin, it will be evaluated with the goal of eliminating the sliding scale insulin.</i> 9-10-15 CW</p>		

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F 281	Continued From page 11 **"Medications must be administered in accordance with the written orders of the attending physician." **"The five rights must be observed in giving each medication: -Right medication. -Right resident. -Right time. -Right route. -Right dose." Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Edition, St. Louis Mo., 2013, page 611, revealed safety guidelines for nursing skills: **"Be vigilant during the entire process of medication administration." **"Ensure that your patients [residents] receive the appropriate medications." **"Know why each medication is ordered for your patient." **"Understand what you need to do before, during, and after medication administration." **"Evaluate the effectiveness and assess for adverse effects after your patients take their medications." **"Set-up and prepare medications in distraction-free areas."	F 281		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314	Measures to heal and prevent further pressure ulcers for Resident 3 have been implemented. The resident is able to walk to and from (continued....)	9/25/15

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F 314	<p>Continued From page 12 services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, interview, record review, and policy review, the provider failed to prevent the occurrence or re-occurrence of pressure ulcers (an injury to the skin and underlying tissue caused by unrelieved pressure, usually over a bony area) for one of two sampled residents (3) who had pressure ulcers. Findings include:</p> <p>1. Review of resident 3's medical record revealed: *She had been admitted on 1/23/14. *Her diagnoses included Alzheimer's (affects memory) disease, dementia (affects memory), constipation, anxiety (nervousness), high blood pressure, osteoarthritis (joint disease), venous insufficiency (failure to circulate blood appropriately), and gout (disease causing painful joints). *She currently had pressure ulcers to both buttocks.</p> <p>Random observations of resident 3 from 8/11/15 at 8:35 a.m. through 8/12/15 at 1:20 p.m. revealed: *She sat in her lift chair (type of recliner with a mechanical lift) in her room frequently. -There was no seat cushion in that chair. *Staff assisted her to the dining room in a wheelchair. -There was no seat cushion in her wheelchair. *She had a concave (specialty mattress with raised edges to help prevent her from rolling out)</p>	F 314	<p>the dining room and staff is walking with resident to each meal instead of pushing her in a wheelchair. When using the wheelchair, staff ensures that a seat cushion is placed in her wheelchair at all times. The resident's care plan has been updated to reflect the most current treatment regimen and lists interventions currently being implemented to heal and prevent pressure ulcers. Interventions include the following: pressure relieving pad in wheelchair; repositioning every two hours and as needed; encouraging resident to lie down for periods between meals; ensuring proper positioning while in the recliner chair to reduce pressure and shearing; promoting adequate (continued...)</p>		

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F 314	<p>Continued From page 13 mattress on her bed. *She used a walker in her room for going to and from the bathroom.</p> <p>Observation and interview on 8/11/15 at 10:17 a.m. with registered nurse (RN) A during resident 3's personal care revealed: *The resident had been in the bathroom. *She was able to walk herself to and from the bathroom with her walker. *She was usually continent (able to control her bowel and bladder). *She wore disposable briefs. *RN A assisted her with personal care and checked the placement of the duoderm (type of dressing) patches to her buttocks. *The patches were in place, and the area around them appeared to be dark purple in color. *RN A stated the resident had pressure ulcers on both of her buttocks, and the duoderm patches were the current treatment for those areas. *The patches had been changed yesterday by her, and again by the night nurse. *She stated the resident liked to sit in her chair a lot which did not help the healing of the pressure ulcers. *The staff had just changed her chair back to a facility lift chair the previous evening because she had not been sitting up as well in the other one.</p> <p>Observation and interview on 8/12/15 at 8:15 a.m. with certified nursing assistant (CNA) J regarding resident 3 revealed: *The resident had pressure ulcers on her buttocks that the nurse did the treatments for. *The resident normally walked herself to the bathroom with her walker. *The CNAs only helped her as needed, maybe once a shift.</p>	F 314	<p>nutrition; providing assistance with toileting and hygiene of the peri area before and after meals and as needed. Nursing cares for the treatment of the pressure ulcer are outlined and updated by the nurses to ensure accuracy. Education has been completed on pressure ulcer prevention at a mandatory in-service on 8/31/15 for all CNAs and nurses. References for in-service content include: Boschert, J. (2014). How to be a nursing assistant: Creating awareness and understanding of those in your care, 6th Ed. AHCA: Washington, DC.; Mamou, M. (2015). Treating pressure ulcers and chronic wounds. Net CE, 141 (1), 16-30. The Assessment/Wound Care Policy was reviewed by the (continued....)</p>	

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F 314	<p>Continued From page 14</p> <p>*She was not on a toileting or repositioning schedule.</p> <p>*She sat in the chair most of the time, but they tried to get her to lay in her bed sometimes after lunch.</p> <p>*Staff pushed her in the wheelchair to and from meals in the dining room.</p> <p>*She agreed the resident did not have a seat cushion in her chair or her wheelchair.</p> <p>*Her mattress was just the same (a regular mattress with no special features to prevent pressure areas from forming) as other residents.</p> <p>Interview on 8/12/15 at 10:20 a.m. with licensed practical nurse K regarding resident 3 revealed:</p> <p>*She did not like to lay down and liked to spend a lot of time in her chair.</p> <p>*She had seat cushions in her chair and wheelchair in the past, but she was unsure what happened to them or when they had been removed.</p> <p>*She should have had seat cushions in her chair and wheelchair for pressure relief.</p> <p>*She had a standard mattress.</p> <p>*The charge nurses would have done the weekly assessments of pressure ulcers.</p> <p>-Those assessments should have been documented.</p> <p>*The nurses completed pressure ulcer treatments as ordered by the physician.</p> <p>*For a resident that had a pressure ulcer:</p> <p>-Interventions should have included repositioning, pressure relieving cushions, dietary involvement, and physician involvement.</p> <p>-Nurses should have implemented interventions and educated the CNAs.</p> <p>*She would have expected changes in the care plan for pressure ulcer care and prevention.</p>	F 314	<p>interdisciplinary team. Head to toe skin monitoring will be done by CNAs on a daily basis and weekly with baths to predict residents at risk and identify skin concerns as they develop. The nurse will be notified with any concern and will take appropriate action according to the policy to promote skin integrity for all residents. Staff will document a skin assessment on a weekly basis. Skin condition and preventative measures for residents will be reviewed by the interdisciplinary team every three months during care planning to ensure quality assurance. Director of Nursing will report findings to the Quality Assurance Performance Improvement committee quarterly for 1 year.</p> <p><i>All residents will be evaluated by the Interdisciplinary Team every 3 months for risk of skin breakdown and to ensure documentation of interventions to protect skin.</i></p>	

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F 314	<p>Continued From page 15</p> <p>Review of resident 3's physician's orders and medication and treatment administration records revealed:</p> <ul style="list-style-type: none"> *On 3/8/15 there was an order to: <ul style="list-style-type: none"> -Avoid pressure to small superficial non-infected areas to the buttocks. -Cleanse with wound wash. -Dry. -Apply Mepilex (special type of dressing). -Assess on Sundays. *They had healed on 5/10/15. *On 5/14/15 there was an order for: <ul style="list-style-type: none"> -Cleanse with wound wash. -Dry. -Apply Mepilex to both buttocks. -Assess on Thursdays. *They had healed on 6/19/15. *On 7/20/15 there was an order for Tegaderm (specific type of dressing) to have been applied to both buttocks. *On 8/10/15 there was an order for: <ul style="list-style-type: none"> -Avoid pressure to area. -Cleanse with wound wash. -Dry. -Apply duoderm (another type of dressing). -Notify physician of non-healing or signs/symptoms of infections. -Assess every Monday. <p>Review of resident 3's Minimum Data Set Summary assessment forms for skin revealed:</p> <ul style="list-style-type: none"> *On 12/22/14: <ul style="list-style-type: none"> -A Braden Risk Assessment (scale indicating risk of developing pressure ulcers) score of twenty that indicated low risk. -Risk for pressure ulcer was circled "No." -"No" was circled for currently having one or more pressure ulcers. *On 3/16/15: 	F 314		

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F 314	<p>Continued From page 16</p> <p>-A Braden score of twenty. -Risk for pressure ulcer was circled for "No." -"No" was circled for currently having one or more pressure ulcers. *On 6/18/15: -A Braden score of sixteen that indicated low risk. -Risk for pressure ulcer was circled "Yes." -"Yes" was circled for currently having one or more pressure ulcers.</p> <p>Review of resident 3's weekly Skin Ulcer/Complex Assessment Notes for March 2015 through August 10, 2015 revealed documentation had been done by several different nurses. The following months revealed weekly documentation for: *March, three times. *April four times. *May, three times. *June, two times. *July, one time. *August, one time on the tenth. *They had not been completed weekly as ordered by the physician. *The stage (scale to determine severity) of the pressure ulcers had not been documented for several of those assessments.</p> <p>Review of resident 3's last reviewed 6/16/15 care plan revealed: *She required: -Assistance of one staff person with dressing. -Set-up and supervision with personal hygiene. *She was independent with toilet use during the day, but she required assistance with perineal (peri-)(private area) care. *A handwritten entry on 3/18/15 to "monitor for skin cracks/tears to buttocks r/t [related to] shearing [friction from moving] and apply Mepilex</p>	F 314			

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F 314	<p>Continued From page 17 PRN [as needed]."</p> <p>*The resident had weakness, knee pain, was able to walk short distances with a walker, and used the wheelchair as needed.</p> <p>*A handwritten entry on 5/14/15 for a problem of stage 2 (open area to the top lay of skin) pressure ulcers to both buttocks.</p> <p>-The intervention for them was "apply Mepilex to buttocks, secure with tegaderm. Assess q [every] week. Avoid pressure."</p> <p>-That was not the current treatment for those areas according to review of the August 2015 treatment administration record.</p> <p>*There was no mention of a repositioning or toileting schedule.</p> <p>*There was no mention of a pressure relieving mattress or seat cushions for the chair and wheelchair.</p> <p>*There was no mention of any:</p> <p>-Pressure ulcers that had started in March 2015.</p> <p>-Changes in interventions since that time.</p> <p>Interview on 8/12/15 at 12:00 noon with the medical director revealed:</p> <p>*She was resident 3's primary physician and stated she:</p> <p>-Was aware of the pressure ulcers on her buttocks.</p> <p>-Thought she had a gel mattress on her bed.</p> <p>-Was unsure what other preventative measures the facility had implemented.</p> <p>*For pressure ulcers the "key is to change position."</p> <p>*She had been aware of an increase in the number of the facility's pressure ulcers related to staffing issues.</p> <p>-She felt the number of pressure ulcers had improved as staffing had improved.</p>	F 314			

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F 314	<p>Continued From page 18</p> <p>Interview on 8/12/15 at 1:30 p.m. with the director of nursing revealed:</p> <ul style="list-style-type: none"> *Resident 3 was not on a repositioning program. -Repositioning would have been done during or around the facility's five meals a day. -She did not always go to the dining room for meals. -She liked to spend a lot of time in her chair. *Resident 3 was not on a toileting program. -She should have been assisted to the toilet before and after meals and as needed. *Resident 3 had a seat cushion in her chair at one time but did not like it. -She was unsure when that had been exactly. -She was unsure if implementing a seat cushion would help her now. *Charge nurses did the pressure ulcer assessments weekly. *There was no specific wound or skin nurse at the facility. *They would have contacted the primary physician before sending residents for a consultation related to pressure ulcers. *She agreed there was missing documentation related to resident 3's weekly pressure ulcer assessments. *She agreed resident 3's care plan had not been updated with changes related to her pressure ulcers. -The only mention of her pressure ulcer treatments and interventions was the 5/14/15 entry for Mepilex. *She agreed resident 3 was identified at a low risk for pressure ulcers but had developed them at the facility. *She confirmed resident 3's pressure ulcers had started in March 2015 and had healed and re-opened a few times. *When new pressure ulcers had been identified 	F 314		

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F 314	Continued From page 19 the nurses should have notified the physician and helped the resident to avoid pressure to those areas. *The facility did not have air mattresses. *All the mattresses were considered pressure reducing from the supplier. *She agreed maybe more could have been done more for resident 3's pressure ulcers. Review of the provider's October 2003 Skin Assessment/Wound Care Protocol policy revealed: *"It is the policy of this facility that all residents will be monitored for impaired skin integrity at admission, weekly, and as needed. Measures will be taken to predict residents at risk, describe prevention activities, and to promote rapid healing in the event a pressure ulcer unavoidably develops." *"4. If the pressure ulcer is not healing and/or signs of additional skin breakdown are evident, alternative interventions will be considered every two weeks and attempted at least every 30 days with consult of a physician." *Prevention activities included: -"1. For resident's unable to reposition themselves, reposition every two hours and as needed." -"3. Apply pressure reduction surface to the bed and chair (foam, gel or static mattress)." -"4. Use site specific support surfaces on the resident's extremities and bony prominences, and keep bony areas from direct contact with each other." *Pressure ulcer protocol included: -"a. Standing order - Avoid pressure!...) -"b. Notify physician of ulcer (SO [standing order] telephone form) and complete Weekly Pressure Ulcer Record."	F 314		

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F 314	Continued From page 20 -"d. Stage Pressure Ulcers as follows:" -"Stage I [1] - A persistent area of redness that does not disappear when pressure is relieved or does not blanch [temporary whitening of skin] when pressure is applied (without a break in the skin)." -"Stage II [2] - Partial thickness skin loss involving epidermis [outer layer of skin], dermis [middle layer of skin], or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater." -"Stage III [3] - Full thickness skin loss involving damage to, or necrosis [dying tissue] of, subcutaneous [lowest layer of skin] tissue that may extend down to, but not through, underlying fascia [connective tissue under the skin]. The ulcer presents clinically as a deep crater with or without undermining [wearing away under the edge] of adjacent tissue." -"Stage IV [4] - Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures. Undermining and sinus tracts also may be associated with Stage IV pressure ulcers."	F 314		
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by:	F 318	Restorative Therapy program has returned to full capacity staffing as of 9/2/15. Restorative Therapy staff member who was on medical leave throughout the summer months has returned to the position full time (five days/week) and is (continued....)	9/25/15

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F 318	<p>Continued From page 21 Surveyor: 32572 Based on observation, interview, record review, and policy review, the provider did not have a restorative therapy program (RT) in place to maintain 10 of 12 sampled resident's (2, 3, 4, 5, 6, 7, 8, 9, 11, and 12) therapies for range of motion. Findings include:</p> <p>1. Random observations from 8/10/15 at 3:45 p.m. through 8/12/15 5:00 p.m. of the therapy room revealed no staff member was present during any of those observations.</p> <p>2. Review of resident 2's medical record revealed: *She had been admitted on 9/22/08. *The 6/17/15 signed physician's order stated "Restorative therapy as tolerated." *The 7/6/15 Minimum Data Set Assessment (MDS) Summary form revealed "Restorative Program: Does not participate." That document revealed: *She had a history of falling. *She used a walker as an ambulatory aide. *Her gait/transferring had been "Impaired" (unsteady, difficulty rising to stand). *Her mental status had been "Forgets limitations."</p> <p>Review of the 7/6/15 significant change MDS assessment reflected assistance had been needed with transferring, ambulation, personal hygiene, and bathing.</p> <p>Review of her 7/14/15 reviewed care plan revealed nothing about a restorative program. The care plan did reflect she needed assistance with transfers, ambulation with the assistance of a walker and use of a gait belt, and assistance with</p>	F 318	<p>providing documentation of therapies for range of motion for residents 2,3,4,5,6,7,8,9,11 and 12. A second aide will be formally trained in restorative therapy to ensure no gap in coverage moving forward. Care plans will be updated for residents 2.3.4.5.6.7,8,9,11 and 12 to reflect physician orders and plan for restorative therapy or physical therapy as part of total care plan. Care plans will be updated for each resident with current interventions for fall prevention, mobility, activities of daily living, skin care and level of assistance needed. MDS nurses, charge nurses and Director of Nursing are responsible for updating care plans according to the Care (continued....)</p>	

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F 318	<p>Continued From page 22 toileting.</p> <p>3. Review of resident 5's medical record revealed: *She had been admitted on 5/29/13. *The 7/15/15 signed physician's order stated "Restorative therapy as tolerated."</p> <p>Review of the 6/22/15 MDS Summary form revealed: "Restorative Program: Does not participate." *She had a history of falls. *Her gait/transferring had been "Impaired" (unsteady, and difficulty rising to stand).</p> <p>Review of her 6/22/15 quarterly MDS assessment revealed: *Assistance had been needed for transferring, dressing, personal hygiene, and bathing.. *She did not walk in her room or the hallway.</p> <p>Review of her 6/30/15 reviewed care plan revealed nothing about the restorative program. The care plan did reflect she needed assistance with dressing, toileting, personal hygiene, and bathing.</p> <p>4. Review of resident 8's medical record revealed: *She had been admitted on 1/26/09. *The 7/15/15 signed physician's order stated "Restorative therapy as tolerated."</p> <p>Review of the 5/25/15 MDS assessment Summary form revealed "Restorative Program: None." That document revealed: *She had a history of falls. *Her gait/transferring had been "Impaired" (unsteady, and difficulty rising to stand).</p>	F 318	<p>Planning policy. Restorative Therapy aide is responsible for documenting daily therapies completed for each resident in the electronic medical record. The Director of Nursing will review the restorative therapy log for complete documentation for each patient 1 x month and report findings to the Quality Assurance Performance Improvement committee quarterly for 1 year.</p> <p><i>"We Care Online Restorative Aide" training program has been contacted regarding Restorative Aide training and certification. One additional Restorative Aide will be in place by 12-31-15 after completing the two-week online training course. 9-16-15 MW</i></p>	

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F 318	<p>Continued From page 23</p> <p>*Her mental status had been "Forgets limitations" and handwritten in was "sometimes."</p> <p>Review of her 5/25/15 quarterly MDS assessment revealed: *Assistance had been needed for transferring, dressing, eating, personal hygiene, and bathing, to remain I [independent] with eating and some hygiene tasks." *She did not walk in her room or the hallway."</p> <p>Review of the 6/2/15 reviewed care plan reflected nothing about the restorative program. The care plan did not reflect assistance needed with activities of daily living (ADL-dressing, bathing, mobility, and transferring).</p> <p>5. Review of resident 11's medical record revealed: *She had been admitted on 7/7/08. *The 7/15/15 signed physician's order stated "Restorative therapy as tolerated."</p> <p>Review of her 11/3/15 MDS assessment Summary form revealed "Restorative Program: None." *The 1/26/15 MDS assessment Summary form revealed: *"AROM [active range of motion, resident able to move arms and legs by herself] 1-5 [one to five] times per week. Did not participate in last seven days." -Restorative goal was to "Maintain strength and ROM [range of motion] to U/E [upper extremities]. *The 4/20/15 MDS assessment Summary form revealed "AROM 1-5 times a week X [times] 1 for 15 minutes." -The goal of the restorative program was to "Maintain her strength and ROM to U/E and</p>	F 318		

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F 318	<p>Continued From page 24</p> <p>complete some ADL tasks of feeding herself, dressing, and P. [personal] hygiene." *The 7/13/15 MDS assessment Summary form revealed: "AROM 1-5X/week -Participated X 1 day for 15 minutes in past 7 days." -The goal of the restorative program was to "Maintain mobility and strength for independence with eating, dressing, and personal hygiene." *All of the MDS assessment Summary forms revealed she did not have a history of falling, used a wheelchair for mobility, had normal gait/transferring, and had been alert.</p> <p>Reiew of resident 11's 7/21/15 revised care plan revealed: *She needed assistance with bed mobility (changing positions while in bed), dressing, personal hygiene, bathing, toileting. *She transferred with the assistance of two staff members and using the mechanical lift (equipment to move the resident from one place to another).</p> <p>Review of resident 11's following Restorative Therapy (RT) Exercises document regarding attendance revealed: *January 2015 revealed attended six times. *February 2015 revealed attended four times. *March 2015 revealed attended seven times. *Unable to find documentation for April, May, and June of 2015. *There had been no electronic documentation of attendance in the RT program for July and August 2015.</p> <p>Surveyor: 35237</p> <p>6. Review of resident 3's medical record revealed:</p>	F 318		

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F 318	<p>Continued From page 25</p> <p>*She had been admitted on 1/23/14.</p> <p>*Diagnoses included Alzheimer's (affects memory) disease, dementia (affects memory), anxiety (nervousness), osteoarthritis (joint disease), and gout (build up of acid that causes painful joints).</p> <p>*The signed 6/17/15 physician's orders revealed an order that stated "activity as tolerated with assistance as needed."</p> <p>*Review of the 6/8/15 MDS Summary Form assessment revealed "Restorative Program: Does not participate." That document also revealed:</p> <p>*She had limited function of her lower extremities (legs).</p> <p>*She used a walker and wheelchair to move around.</p> <p>*She had a history of falls.</p> <p>*She was independent in her room, but she required total assistance of one staff person when outside of her room.</p> <p>*She had an unsteady balance with standing and walking.</p> <p>*She had fallen on 12/19/14, 7/14/15, 7/16/15, and 7/30/15.</p> <p>Review of the 6/16/15 reviewed care plan revealed nothing about the restorative program. It did reflect her need for assistance with dressing, personal hygiene, and moving around at times.</p> <p>Observations from 8/10/15 through 8/12/15 from time to time revealed:</p> <p>*She was able to use a walker to move in her room independently.</p> <p>*She was wheeled to the dining room in a wheelchair by staff for meals.</p> <p>Review of resident 3's 12/22/14, 3/16/15, and</p>	F 318		

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F 318	<p>Continued From page 26</p> <p>6/8/15 MDS assessments revealed: *She had limitations with both her lower extremities. *She had needed limited to extensive assistance of staff with transfers, moving around outside of her room, toileting, and personal hygiene in December and March. *She had needed extensive to total assistance of staff with moving around outside of her room, toileting, and personal hygiene in June.</p> <p>7. Review of resident 4's medical record revealed: *He had been admitted on 2/25/14. *Diagnoses included: congestive heart failure (heart not working properly), Bells Palsy (weakness of the muscles on one side of the face), diabetes (abnormal blood sugar levels), Alzheimer's disease, osteoarthritis (bone disease), and dementia. *The signed 7/15/15 physician's orders revealed an order for "Activity as tolerated, Restorative Therapy as tolerated."</p> <p>Review of her 5/25/15 MDS Summary Form assessment revealed: **"Restorative Program: AROM 1-5 X a week. Participated X 2 days for 5 min [minutes] each session in past 7 days." **"Restorative goal: Maintain ROM & [and] strength for ADL's and ambulation [walking]." *He was independent but needed supervision for transfers at times. *He needed supervision with walking outside of his room. *He needed extensive assistance from one staff person with dressing and toileting. *He needed limited assistance of one staff person with hygiene.</p>	F 318			

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F 318	<p>Continued From page 27</p> <p>*He had an unsteady balance with standing and walking. *He had fallen on 9/28/14, 5/19/15, 7/5/15, and 7/19/15.</p> <p>Review of his 6/2/15 reviewed care plan revealed he was at high risk for falls and had an intervention of "Restorative consult - AROM 1-5X/week as tolerated to maintain ROM & strength for ADL's and ambulation."</p> <p>Review of resident 4's 12/8/14, 3/2/15, and 5/25/15 MDS assessments revealed: *He had limitations to both lower extremities. *In December and March: -He had been independent with transfers, and with walking in his room and outside of his room. -He had needed extensive assistance of one staff person with dressing and toileting. *In May: -He had been independent with walking in his room. -He needed supervision for transfers and walking outside of his room. -He needed extensive assistance of one staff person with dressing and toileting.</p> <p>Review of resident 4's following Restorative Therapy Exercises log sheets revealed: *In August 2014 he had no days documented. *In September 2014 he had one day documented. *In October 2014 there was no log in his medical record. *In November 2014 there were four days documented. *In December 2015 there were nine days documented.</p>	F 318			

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F 318	<p>Continued From page 28</p> <p>Review of resident 4's Restorative ROM Active notes from the electronic medical record (EMR) revealed: *In May 2015 he had six days of documentation. *Further documentation had been requested from the DON but had not been received by the end of the survey.</p> <p>8. Review of resident 12's medical record revealed: *She had been admitted on 5/6/14. *Her diagnoses included high blood pressure, congestive heart failure, macular degeneration (affects eyesight), anxiety, osteoarthritis, diabetes, and low back pain. *The signed 7/15/15 physician's orders revealed an order for "Activity as tolerated with walker and assistance, Restorative Therapy as tolerated."</p> <p>Review of her 7/14/15 reviewed care plan revealed: *No mention about the restorative program. *It did reflect she needed assistance with transfers, using the wheelchair outside of her room, dressing, toileting, and hygiene. *She had fallen on 7/12/14, 7/15/14, 3/2/15, 3/28/15, and 6/6/15.</p> <p>Interview on 8/12/15 at 8:20 a.m. with resident 12 revealed: *She had fallen in the past. *She could not walk by herself. *She had been to restorative exercises twice, but she had not been since the restorative therapy (RT) aide had been out on leave. *She knew she needed exercise for her legs. *She walked to the dining room for supper but would have staff give her a ride in the wheelchair for lunch.</p>	F 318			

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F 318	Continued From page 29 Surveyor: 22452 9. Review of resident 6's medical record revealed she had been admitted on 4/1/15. Review of resident 6's 4/1/15 physician's orders revealed "Restorative therapy as tolerated." Review of resident 6's 6/22/15 Minimum Data Set (MDS) assessment summary form revealed: **"Sit to stand balance, Independent and unsteady." **"Walking, Independent and unsteady." **"Turn around, Independent and unsteady." **"Move on/off toilet, Independent and unsteady." **"Surface/surface transfer, Independent and unsteady." **"Functional limitations to lower extremities (legs), Unsteady gait [walking]." *Falls and related injury on 4/12/15 and 5/3/15. Review of resident 6's 4/13/15 and 6/22/15 MDS assessments revealed: *4/13/15, "No upper or lower extremities limitations." *6/22/15, "No upper extremities limitations. Impaired bilateral [both] lower extremities limitations." Review of resident 6's 4/20/15 care plan revealed: **"Maintain activities of daily living (ADL) [dressing, grooming, and bathing] function." *There was no documentation of a restorative program. 10. Review of resident 7's medical record revealed: *A 3/12/15 admission date from an acute care	F 318		

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F 318	<p>Continued From page 30</p> <p>hospital with a hip fracture that had occurred in a fall at home.</p> <p>*He was hospitalized 4/7/15 through 4/23/15 for pneumonia and cardiac (heart) problems.</p> <p>*He was hospitalized 7/27/15 through 7/31/15 for shortness of breath and cardiac problems.</p> <p>Review of resident 7's 6/1/15 and 8/4/15 MDS summary assessment revealed "None, does not participate in restorative nursing."</p> <p>Review of resident 7's 1/23/15 and 6/1/15 MDS summary assessment revealed bilateral limitations for both upper and lower extremities.</p> <p>Review of resident 7's 3/12/15 physician's orders revealed: *"Physical therapy [PT] to increase strength, improve balance, and increase endurance." *Restorative therapy as tolerated.</p> <p>Review of resident 7's 4/23/15 and 7/31/15 physician's orders revealed "Activity as tolerated."</p> <p>Review of resident 7's 3/11/15 care plan revealed: *"Limited function to upper and lower extremities due to fracture left hip, pulmonary [lung] emboli [clot], and pneumonia." *"Improve ADL function in personal hygiene and dressing upper extremities." *There was no documentation regarding PT or a restorative program.</p> <p>11. Review of resident 9's medical record revealed: *A 8/30/73 admission date. *Diagnoses of muscular dystrophy (lessened muscle mass) and cerebrovascular accident (stroke) with left-sided hemiparesis (weakness).</p>	F 318			

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F 318	<p>Continued From page 31</p> <p>Review of resident 9's 1/19/15 care plan revealed: **"Will maintain ADL function." *There was no documentation of a restorative program to maintain his ADL function.</p> <p>Surveyor: 35237 12. Interview on 8/12/15 at 8:45 a.m. with the DON revealed: *RT as tolerated on the physician's orders was a standing order at the facility. *The normal restorative therapy aide had been on leave since the beginning of July. *They had other certified nursing assistants (CNA) that were able to do RT, but they had not been doing RT due to staffing. *They did not have RT on the weekends. *The restorative aide had been documenting notes for RT in the EMR recently. -She had been unsure when the RT aide had started documented in the EMR. *She confirmed the log sheets for April 2015 had minimal documentation. *She was unsure of how to print a report of the days RT had been documented on from the EMR. *She agreed the RT list the staff used did not match who was actually documented on. -An example was resident 4 was not on the RT list, but had documented RT notes and was care planned for RT. *Resident 12 did not really get started with RT and had not had any RT since the usual scheduled restorative therapy aide left.</p> <p>Surveyor: 22452 Interview on 8/12/15 at 10:30 a.m. with the director of nursing regarding the restorative program revealed:</p>	F 318		

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F 318	<p>Continued From page 32</p> <p>*Restorative aide/certified nursing assistant (CNA) F who usually worked in the restorative department had been on medical leave since 7/7/15 and was off for six weeks.</p> <p>*They had no one consistent staff person that had been in the restorative department since CNA F had been on leave.</p> <p>*They had filled in a few hours with other CNAs, but that had not been consistent due to lack of nursing staff on the floor.</p> <p>*She knew the nursing staff did range of motion exercises when they assisted the residents with dressing and undressing.</p> <p>*She was unsure why resident 6 had not been referred for a restorative program. Usually a referral was made to either PT or restorative when residents' care plans were discussed.</p> <p>*PT had initially been working with resident 7 prior to his 4/7/15 hospitalization. He had returned from the hospital on a restorative program, as the doctor did not feel he could handle PT due to weakness and his poor tolerance. The last day she could locate documentation he had received restorative exercises was on 6/16/15.</p> <p>*There was documentation resident 9 had refused restorative care in 2010. She agreed staff should have checked with him more frequently regarding restorative care since there had been no documentation for five years.</p> <p>*Any resident who received restorative care would receive the service from one to five days per week. If there was staff available they would receive the cares, however residents would not receive any restorative care if there was no staff available.</p> <p>13. Interview on 8/12/15 at 11:00 a.m. with PT G regarding the restorative program revealed: *She knew April 2015 was the last month the</p>	F 318			

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F 318	Continued From page 33 restorative aide had done paper charting. She confirmed the charting was poor for April and the May 2015 charting "was hit and miss". *She was at the facility for a very short time each day, and that was only if she had a resident on PT services. She had only one resident who received PT services at that time. *She knew restorative aide F used standard restorative programs that had been set-up by a previous PT. *She did not see the residents who are on a restorative program unless they were receiving skilled PT. *When she discharges someone from PT she wrote up a restorative program and talked to restorative aide F. *She had not done any inservice education since she has consulted at the facility during the past year. Review of the provider's January 2006 PT/Restorative Exercises policy revealed: *"The PT will be available to the nursing home upon physicians' referral and will provide in-service training to nursing service personnel on an ongoing basis." *"The PT will assist with development of restorative exercise programs as needed to promote each residents' highest physical function." *"These programs will be carried out by a restorative assistant who has completed specialized training in this area."	F 318			
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323			

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F 323	<p>Continued From page 34 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237 A. Based on observation, interview, record review, and policy review, the provider failed to implement appropriate interventions to prevent future falls for three of eight sampled residents (3, 4, and 12) who had falls. Findings include:</p> <p>1. Review of resident 12's medical record revealed: *She had been admitted on 5/6/14. *She was alert and oriented. *She had a BIMS (memory test) score of 14 which indicated no memory issues. *She had impaired vision. *Her diagnoses included high blood pressure, congestive heart failure (heart not working properly), macular degeneration (affects eyesight), anxiety (nervousness), osteoarthritis (joint disease), diabetes (abnormal blood sugar levels), history of urinary tract (bladder) infections, and lumbago (low back pain).</p> <p>Random observations from 8/11/15 through 8/12/15 revealed resident 12 at times: *Used a walker and one staff person assistance to move around. *Used a wheelchair with one staff person assistance to move around.</p> <p>Interview on 8/12/15 at 8:20 a.m. with resident 12</p>	F 323	<p>Resident 12 is participating in restorative therapy again as of 9/2/15 after return of full-time restorative therapy aide. Current fall prevention strategies will be updated in the care plan for residents 3, 4 and 12. Fall prevention education was conducted at mandatory staff in-service on 8/31/15. Content included information on fall prevention strategies for long term care residents. References include: Boschert, J. (2014). How to be a nurse assistant: Creating awareness and understanding of those in your care, 6th Ed. AHCA: Washington, D.C., and Willy, B. (2014). Strategies for reducing falls in long-term care. Annals of Long Term Care, 22 (1), 1-18. Fall (continued.....)</p>	9/25/15

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F 323	<p>Continued From page 35</p> <p>revealed:</p> <ul style="list-style-type: none"> *She had fallen in the past. *She could not walk by herself. *She had been to restorative exercises twice, but she had not been since the restorative therapy (RT) aide had been out on leave. *She knew she needed exercise for her legs. *She walked to the dining room for supper but would have staff give her a ride in the wheelchair for lunch. <p>Review of resident 12's Fall Follow-Up progress notes by nursing revealed on the following dates:</p> <ul style="list-style-type: none"> *6/13/14 she had a fall with no injury. -She had attempted to transfer herself. -She had not used her call light to ask for assistance. -To prevent another fall it stated "again highly remind and encourage to use her call light which is always given and explained to her and was at this time also in her easy chair when she was found on the floor in front of her bed. She always says, "ya, Maybe I should" when encourage and reminded but yet 'thinks' she can get there whether it's to the bathroom, bed, or chair. Will continue use of motion monitor also." *7/12/14 she had a fall and hit her head. -She had been walking with a certified nursing assistant (CNA) and tried to reach for an item and fell. -To prevent another fall it stated "staff should always use a gait belt when ambulating/transferring [resident's name]." *7/15/14 she had a fall with no injury. -She had been walking with staff to the dining room and tripped. -To prevent another fall it stated "use gait belt with amb [ambulation]." *3/2/15 she had a fall and hit her head. 	F 323	<p>prevention and Accidents, Falls and Safety Precautions policies reviewed and revised. Fall Prevention committee including interdisciplinary members will meet 1 x month for 6 months to review each fall and recommend interventions to prevent subsequent falls. Interventions will be updated in resident care plans on an as needed basis by charge nurses and quarterly by Director of Nursing or Minimum in conjunction with care plan meetings. Recommendations from the Fall Prevention Committee will be implemented by certified nurse assistants, nurses and activity department. The Director of Nursing will continue to review all falls and submit a fall report identifying causes, noting potential interventions and incidence (continued.....)</p> <p style="text-align: right;"><i>by charge nurses by Director of Nursing or Minimum Data Set nurses 9-16-15 CW</i></p>		

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F 323	<p>Continued From page 36</p> <p>-She had been transferring herself from the bed. -To prevent another fall it stated "encourage res [resident] to call for help and not get up per self." *3/28/15 she had a fall with no injury. -She had been walking to the bathroom with staff, kicked the wheel of the walker, lost her balance, and was lowered to her knees. -To prevent another fall it stated "continue to assist resident. Remind resident with transfers to be aware of assistive device." *6/6/15 she had a fall and hit her head. -She was attempting to transfer herself to the bathroom. -She had a hematoma [swollen bruise] and two lacerations [cut] to the back of her head, and was sent to the emergency room for stitches. -To prevent another fall it stated "resident understands the risks toileting herself. However she refuses to wait for staff to assist her."</p> <p>Review of resident 12's reviewed 7/14/15 care plan revealed: *She was a high risk for falls and she had a history of falls. *Interventions for falls included: -"Keep call light attached to her upper body clothing so that she can find it when she wants to call for assist." -"Keep room clutter free. Do not change environment in her room without input from [resident's name]. Keep room well lighted." -"Wear non-skid footwear when out of bed." -"Uses w/c [wheelchair] for mobility [moving around] which is pushed by others. She will also self propel [move] w/c at times." -"Knock and announce yourself when you enter the room so as not to startle [resident's name]." -"Wears hearing aide to both ears - assist as needed."</p>	F 323	<p>of falls to the Quality Assurance Performance Improvement Committee quarterly for 6 months.</p> <p><i>Resident 6's care plan reviewed and updated with current elopement interventions. Review of Wanderguard System completed during 8-31-15 mandatory inservice for all departments. Review of elopement prevention interventions that apply to all residents will be reviewed and discussed during 9-21-15 Certified Nurse Assistant and Nurses meetings. Annual review of elopement prevention interventions will be completed with all nursing cont...</i></p>	

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F 323	<p>Continued From page 37</p> <p>- "Provide assist of 1 with all transfers." - "Keep bed in lowest position while in bed - check every 2 hours." - "Wears eye glasses - assist with cleaning and putting them on." - "Medicated with Systane [brand name of eye drop] Solution eye drops as ordered." - "Infrared monitor on when resident in bed." That had been discontinued on 5/4/15. *There were no specific interventions related to the falls dated above.</p> <p>2. Review of resident 3's medical record revealed: *She had been admitted on 1/23/14. *She was alert but confused. *Her diagnoses included Alzheimer's (affects memory) disease, dementia (affects memory), constipation, anxiety, high blood pressure, osteoarthritis, and gout (disease causing painful joints).</p> <p>Random observations of resident 3 from 8/11/15 at 8:35 a.m. through 8/12/15 at 1:20 p.m. revealed: *She sat in her lift chair (type of recliner with a mechanical lift) in her room frequently. *Staff assisted her to the dining room in a wheelchair. *She had a concave (specialty mattress with raised edges to help prevent her from rolling out) mattress on her bed. *She used a walker in her room for going to and from the bathroom.</p> <p>Review of resident 3's Fall Follow-up progress notes by nursing revealed on the following dates: *12/19/14 she had a fall with no injury. -She was found sitting on the bathroom floor.</p>	F 323	<p><i>department staff during regularly scheduled department meetings. 9-18-15 CW</i></p>		

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F 323	<p>Continued From page 38</p> <p>-To prevent another fall it stated "nonslip shoes." *7/14/15 she had a fall and hit her head. -She was walking to supper with her walker and staff assistance. -To prevent another fall it stated "use wheelchair to transfer to meals." *7/16/15 she had a fall with no injury. -She was attempting to transfer herself from the bathroom to her bed. -To prevent another fall it stated "resident does have a uti [urinary tract infection] so no ua [urinalysis] chemstrip [test] obtained as she is on antibiotics. Continue to monitor closely and assist as needed with cares, toileting, etc. Tylenol given for temp." *7/30/15 she had a fall and received a skin tear to her left elbow. -She had been found lying on her left side in front of the bed. -To prevent another fall it stated "remind resident to use call light for staff assist."</p> <p>Review of resident 3's 6/16/15 reviewed care plan revealed: *There was no problem area related to falls. *No mention of a history of falls. *There were no interventions related to falls or prevention of falls.</p> <p>3. Review of resident 4's medical record revealed: *He had been admitted on 8/23/12. *His diagnoses included congestive heart failure, diabetes, Alzheimer's disease, osteoarthritis, constipation, dementia, and a history of fractured (broken) ribs. *He was alert with mild confusion and forgetfulness. *He had a 5/22/15 pre-operative history and</p>	F 323			

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F 323	<p>Continued From page 39</p> <p>physical and chest x-ray that showed multiple displaced left rib fractures related to a recent fall.</p> <p>Random observations from 8/10/15 through 8/12/15 revealed he used a walker independently to move around in his room and the hallways.</p> <p>Review of resident 4's Fall Follow-up progress notes by nursing revealed: *9/28/14 he had a fall with abrasions to his left arm and leg. -He had slipped while undressing for bed. -To prevent another fall it stated "resident informed to always wear shoes or gripper socks." *5/19/15 he had a fall and hit his head. -He was in his wife's room and stumbled when he was trying to leave. -To prevent another fall it stated "remind resident to slow down when turning and walking." *7/5/15 he had a fall with no injury. -He said he had slipped out of his recliner. -To prevent another fall it stated "remind resident to call for assistance." *7/19/15 he had a fall with no injury. -He stated he slid off the edge of the bed. -To prevent another fall it stated "encourage resident to slow down and be aware of positioning."</p> <p>Review of resident 4's 6/2/15 reviewed care plan revealed: *He was at a high risk for fall and he had a history of falls. *The last fall was listed as 5/19/15. *There was no mention of his rib fractures related to the fall. *The interventions for falls included: -"Wear non-skid footwear when out of bed." -"Keep call light within reach when in bed."</p>	F 323			

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F 323	<p>Continued From page 40</p> <p>-"[resident's name] ambulates with walker in his room independently. his gait [walking] is unsteady but is able to stabilize self with use of walker. he may require supervision, cueing [reminders], and direction reminders to slow down and use of walker when ambulating outside of his room or outside of the facility. Ensure that he uses his walker when ambulating."</p> <p>-"Announce yourself as you enter the room so as not to startle [resident's name]."</p> <p>-"Uses 4 wheeled walker for ambulation at all times - ensure that he uses it when ambulating."</p> <p>-"Handrails X [times] 2 to bed to assist with bed mobility [moving] and positioning."</p> <p>4. Interview on 8/12/15 at 10:20 a.m. with licensed practical nurse K revealed: *Charge nurses did the Fall Follow-up notes for all falls. *The nurses implemented the interventions to prevent future falls. *Interventions might have included to remind the resident to use the call light or not to leave them unattended. *Appropriate interventions would have depended on the circumstance related to the fall and the resident involved. *If a resident had memory impairment then reminders to use the call light would not be appropriate. *The nurses did not make the changes on the care plan for the interventions related to the fall.</p> <p>Interview on 8/12/15 at 1:30 p.m. with the director of nursing revealed: *Fall interventions should have been appropriate for the resident to prevent future falls. *Sometimes it would have been appropriate to remind the resident to use the call light but not for</p>	F 323			

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F 323	<p>Continued From page 41</p> <p>residents with memory issues. *The care plans should have been updated to reflect appropriate interventions to prevent falls.</p> <p>Review of the provider's May 2008 Fall Prevention policy revealed: **1. Every resident fall is followed by a fall investigation completed by the RN/LPN [registered nurse/licensed practical nurse] in charge of resident care at the time of the fall. The fall investigation involves but is not limited to evaluation of the resident's current medication regimen and/or changes in medications, previous fall history, behavior issues, medical conditions, bowel and bladder habits, cognitive [memory] condition, and environmental factors. The nurse is also required to offer recommendations to prevent further incidents for this resident."</p> <p>Review of the provider's 11/21/06 Accidents, Falls, and Safety Precautions policy included: **1. All residents are assessed for the risk of falling on admission, annually, quarterly with significant change, and as needed based on clinical assessment." **2. Criteria for residents at risk for falling includes: residents who have fallen 2 or greater times in the past 3 months, new residents for the first month, incontinence, disoriented or intermittent confusion, unsteady gait, sensory impairment (vision and/or hearing), medications, and predisposing conditions." **3. An individualized plan of care will be developed and implemented for residents at risk for falling." **8. Call lights and bedside articles are to be kept within reach." **10. Non-skid footwear should be used." **11. Pathways are to remain free of obstacles."</p>	F 323			

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F 323	<p>Continued From page 42</p> <p>*"13. Residents who have fallen will have a urine chemstrip [test] done with their next voiding [urination] to rule out UTI [urinary tract infection]."</p> <p>*"16. Dates of all falls are to be documented on the care plan."</p> <p>Surveyor: 22452</p> <p>B. Based on record review, interview, and policy review, the provider failed to assess and document elopement (leaving facility without staff knowledge) precautions for one of two sampled residents (6) who had attempted to elope. Findings include:</p> <p>1. Review of resident 6's medical record revealed a 4/1/15 admission date.</p> <p>Review of resident 6's 4/2/15 through 6/30/15 nursing notes revealed:</p> <p>*4/2/15 at 2:00 p.m., "Use of walker upon ambulation [walking] about her room and to and from activity and meals. Needs directions and cueing [reminders or prompting] as has stated she feels a bit lost as unable to know where to go or what to do."</p> <p>*4/3/15 at 6:26 a.m., "Resident up wandering times 2. Easily redirected and assisted back to bed."</p> <p>*4/3/15 at 11:15 p.m., "I was in another resident's room assisting them in the bathroom when she walked in. She said she was looking for someone and stood in the doorway. I assisted her out of the room explaining that the person she was looking for was not there and called for a certified nursing assistant [CNA] to come and assist her. She was easily redirected. The CNA found her down the hall in another resident's room. They showed her back to her room and where the bathroom was."</p>	F 323			

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F 323	<p>Continued From page 43</p> <p>*4/4/15 9:30 p.m., "Resident came out into the hall looking for a bathroom. She was easily redirected back into her room and shown where the bathroom was."</p> <p>*4/6/15 at 5:05 a.m., "She was noted to be up a couple times by staff. They showed her where her bathroom was as she could not remember."</p> <p>*4/12/15 at 6:55 a.m., "Resident eloped at 5:30 a.m. Staff walked with resident outside. Resident was fully dressed without her walker and carrying two small bags of belongings. Staff attempted multiple interventions. Tried to redirect and reorient. Resident became more upset and resistant. Took 3 staff to redirect the resident back to facility and room. Resident attempted to elope 2 more times and threw a bottle at the staff. Staff offered to call family and resident stated no. Told the staff she was being held hostage and would not do any good. Resident very upset and refused to talk and refused other suggestions and interventions. Resident was left safe in her room and monitored from a distance and given space. Oncoming staff notified."</p> <p>*4/12/15 at 11:52 a.m., "Resident sat in her recliner this morning. She would not look at the person speaking to her. She kept looking down with her eyes closed. I informed her I had her medicine if she would take it. She did open her eyes and look at me. She then proceeded to take her medications. She has not attempted to leave the facility."</p> <p>*4/12/15 at 1:27 p.m., "Obtained a urine specimen with results positive for leukocytes [indicates infection]. Resident informed of urine test results and doctor's orders and stated she knew she had a bladder infection."</p> <p>*4/12/15 at 5:45 p.m., "Daughter called the facility at 3:30 p.m. She was updated on her event [the resident's] early this morning and the urinary tract</p>	F 323			

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F 323	Continued From page 44 infection and the treatment. She voiced appreciation. She did say her mother has done this in the past looking for her husband. Mom did that in the apartment she was living in. That is why we decided she needed to live in the nursing home." *4/21/15 at 3:58 p.m., "Admission care plan reviewed with resident present as well as various staff and daughter via [by] phone. Discussed possibility of placing a Wanderguard [bracelet that alarms when a resident goes out an alarmed door] device on her if she would attempt to leave the facility. As noted she has tried two times. Recently diagnosed with a urinary tract infection. Noted on her assessment her vision is impaired." *5/3/15 at 12:20 p.m., "A urine sample was obtained and positive for leukocytes. Resident's daughter called facility and was updated on her incident this morning and the diagnosis of urinary tract infection and treatment." *5/5/15 at 4:31 p.m., "Since her admission she has attempted to leave the facility. All three attempts were between the hours of 9:00 p.m. and 6:00 a.m. During the day she is content. A Wanderguard device was placed on her walker as she refused to allow it to be placed on her ankle or wrist. She was given instructions as to why the device was placed, where it will be placed, and how it works. She stated she would rather be dead than wear one of those prison alarms. She told me she would cut it off. After discussing it with her she reluctantly agreed to have it placed on her walker. The device will be on for ninety days and will be determined at that time if she remains an elopement risk." *5/6/15 at 9:41 a.m., "The night nurse reported this morning that she became very upset last evening because of the Wanderguard attached to her walker. She threatened to leave the facility.	F 323			

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F 323	<p>Continued From page 45</p> <p>The night nurse removed the Wanderguard. This morning she has been content and smiling." *5/13/15 at 11:43 a.m., "Resident finished her last dose of Cipro [antibiotic]. A chemstrip urinalysis was done with positive results for leukocytes, blood, and protein." *5/16/15 at 10:49 a.m., "Received call from the doctor and orders obtained for a urinary tract infection. Oral antibiotic therapy begun." *6/7/15 at 10:46 a.m., "Another resident reported she came into her room at 11:00 p.m. last night and asked her if she heard the med talking in the hallway as to where they were going to sleep. She would not leave her room right away and kept talking. Finally she left the room." *6/21/15 at 3:27 p.m., "Daughter called and stated resident's oldest son died. Family members decided to take resident home with them for a week." *6/23/15 at 11:28 a.m., "Due to her diagnosis she is often confused as to what family members are alive and where she is. She will often become more confused in the evenings and look for her husband who has passed away or want to leave and puts on her shoes with still wearing her night clothes." *6/30/15 at 5:49 a.m., "Was awake and dressed by midnight. She was up walking in the halls but did agree to lay down in bed and rest with her clothes on. She was up again by 4:30 a.m."</p> <p>Review of resident 6's 5/5/15 initial wandering assessment guide revealed: *To the question is the resident resistance to being placed in a long-term care facility there was documentation "Voiced dissatisfaction." **"She has attempted to elope three times since her admission on 4/1/15. All three occurred 9:00 p.m. to 6:00 a.m."</p>	F 323			

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F 323	<p>Continued From page 46</p> <p>**"The Wanderguard device was placed on her walker and she became angry with it being placed on her ankle."</p> <p>Review of resident 6's 4/20/15 care plan revealed "Consider Wanderguard to prevent wandering."</p> <p>Interview on 8/11/15 at 2:30 p.m. with the director of nursing regarding resident 6 revealed: *The initial wandering assessment was not completed on 4/1/15 when she was admitted as she was showing no wandering behavior. *She was uncertain why the assessment had not been completed on 4/12/15 when she attempted to elope three times. *She was unsure why the Wanderguard device had not been started on 4/21/15 after it had been discussed in a care plan meeting and the daughter had agreed to it's use. *The Wanderguard device was started on 5/5/15 as the resident was experiencing some respiratory symptoms, and they thought her behavior might change. *She knew the staff did more frequent checks on her with her wandering behavior but did not consistently document them.</p> <p>Review of the provider's June 2014 Wanderguard in Conjunction with Door Alarm policy revealed: **"The Wanderguard system will be utilized to ensure the safety of wandering residents." **"Assessments will be completed on residents who are a risk for wandering at the time of admission. If a resident flags as a wandering risk, a Wanderguard pendant will be put on the resident's ankle or wrist." **"There will be an assessment completed every ninety days on residents who are wearing the Wanderguard pendants."</p>	F 323			

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F 323	Continued From page 47 Review of the provider's November 2002 Elopement Prevention policy and procedure revealed: **"It is the policy of this facility to identify and prevent potential elopement of residents." **"The facility will identify wandering behavior through the utilization [use] of admission, assessment process, and the Minimum Data Set [MDS]." **"Individualized approaches will be developed for each resident to provide a safe environment." **"Assess risk for elopement on admission based on cognitive status and behavior suggesting elopement such as statements about going home or running away." **"Develop an individualized care plan based on assessment, identification of causes, and specific approaches used to provide a safe environment." **"Educate staff regarding elopement policies and procedures during department orientation."	F 323			
F 325 SS=E	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced	F 325			

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F 325	<p>Continued From page 48</p> <p>by: Surveyor: 22452</p> <p>Based on observation, record review, interview, and policy review, the provider failed to ensure physicians' orders were followed for the use of thickened liquids for three of three sampled residents (7, 9, and 10) on thickened liquids. Findings include:</p> <p>1. Observation on 8/11/15 at 11:15 a.m. of resident 7 revealed he: *Was sitting at the diningroom table in his wheelchair. *Had drank three-fourths of a cup of unthickened coffee. *Had a four ounce glass each of honey thickened juice and water in front of him.</p> <p>Interview at that time with certified nursing assistant (CNA) H regarding resident 7 revealed: *She had just sat down to assist him with his meal and had not given him his coffee. *Whoever had put the coffee in front of him should have thickened it to honey consistency. *The kitchen had pre-thickened honey water and juice, and the CNAs did not have to thicken those liquids. *He often coughed at meals, and "It was often a coughing match at meals between him and the other two residents who were on thickened liquids."</p> <p>Review of resident 7's 4/23/15 physician's orders revealed "Honey thickened liquids."</p> <p>Review of a 0.16 ounce of Hormel Thick and Easy instant food and beverage thickener for honey consistency revealed "Add one packet to four ounces of liquid."</p>	F 325	<p>The Director of Nursing and Dietary Services Manager worked together to revise the Thickened Liquids policy. As of 8/31/15, thickened liquids are prepared by dietary staff only for all meals and snacks. Certified nursing assistants and nursing staff no longer prepare thickened liquids. Residents 7, 9 and 10 receive all liquids for snacks and meals that have been prepared by trained dietary staff. Mandatory education provided to all staff on 8/31/15 regarding thickened liquids and dysphagia. Residents and families educated via one on one education on importance of thickened liquids for individuals with dysphagia. Education provided to staff, residents and families (continued...)</p>	9/25/15	

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F 325	<p>Continued From page 49</p> <p>2. Observation on 8/11/15 at 11:25 a.m. of resident 9 revealed: *He was sitting at the diningroom table and CNA I was assisting him to eat his noon meal. *CNA I had assisted him with a four ounce glass of unthickened juice and a four ounce glass of unthickened lemonade. *CNA I was not aware his liquids were to have been thickened to nectar consistency, and she stated "He seemed to do okay." *He was coughing frequently during the meal.</p> <p>Interview on 8/11/15 with an unidentified cook regarding resident 9 revealed: *They did not thicken any of his liquids, because he liked ice in them. *Nursing was to thicken all his liquids but often did not.</p> <p>Review of resident 9's 8/7/15 updated physician's orders revealed "Nectar consistency liquids."</p> <p>Review of a 0.16 ounce of Hormel Thick and Easy instant food and beverage thickener for nectar consistency revealed "Add one packet to four ounces of liquid."</p> <p>Interview on 8/12/15 at 11:15 a.m. with the director of nursing (DON) regarding the above revealed: *She was not aware the CNAs were not thickening their liquids correctly. *The CNAs should have been mixing the liquids according to the directions on the back of the thickener packets. *She was not aware dietary was not doing any thickening of resident 9's liquids. Surveyor: 35237</p>	F 325	<p>regarding the use of straws for individuals using dysphagia and risk of aspiration with use of straws. Care plans for residents 7, 9 and 10 will be updated to reflect current thickened liquid consistency required. Dietary manager and staff responsible for providing appropriate liquid consistency to each resident. Quality assurance completed daily and with each meal pass to ensure appropriateness of consistency. Nursing staff educated regarding use of "fork test" to ensure safety and reduce risk of aspiration pneumonia. Dietary manager and Director of Nursing will work in conjunction to ensure resident safety and appropriately prepared liquids. Care plans will be (continued...)</p>		

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F 325	Continued From page 50 3. Observation and interview on 8/11/15 at 5:15 p.m. of CNA B assisting resident 10 in the dining room revealed: *The resident was sitting in a wheelchair at the table. *She sat to his left and assisted him with eating and drinking. *He had a plate of pureed food and four cups of liquids including: -A chocolate protein shake. -A strawberry supplement. -A cup of cranberry juice. -A cup of water. *He was supposed to get nectar (thicker consistency than regular liquids) thickened liquids. *The cranberry juice was the only liquid that appeared to be thicker than normal. *There were straws in all of the above. *He occasionally coughed after he took a drink. *She stated: -The CNAs thickened the liquids. -All of the liquids should have had one packet of the nectar thickener added and mixed in. -She only put one half of the packet into the chocolate shake. -The water was pre-thickened, and they would not add any extra thickener. -She would go with what the resident preferred for how thick to make the liquids. -Straws were okay to use with residents who needed thickened liquids. Observation on 8/12/15 at 10:00 a.m. of resident 10 in his room revealed: *He was sitting in his recliner resting. *There were liquids on top of his dresser by his bed that included:	F 325	updated to reflect any new orders or interventions on an as needed basis and by Director of Nursing or Minimum Data Set nurses. Charge nurse will report to the Director of Nursing 1 x week for 6 months if thickened liquids are appropriately mixed. Director of Nursing will report findings to the Quality Assurance Performance Improvement committee quarterly for 6 months. Quality assurance board will be completed daily for three months by charge nurses on three separate drinks/days. Quality assurance board was created for documentation of audits and will occur daily for three months and weekly for eight months beginning on 9/17/15. CW 9-16-15		

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F 325	<p>Continued From page 51</p> <ul style="list-style-type: none"> -A clear plastic water mug with a lid and a straw that had water in it. -A small cup of water. -A cup of a dark liquid that appeared to be prune juice with a straw in it. -A coffee mug of a dark liquid that appeared thicker than the others. <p>Observation and interview at 10:15 a.m. with CNA E in resident 10's room revealed:</p> <ul style="list-style-type: none"> *He should have had nectar thickened liquids. *The coffee mug had water and prune juice mixed together. *The water mug had water that was thinner than nectar consistency. *The CNAs thickened the resident's liquids in his room. -They used the packets of thickener to make it nectar consistency. *When she mixed his water she would have added the water, thickener, ice, and stirred it. -She agreed adding the ice would have made it thinner than nectar consistency when it melted. -She stated the resident did cough when he drank if his liquids were not thick enough. -She felt it was okay for a resident to use straws with the thickened liquids. <p>Review of resident 10's medical record revealed:</p> <ul style="list-style-type: none"> *His last signed 7/15/15 physician's orders were for nectar consistency liquids. *He required assistance with eating and drinking. *He had a history of swallowing problems that included coughing and choking. <p>4. Interview on 8/12/15 at 11:20 a.m. with the director of nursing revealed:</p> <ul style="list-style-type: none"> *She was unsure if it was okay to use straws for residents that required thickened liquids. 	F 325		

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F 325	Continued From page 52 *She thought if a resident had a swallowing problem the thickened liquids were intended to slow down the liquid, and the straw would have made it faster therefore increasing the risk to the resident. *She agreed there was a potential risk to those residents if the liquids were not mixed to the correct consistency. *They had no specific policy to address straws in thickened liquids. Review of the provider's June 2008 Food/Fluid Thickening policy revealed: *"Residents with poor oral motor control or poor airway protection will be provided with thickened liquids as recommended by the speech language pathologist (SLP) or charge nurse and ordered by the physician." *"The following consistencies may be ordered based on individual needs:" -"THIN...DO NOT ADD THICKENER." -"NECTAR-LIKE - thickened to nectar consistency such as apricot or peach nectar..." -"HONEY-LIKE - thickened to honey consistency..." -"SPOON-THICK - thickened to pudding consistency..." -"Individual thickener packets are available with instructions for nursing staff to thicken liquids as ordered by physician."	F 325		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371	The stove hood and hood panels were cleaned thoroughly. Bids are being obtained for the replacement of the hood panels. Cleaning of the stove hood and hood panels will be added to the (cont...)	9/25/15

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F 371	<p>Continued From page 53 under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation and interview, the provider failed to ensure sanitary conditions in the kitchen were maintained for the following: *Five of five stove hood panels. *The front of two cupboards had the laminate chipped away exposing raw wood *The trim for five cupboards had been pulled away exposing raw wood. Findings include:</p> <p>1. Observation on 8/10/15 at 3:45 p.m. and random observations on 8/11/15 from 8:15 a.m. through 4:00 p.m. revealed the hood panels above the stove had: *Dark brown stains throughout all five panels and a large amount of gray debris on the back of a white sign beside the hood panels. -The posting on the hood panels stated it had last been cleaned on 3/15/15. *The front of two cupboards had laminate missing creating an absorbent non-cleanable surface. *The trim for five cupboards had pulled away creating an absorbent non-cleanable surface.</p> <p>Interview on 8/11/15 at 11:30 a.m. with the dietary manager confirmed the above findings. She was unaware how often the hood had been cleaned. Interview on 8/11/15 at 4:00 p.m. with the administrator confirmed the above findings.</p>	F 371	<p>monthly Dietary cleaning checklist. A policy was created to explain the Dietary cleaning checklist. Dietary Manager will monitor the completion of the monthly cleaning of the stove hood and hood panels for 1 year and report the findings to the Quality Assurance Performance Improvement quarterly meetings for 1 year. Dakota Woodworking has been contacted and has come to the Nursing Home kitchen on 8/28/15 to measure current cabinet fronts. Dakota Woodworking will be replacing the cabinet fronts and cabinet trim with 2 mil laminate. Dietary manager will monitor the cabinets 1 x month for 1 year to make sure they always have a cleanable surface. The Dietary Manager will report the findings to the Quality (continued....)</p>	

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NAME OF PROVIDER OR SUPPLIER AVERA EUREKA HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 J AVENUE POST OFFICE BOX 40 EUREKA, SD 57437		
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F 371	Continued From page 54 A policy had been requested for sanitation in the dietary department. None was provided by the end of the survey.	F 371	Assurance Performance Improvement Committee quarterly meetings for 1 year.		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, interview, and policy review, the provider failed to ensure the control and accountability (of Tramadol (government-controlled narcotic-like pain medication) for one of one sampled resident (14). Findings include:	F 425	Documentation for administration of government-controlled narcotic-like pain medications will be accounted for accurately by licensed nurses. Resident 14's medication administration record was amended to reflect accurate documentation for administration of Tramadol. Controlled Narcotics policy was revised to reflect the administration and documentation process. Nurse will administer the drug, document appropriately in the electronic medication administration record and also document on the drug card the date, time and initials of the nurse administering the (continued)	9/2/15	

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F 425	Continued From page 55 1. Observation on 8/12/15 at 9:30 a.m. of resident 14's Tramadol in the medication cart revealed: *There was documentation the medication cassette had been filled by the pharmacy on 6/11/15 with thirty-one pills. *There were five pills left in the cassette. Review of resident 14's 6/11/15 through 8/12/15 medication administration records (MAR) and as needed (PRN) records revealed: *There was documentation she had received twenty-three PRN doses during that time frame. *There was a discrepancy (difference) of three pills from what had been sent from the pharmacy and for what had been documented as administered to the resident. Interview on 8/12/15 at 10:30 a.m. with the director of nursing regarding resident 14 revealed she: *Confirmed there was a discrepancy of three pills from what had been sent from the pharmacy and for what had been documented as administered to the resident. *Thought maybe the nurses had given her a Tramadol and had forgotten to document it. Review of the provider's May 2013 Administration of Medication policy revealed "The nurse administering the medication must initial the residents' medication administration record on the appropriate line and date."	F 425	medication. Education was completed via e-mail communication to all nurses on 9/2/15 to document administration of controlled narcotic and narcotic-like pain medications with process outlined in revised policy. Quality assurance will be achieved through monthly consultant pharmacist audits or by the Director of Nursing in the pharmacist's absence. All discrepancies will be reported immediately to Director of Nursing and/or Administrator. Director of Nursing will report pharmacist audit findings to the Quality Assurance Performance Improvement committee quarterly for one year.	
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	F 441	All residents on controlled and narcotic-like pain medications will be periodically audited by consultant pharmacist or by Director of Nursing. Audit log will be maintained by Director of Nursing. 9-16-15 CW	

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F 441	<p>Continued From page 56 to help prevent the development and transmission 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: 32572 Based on observation, interview, record review, and policy review, the provider failed to ensure an</p>	F 441	<p>Infection Control policy developed to guide actions to investigate, control and prevent infections within the facility. Mandatory in-service was completed 8/31/15 on current evidence based practice detection and management of UTI's for all nurses. Infection control nurse will attend Infection Control conference October 1-2, 2015, to promote evidence based practice implementation at the facility. She will share the information with nursing staff at an October 2015 department meeting. Urinary tract infection rates reviewed and new policy will be implemented by 9/25/15 after review with Medical Director, Consultant Pharmacist and Director of Nursing. Urinary tract infection policy will exist to (continued.....)</p>	9/25/15	

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F 441	<p>Continued From page 57</p> <p>infection control program had been implemented appropriately for the treatment of asymptomatic (no symptoms) urinary tract infections (UTI) for 8 of 12 sampled residents (1, 2, 3, 4, 5, 6, 8, and 11). Findings include:</p> <p>Surveyor: 35237 1. Review of the provider's 11/21/06 Accidents, Falls, and Safety Precautions policy revealed "Residents who have fallen will have a urine chemstrip done with their next voiding [urinating] to rule out UTI."</p> <p>Surveyor: 32572 2. Review of resident 2's medical record revealed: *She had a history of falls that had occurred on 10/7/14, 2/17/15, and 6/21/15. -After those falls a chemstrip UA (testing of urine for infection) had been completed. No symptoms (pain and burning with urination, unable to urinate, strong urine odor, cloudy urine) of UTI had been present.</p> <p>3. Review of resident 5's medical record revealed: *She had a history of falls that had occurred on 11/28/14, 12/16/14, 1/19/15, 1/29/15, 2/15/15, and 3/5/15. *After the above falls a chemstrip UA had been completed.</p> <p>Review of the nursing notes revealed no symptoms of UTI had been present.</p> <p>4. Review of resident 8's medical record revealed: *She had a history of falls and one had occurred on 3/8/15.</p>	F 441	<p>ensure maintenance of current evidence based practice for treatment of suspected urinary tract infections and to provide guidelines for Chemstrip analysis use with a specified set of assessment criteria to prevent overuse of antibiotic therapy in resident population. Accidents, Falls and Safety Precautions policy revised to remove "Residents who have fallen will have a urine chemstrip done with their next voiding to rule out UTI." Policy updates and education to nursing staff is the responsibility of the Director of Nursing and will be completed by 9/25/15. Ongoing infection control education will be provided on an annual basis for all nurses and also at orientation. Quality assurance of policy implementation will (continued....)</p> <p style="text-align: right;">9-14-15 CW</p>	

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F 441	<p>Continued From page 58</p> <p>*She had been on preventative antibiotics due to a history of UTIs. *She had been placed on a different antibiotic after the fall.</p> <p>Review of the nursing notes revealed no symptoms had been present for change in antibiotic therapy.</p> <p>5. Review of resident 11's medical record revealed: *She had been treated for seven UTIs since July 2014 with the last UTI on 7/6/15. *The physician's order "Encourage fluids" had been discontinued on 7/11/15.</p> <p>Surveyor: 22452</p> <p>6. Review of resident 6's 4/6/15 through 6/6/15 resident's notes revealed: *4/6/15 at 5:05 a.m., "She was noted to be up a couple of times by staff. They showed her where her bathroom was as she could not remember. Resident was incontinent of urine and her pull-up [disposable undergarment] was wet so staff assisted her in changing it and with cares. She had no complaints and no problems noted." *4/12/15 at 6:55 a.m., "Resident eloped at 5:30 a.m. Staff walked with resident outside. Resident was fully dressed without her walker and carrying two small bags of belongings. Staff attempted multiple interventions. Tried to redirect and reorient. Resident became more upset and resistant. Took 3 staff to redirect the resident back to facility and room. Resident attempted to elope 2 more times and threw a bottle at the staff. Staff offered to call family and resident stated no. Told the staff she was being held hostage and would not do any good. Resident very upset and refused to talk and refused other suggestions and</p>	F 441	<p>be reviewed monthly by the Director of Nursing and findings will be reported to the Quality Assurance Performance Improvement committee quarterly meetings for 6 months.</p> <p><i>Review of protocol was completed with Director of Nursing and Medical Director regarding residents with symptomatic and asymptomatic urinary tract infections. A policy has been developed for Urinary Tract Infection protocol. The new policy addresses prevention, treatment, recurrence/re-infection, and antibiotic resistance.</i></p> <p><i>Both the "Accidents, Falls, and Safety Precautions" policy and "Urinary Tract Infection" policy address signs and symptoms of possible infection. Two or more signs and/or symptoms must be present before doing a Chemstrip. When any resident falls, a Chemstrip will not be done unless there are additional signs/symptoms of infection.</i></p>	

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F 441	Continued From page 59 interventions. Resident was left safe in her room and monitored from a distance and given space. Oncoming staff notified." *4/12/15 at 1:27 p.m., "Obtained a urine sample at 12:10 p.m. with results positive for leukocytes [usually indicates infection in the urine]. Doctor was notified of incident at 5:30 a.m. and the urine results. Received a telephone order for Cipro [antibiotic] 500 milligrams [mg] twice a day for ten days then repeat a urine chemstrip in two weeks on 4/27/15. Diagnosis of urinary tract infection. Doctor states resident has a history of urinary tract infections. At 12:30 p.m. the resident was notified and stated she knew she had a bladder infection. She pointed to her lower abdomen and said she had pain." *4/12/15 at 10:16 p.m., "Resident had a fall at 8:30 p.m. Resident currently being treated for a urinary tract infection." *5/3/15 at 12:20 p.m., "She was laying at the foot of her bed so the sun would shine on her. See fall intervention. At 9:30 a.m. a urine sample was obtained and was positive for leukocytes. She said she had not had any burning with voiding but has had bladder pain on and off for the last couple of days. Received an order for Cipro 500 mg twice a day for ten days and then repeat a urine chemstrip in ten days." *5/13/15 at 11:43 a.m., "She finished her last dose of Cipro 500 mg last evening at 5:00 p.m. A chemstrip urine was done this morning. Her urine was clear and yellow with positive results of leukocytes, blood, and protein. Doctor ordered a clean catch urine with culture and sensitivity [determines which antibiotic to treat infection with]." *5/16/15 at 10:49 a.m., "Doctor's order to start Cefadroxil [antibiotic] 500 mg twice a day for ten days and repeat urine chemstrip on 5/27/15."	F 441	Residents' 1, 2, 3, 4, 5, 6, 8, 11 care plans have been updated to reflect current urinary tract infection prevention and treatment information along with fall and elopement prevention interventions as appropriate. 9-16-15 CW		

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F 441	<p>Continued From page 60</p> <p>*5/27/15 at 1:39 p.m., "Repeat urine chemstrip done. Doctor informed and no change in orders other than to encourage fluids."</p> <p>*6/6/15 1:28 p.m., "When giving her medications she complained of burning with voiding and frequency. Urine sample results were within normal limits. Resident was informed of results and encouraged to drink large amounts of water. She replied she always drinks lots of water."</p> <p>Interview on 8/12/15 at 11:00 a.m. with the director of nursing (DON) regarding resident 6 revealed:</p> <p>*They had tried to educate her on her hygiene practices with wiping herself after toileting due to her frequent infections.</p> <p>*She was independent with toileting and changing her soiled undergarments and refused staff intervention.</p> <p>*It was their protocol to check a urine chemstrip after she had fallen on 4/12/15 and 5/3/15. She had really not been complaining of urinary symptoms prior to the falls.</p> <p>Surveyor: 35237</p> <p>7. Review of resident 1's medical record revealed:</p> <p>*She had a fall on 7/8/15 trying to help her roommate get a drink.</p> <p>-After that fall she had a chemstrip UA done and was started on antibiotics for a UTI.</p> <p>-There were no documented symptoms of infection.</p> <p>*After being treated with an antibiotic she had a follow-up chemstrip UA done on 7/15/15 and was started on a different antibiotic.</p> <p>-There were no documented symptoms of infection.</p>	F 441		

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F 441	<p>Continued From page 61</p> <p>8. Review of resident 3's medical record revealed: *She had a history of falls that had occurred on 12/19/14, 7/14/15, 7/16/15, and 7/30/15. *After those falls she had chemstrip UAs done and was treated with antibiotics on 7/15/15 for a UTI. -There were no documented symptoms of infection.</p> <p>9. Review of resident 4's medical record revealed: *He had a history of falls that had occurred on 9/28/14, 5/19/15, 7/5/15, and 7/19/15. *After those falls he had chemstrip UAs done. *He was treated with antibiotics on 7/5/15 for ten days for a UTI and had a follow-up chemstrip UA done on 7/15/15. *He was treated with antibiotics on 7/20/15 for 10 days with a different antibiotic and had a follow-up chemstrip UA done on 8/3/15. *There were no documented symptoms of infections.</p> <p>10. Interview on 8/12/15 at 9:45 a.m. with LPN/infection control nurse K revealed: *She had worked at the facility for fifteen years. *She did not have specific training for infection control but had been to a few conferences in the past. *She usually worked on infection control for about one hour each week since she worked as a charge nurse most of the time. -During that one hour she completed infection control report forms for the quality assurance committee and did staff and resident immunizations as needed. *She did not do any infection control training with the staff.</p>	F 441			

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F 441	<p>Continued From page 62</p> <ul style="list-style-type: none"> *She completed infection control report forms for all the UTIs and upper respiratory infections monthly. *She did not complete forms for any other type of infections. *Tracking of infections was done by the local hospital as part of quality assurance. -She was not a part of the tracking or trending of infections. -She thought infections were discussed as part of quality assurance performance improvement (QAPI) meetings at the facility. *Chemstrip UA tests were a standing order. *They automatically did chemstrip UA tests on any resident that had a fall. *It was their policy and the medical director wanted chemstrip UAs done after all falls. *They found a lot of UTI's doing the chemstrip UAs. *If a chemstrip was positive the physician was updated, and the resident was almost always treated with antibiotics. *She tracked cultures (test to show specific germs), but not many cultures were ordered. *Follow-up UAs were done on almost all UTIs. *The physicians were ordering antibiotics for UTIs based on the chemstrip UA. *She agreed the resident's might not necessarily need antibiotics every time. *She agreed some residents had been treated for UTIs and had no symptoms of infection. *She had heard of the risk of multi-drug resistant organisms (infections that were hard to treat ,because they were resistant to most antibiotics) due to overuse of antibiotics. *She thought the local hospital recommended having at least two symptoms of infection prior to treating with an antibiotic. *She confirmed there could have been false 	F 441			

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F 441	<p>Continued From page 63 positives with the chemstrip UAs.</p> <p>Interview on 8/12/15 at 11:45 a.m. with the medical director revealed: *There were residents with chronic or repeat UTIs. *She thought there were more UTIs in the summer due to lack of hydration. *The provider did chemstrip UAs after all falls. *When asked if a chemstrip UA should have been done after every fall she stated it depended on the resident. If they had been confused then it could be done, but if they had a trip or slip out of the bed they might not have needed one. *When asked about treating UTIs without active symptoms of infections her response was a question back to the surveyors if they should not treat asymptomatic UTIs. *She stated maybe they could have changed the policy for chemstrip UA after all falls. *She agreed there could have been false positive or negative results with the chemstrip UAs. *She agreed they might not have been true infections for those based on the chemstrip UA results. *She stated they would have done cultures if the resident had persistent abnormal chemstrip UAs. *She agreed there was potential for contamination since they used a clean catch (method for collecting urine in a cup) technique for most of the chemstrip UAs. *She attended QAPI meetings. *They discussed the number of infections at QAPI.</p> <p>Interview on 8/12/15 at 1:30 p.m. with the director of nursing revealed: *They did chemstrip UA tests after all falls per their policy.</p>	F 441		

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F 441	<p>Continued From page 64</p> <p>-She thought that had started as a correction to a past survey deficiency several years ago.</p> <p>-She felt they caught a lot of UTIs doing UAs following falls.</p> <p>-She confirmed they might not need to do a chemstrip UA if there were no other symptoms of infection other than a fall.</p> <p>*It was standard procedure for them to do follow-up UAs following antibiotic treatment for UTIs.</p> <p>*They performed mostly clean catch UAs.</p> <p>-There was a risk of contamination for clean catch UAs, therefore false positive results could have occurred.</p> <p>*She agreed there could be false positive results with the chemstrip UAs in general.</p> <p>*She agreed a positive chemstrip UA did not necessarily mean the resident had an infection.</p> <p>*Infection control training was done with all employees after they were hired, and the nursing assistants had additional training.</p> <p>*She helped track the antibiotics that were given at the end of every month.</p> <p>-She had not noticed any real trends related to infections.</p> <p>*She had noticed they had more UTIs recently than in past years, and they had increased in July 2015.</p> <p>*She stated she had heard of not treating UTIs unless there were two or more signs or symptoms of infection.</p> <p>*She agreed they had been treating some resident's for UTIs that had no symptoms of infection documented.</p> <p>Review of the provider's March 2009 POCT (point of care testing) Urinalysis Reagent Dipstix policy that was what they used for the chemstrip UAs revealed:</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER AVERA EUREKA HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 202 J AVENUE POST OFFICE BOX 40 EUREKA, SD 57437		
(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 65</p> <p>***UA Dipstix analysis should be performed within 2 hrs [hours] of collections or placed in the refrigerator.</p> <p>***Strict compliance with directions is required to insure reliability of the strips. When stored in the original container at room temperature...</p> <p>***Read the test results carefully at the specified time intervals, against a white background in a good light with the test area held near the appropriate color chart on the bottle.</p> <p>*For leukocytes (white blood cells in the urine): -Positive results should have been verified with a microscope. -False negatives could have occurred when the resident was taking cephalexin, gentamicin, or tetracycline (types of antibiotics) or had elevated glucose (sugar) and protein concentrations. -False positives could have occurred due to vaginal contaminants (improper cleaning prior to the test) or drugs or foods that colored the urine red.</p> <p>Review of the provider's January 2006 Infection Control Program policy revealed "3. An effective Infection Control program is the responsibility of the Medical/Dental Staff and all employees and volunteers of [name of facility]."</p> <p>Review of the provider's January 2006 Infection/Transfusion Committee Objectives revealed: ***2. To review, added or approve policies submitted for the prevention and control of infections in patients, residents, clients and employees." ***3. To analyze reports of all infections occurring in the hospital and alternative [name of facility] settings, among residents, patients, clients and staff, and where necessary approve or request</p>	F 441		

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F 441	<p>Continued From page 66</p> <p>epidemiological [study of diseases] studies to determine mode of transmission to prevent recurrence of infectious conditions." ***8. To review and evaluate all aseptic, isolation, and sanitation techniques employed in the healthcare center."</p> <p>Review of the provider's January 2013 Infection Surveillance Report policy included: ***5. Infection rates for targeted surveillance are computed using the following definitions and formulas:" ***b. Symptomatic Urinary Tract Infections (in both catheterized and uncatheterized residents) will be computed at a rate of infections per 1000 resident days. Each infection must meet one of the following criteria: -1. Physician written diagnosis of UTI with at least one of the following: positive urine culture with no > [greater than] 2 uropathogens [germ in urine], signs and symptoms of infections, fever (> 38 degrees C) or chills, new or increased burning pain on urination, frequency or urgency, new flank pain, suprapubic [lower abdomen] pain or tenderness, change in character of urine, worsening of mental or functional status (may be new or increased incontinence). -2. Resident experiences at least two of the above criteria and physician institutes appropriate antimicrobial [anti-germ] therapy. The request for antibiotic therapy should include the reporting of symptoms, to ensure that unnecessary antibiotics are not ordered. -3. Catheterized resident experiences a combination of fever and worsening mental or functional status."</p> <p>Review of the provider's January 2013 Monthly Report of Healthcare Associated Pathogens and</p>	F 441		

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F 441	Continued From page 67 Sites policy revealed "2. Culturing of possible infections is encouraged to monitor for potential patterns in organisms, to document actual infection data, and to augment antibiotic stewardship efforts in the LTC [long term care] setting."	F 441			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435078	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/11/2015
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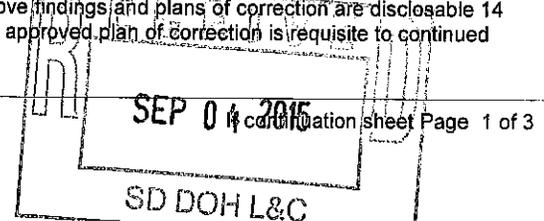
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K 000	<p>INITIAL COMMENTS</p> <p>A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 08/11/15. Avera Eureka Health Care Center was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of the deficiency identified at K050, K062, K064, and K069 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	<p><i>Addendums noted with an asterisk per 9/10/15 telephone to facility administrator. CH/sook/JS</i></p>	
K 050 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the provider failed to ensure all staff were familiar with fire drill procedures. Five randomly observed residents were not relocated to a point of safety during the fire drill. Findings include:</p> <p>1. Observation at 12:30 p.m. on 8/11/15 revealed the fire drill was held in resident room 107 in the</p>	K 050	<p>A mandatory inservice was held on 8/31/15 for all staff. The fire drill procedure was reviewed with all staff emphasizing that residents must be kept behind the fire doors away from the fire. A quiz was given over the content of the presentation and reviewed with all staff. Plant Operations will continue with one fire drill each month at least quarterly on each shift and will report findings from the fire drill to the Performance Improvement Committee quarterly for one year.</p>	8/31/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Carmen Weber</i>	TITLE <i>Administrator</i>	(X6) DATE <i>9-2-15</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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K 050	Continued From page 1 central building smoke compartment. At the conclusion of the drill it was discovered that five residents were observed still located in the day room of that smoke compartment. They had not been relocated to a smoke tight room or outside the smoke compartment during the drill. The maintenance supervisor correctly pointed out that condition during the fire drill review with staff. Interview with the maintenance supervisor at 2:00 p.m. on 8/11/15 revealed the staff responding to the drill should have relocated the residents to a point of safety.	K 050		
K 069 SS=B	The deficiency had the potential to affect 100% of residents located in the smoke compartment. 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: Based on record review and interview, the provider failed to connect the kitchen range hood extinguishing system in accordance with National Fire Protection Association 96. Findings include: 1. Record review on 8/11/15 at 2:15 p.m. of the range hood extinguishing system inspection report dated 4/29/15 revealed the stove gas supply valve did not shut off the fuel to the stove. It was also noted the hood did not shut down. Interview with the maintenance supervisor at 2:30 p.m. revealed the contractor would need to access the attic space above the kitchen to correct those items. The deficiency affected two of several	K 069	The range hood and all attached equipment was serviced on 9/1/15 by a new ansul company, Dakota Fire Equipment. [REDACTED] *CH/5000H/155 [REDACTED] [REDACTED] Plant Operations Manager will monitor the maintenance of the ansul system so that it is completed semi-annually for one year. Plant Operations Manager will report the findings to the Quality Assurance Performance Improvement committee quarterly for 1 year.	9/1/15

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K 069	Continued From page 2 requirements for protecting cooking facilities.	K 069			

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435078	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	DATE SURVEY COMPLETE: 8/11/2015
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NAME OF PROVIDER OR SUPPLIER avera eureka health care center	STREET ADDRESS, CITY, STATE, ZIP CODE 202 J AVENUE POST OFFICE BOX 40 EUREKA, SD
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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K 062

NFPA 101 LIFE SAFETY CODE STANDARD

Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5

This STANDARD is not met as evidenced by:

Based on record review, observation, and interview, the provider failed to ensure the automatic sprinkler system was maintained in accordance with the National Fire Protection Association (NFPA) 25 (sprinkler replacement and hydraulic information). Findings include:

1. Record review at 12:45 p.m. on 8/11/15 of the provider's automatic sprinkler system inspection report dated 4/29/15 revealed two dry HSW heads (one in the kitchen walk-in cooler and one in the kitchen walk-in freezer) were noted to be corroded and over ten years old that needed replacement
2. Observation at 1:15 p.m. on 8/11/15 of the provider's automatic sprinkler system revealed there was not a hydraulic information hard sign located at the riser for the sprinkler system

Interview with the maintenance supervisor at 2:30 p.m. on 8/11/15 confirmed those findings.

The deficiency affected two of numerous requirements for the fire sprinkler system

K 064

NFPA 101 LIFE SAFETY CODE STANDARD

Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10

This STANDARD is not met as evidenced by:

Based on record review and interview, the provider failed to ensure fire extinguishers were maintained in accordance with the National Fire Protection Association (NFPA) 10. Two extinguishers (family room and kitchen) failed their annual inspection. Findings include:

1. Record review at 2:00 p.m. on 8/11/15 of the provider's extinguisher report dated 4/29/15 revealed the 5# ABC fire extinguisher in the family room (2002 year of manufacture) and the 6L K type fire extinguisher in the kitchen (2009 year of manufacture) needed the 12 year hydrostatic test and the 6 year hydrostatic test performed, respectively.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435078	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	DATE SURVEY COMPLETE: 8/11/2015
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
K 064	<p>Continued From Page 1</p> <p>Interview with the maintenance supervisor at 2:30 p.m. on 8/11/15 confirmed those findings.</p> <p>The deficiency affected two of numerous requirements for fire extinguishers</p>		

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S 000	Initial Comments Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 8/10/15 through 8/12/15. Avera Eureka Health Care Center was found not in compliance with the following requirement: S165, S206 and S322.	S 000		
S 165	44:04:02:17 OCCUPANT PROTECTION Each licensed health care facility covered by this article must be constructed, arranged, equipped, maintained, and operated to avoid injury or danger to the occupants. The extent and complexity of occupant protection precautions is determined by the services offered and the physical needs of the... residents admitted to the facility. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 22452 Based on observation, interview, and policy review, the provider failed to ensure the front exit door was alarmed or attended on one of two days (8/11/15). Findings include: 1. Observation on 8/11/15 at 6:00 p.m. when the surveyors exited the building for the day revealed: *The front entrance door was unattended and unalarmed. *The alarm panel at the nurses station was colored yellow for the front door indicating the alarm was shut off. *There were four randomly observed residents sitting in wheelchairs in the day room across from	S 165	A mandatory inservice was held for all staff and staff were told that the front door alarm is never to be shut off for any reason because it is an unattended entrance and that all staff is to respond immediately to door alarms when they begin sounding and that they are not to shut off the door alarm without checking the door and determining who has entered or exited the door that is alarming. A presentation on the door alarm system was also completed with all staff to ensure their understanding of what the green, yellow, and red lights on the door alarm system indicate. Administrator will monitor the door alarm panel 1 x week to ensure that the (continued.....)	8/31/15

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

TITLE

(X8) DATE

Carmen Weber

Administrator

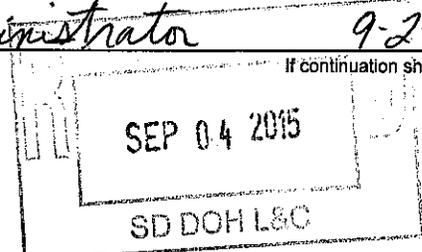
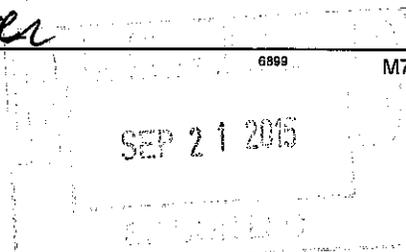
9-2-15

STATE FORM

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If continuation sheet 1 of 5



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10618	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2015
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S 165	Continued From page 1 the door. *There were four randomly observed residents sitting on the patio just outside the front door. Interview on 8/12/15 at 3:00 p.m. with the administrator regarding the above findings revealed the: *Front exit door should have been alarmed if no one was at the nurses station. *Yellow light on the alarm panel for the front door would mean the alarm was not turned on. Review of the provider's November 2002 Elopement Prevention policy and procedure revealed: **Assure that all door alarms are activated [working]." **Assure all staff is to respond to alarms immediately."	S 165	front door alarm is always activated. Administrator will report the findings to the Quality Assurance Performance Improvement Committee quarterly meetings for 1 year. <i>Mandatory inservice was held on 8/31/15 CW 9-16-15</i>	
S 206	44:04:04:05 PERSONNEL-TRAINING The facility must have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs must cover the required subjects annually. These programs must include the following subjects: (1) Fire prevention and response. The facility must conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills must be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) ...Resident rights; (7) Confidentiality of...resident information;	S 206	Employee B is no longer employed at the facility. Employee C will complete all orientation lessons and due mandatory education before she can work on the floor. All managers were educated that every new employee must complete orientation (continued.....)	9/21/15

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S 206	<p>Continued From page 2</p> <p>(8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of...residents with unique needs; and (10) Dining assistance, nutritional risks , and hydration needs of...residents.</p> <p>...Additional personnel education shall be based on facility identified needs.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32572 Based on educational transcript review and interview, the provider failed to conduct or ensure orientation training had been completed for two of five sampled employees (A and B). Findings include:</p> <p>1. Review of employees A and B's personnel records revealed: *Employee A had been hired on 4/13/15 and had not completed the orientation training program. *Employee B had been hired on 7/8/15 and had not completed any of the orientation training program.</p> <p>Interview on 8/12/15 at 2:15 p.m. with the director of nursing confirmed the above employees educational transcripts had no documentation the orientation training had been completed. She had been unsure if they had completed the orientation program.</p> <p>Review of the provider's undated Resident Information booklet that is given to all new admissions revealed: *Our staff is trained to perform many different nursing services."</p>	S 206	<p>and all orientation lessons before they can work in their respective departments. After employee completes the orientation, the manager must confirm all lessons for orientation are complete by checking the employee's transcript on the Healthstream program before they can begin any other training with the employee. Administrator will check new employee transcripts 1 x month for 1 year to make sure all new employees have completed mandatory education before any other training began. Administrator will report findings to the Quality Assurance Performance Improvement Committee quarterly for 1 year.</p> <p><i>Mandatory education was done for the managers on 9-1-15 during Daily Line Up. Employee A has worked at the facility since 9-15-03. Employee B is who was hired</i></p>	

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S 206	Continued From page 3 *This training begins when staff members are hired and continues throughout their employment."	S 206	<i>on 4-13-15 and Employee C on 7-8-15. Employees were referred to wrong on the original plan of correction. 9-16-15 CW</i>	8/31/15
S 322	<p>44:04:08:04.01 CONTROL AND ACCOUNTABILITY OF MEDICATIONS</p> <p>Written authorization by the attending physician must be secured for the release of any medication to a...resident upon discharge or transfer. The release of medication must be documented in the...resident's record, indicating quantity, drug name, and strength.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32572 Based on record review and interview, the provider failed to ensure the accountability of medications for one of one sampled discharged resident (13). Findings include:</p> <p>1. Review of resident 13's electronic and paper medical record revealed no documentation of the medications that had been sent home with the resident.</p> <p>Interview on 8/12/15 at 11:15 a.m. with the director of nursing confirmed the above findings. She stated documenting "the name of the medication, Rx [prescription] number, and the number of medications" sent home had been "the facility standard of practice." The facility did not have a policy on discharge of medications to</p>	S 322	<p>Resident 13's electronic chart was amended to include documentation of medications that were sent home with the resident. Education was provided to all nurses on the requirement to count and document all medications that are sent home with a resident. All new nursing staff upon hire will receive education from Director of Nursing regarding documentation of medications when sending a resident home. Nurses will be re-educated at least once annually during monthly department meetings facilitated by the Director of Nursing. Quality Assurance will occur through charge nurse and Director of (continued.....)</p>	

South Dakota Department of Health

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 322	Continued From page 4 home.	S 322	<p>Nursing reviewing charting prior to any resident being discharged home. Director of Nursing will review charts of residents discharged to home to ensure documentation of medications that were sent home with the resident is present in the chart and will report findings to the Quality Assurance Performance Improvement committee quarterly for 6 months.</p> <p><i>Director of Nursing will review all charts of residents discharged to home. Residents discharged elsewhere are unlikely to have any medications sent with the resident.</i> 9-16-15 <i>CW</i></p>	