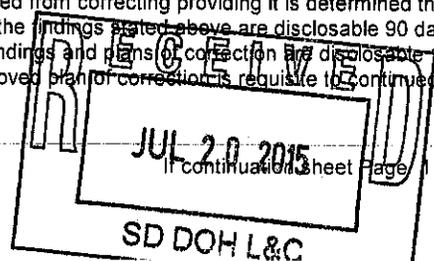


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F 000	INITIAL COMMENTS Surveyor: 34030 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/22/15 to 6/24/15. Oakview Terrace was found not in compliance with the following requirements: F241, F280, F325, F431, and F441.	F 000	<i>Addendums noted with an asterisk per 8/5/15 email from facility DON. SW/SMH/JS</i>	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based one observation, interview, record review, and policy review, the provider failed to ensure *Comments regarding one of one sampled resident (6) with cognitive impairment (memory loss) was done in a dignified manner by one of one certified nursing assistant (CNA) (B). *Transfer belts had been removed from three of three sampled residents (6, 7, and 8) and several randomly observed residents. Findings include: 1. Review of resident 6's medical record revealed: *An admission date of 4/2/15. *Diagnoses of Alzheimers (memory loss), cellulitis (infection) in the right leg, and osteoarthritis (swollen and painful joints) in both of her knees. *She was dependent upon staff to assist her with	F 241	A new policy entitled "Dignity" was drafted/approved by the Social Worker on 7/10/15. Policy includes definition of dignity and what constitutes respect. Policy directs staff to speak respectfully to residents and to refrain from resident care practices that are demeaning. Staff-specific education was completed by the DON with C.N.A. (B) on 7/10/15 regarding verbalizations and 7/14/15 regarding removing gait belts. Education consisted of appropriate verbal interactions with residents and removal of gait belts after use. Education was completed by the DON with C.N.A. (I) and C.N.A. (K) on 7/13/15 and with C.N.A. (A) on 7/14/15 regarding removing gait belts. Education consisted of removal of gait belts after use. C.N.A. (J) resigned with last shift on 6-30-15. Education of all facility staff occurred on 7/21/15. Education was completed by Social Worker and DON. Education consisted of review of Dignity, and Gait Belt Requirement and Proper Usage policies instructing staff to speak respectfully to residents and to refrain from resident care practices that are demeaning such as leaving gait belts on when not being used. Staff who did not attend the 7/21/15 in-service will meet individually with the Social Worker/DON by 7/23/15. (continued on page 2 of 29)	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nicholas R. Brandon TITLE: CEO (X6) DATE: 7-15-15

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



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F 241	<p>Continued From page 1</p> <p>transfers, moving in bed, and set-up for meals. *She had required supervision and staff assistance to eat during meals.</p> <p>Observation on 6/23/15 of resident 6 during the breakfast meal revealed: *She had: -Been seated in a wheelchair (w/c) at a table in the dining room. There had been two other residents sitting at the same table. -Been leaning forward in her w/c and appeared to be asleep. -Glasses of fluids and a plate of food available for her to eat. -Not made an attempt to start eating. *CNA J sat down and attempted to assist her with her meal, but she had refused to eat. *An unidentified tablemate had asked CNA J why she had not been eating. *CNA B who had been sitting at a table 5 feet from her's loudly responded to that question by stating "She is being stubborn and acting like she is 100 hundred years old. I'd be stubborn too if I was 100."</p> <p>Observation on 6/23/15 of resident 6 during the noon meal revealed the same circumstances as above. After an unidentified table mate again asked CNA J why the resident had not been eating, CNA B again stated "She is just being stubborn and acting like she is 100 hundred years old."</p> <p>During both of the above observations the surveyor had been located approximately ten feet from the resident. The surveyor and the residents in the surrounding area were able to hear CNA B make those statements.</p>	F 241	<p>Continued From Page 1</p> <p>QA audits to ensure verbalizations are respectful and gait belts are removed after use will be done weekly for 2 months. X If substantial compliance is achieved, QA audits will be done monthly for an additional 3 months then quarterly for another 6 months. _____ * QA audits will be conducted by the Social Worker or her designee. The Social Worker will report audit findings to the QA committee monthly.</p> <p><i>sw/soroh/JJ</i></p> <p><i>for residents #2, 6, 7 and 8 plus one random selected resident sw/soroh/JJ</i></p>	7/23/15	

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F 241	<p>Continued From page 2</p> <p>Interview on 6/24/15 at 3:10 p.m. with the director of nurses (DON) and the social services worker (SSW) revealed they agreed the above statements made by CNA B regarding resident 6 had not been appropriate and dignified.</p> <p>Review of the provider's Resident Rights handbook revealed "When you enter a long-term care facility, you must be treated with respect, dignity and consideration."</p> <p><i>*2 subspoth/jj</i></p> <p>2. Random observations of resident on 6/23/15 from 8:20 a.m. through 5:30 p.m. revealed he had been wearing a gait belt (device to assist the resident with transfers and walking) around the area of his waist. The gait belt had not been removed when he was eating his meals or sitting in his recliner in his room. He had been observed wearing the gait belt during the entire time frame above.</p> <p>Interview on 6/23/15 at 2:45 p.m. with resident 6 revealed: *He had confirmed the gait belt was used by the staff when he needed to transfer or walk. *The gait belt had not been removed after the staff had assisted him. *He would have worn the gait belt throughout the entire day.</p> <p>Random observations on 6/23/15 from 11:00 a.m. through 4:45 p.m. of two unidentified residents in the Northview unit revealed they had been wearing a gait belt around the area of their waist. The gait belts had not been removed during the dinner meal or while at rest.</p> <p>Interview on 6/23/15 at 9:20 a.m. with CNA A revealed:</p>	F 241		
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F 241	Continued From page 3 *She had confirmed the gait belts were used to assist residents with transfers and walking. *The gait belts: -Were left on the residents while they were eating their meals. They should have been loosened during that time. -Should have been removed when the residents were in their rooms. Interview on 6/24/15 at 3:00 p.m. with the DON and SSW confirmed the gait belts should have been removed after walking or transferring the residents. Surveyor: 26180 3. Random observations in the south memory care unit on 6/22/15 in the afternoon and through supper, and on 6/23/15 throughout the day revealed: *Several residents, including residents 7 and 8, had gait belts on. *The gait belts were not removed from the residents during times they were not needed. Review of the provider's 9/7/04 Gait Belt Requirement and Proper Usage policy revealed "When the activity of daily living is completed, remove gait belt unless resident prefers to keep it on for future use."	F 241			
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.	F 280			

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F 280	Continued From page 4 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, record review, interview, and policy review, the provider failed to ensure care plans were reviewed and revised for four of twelve sampled residents (1, 4, 7, and 9). Findings include: 1. Random observations of resident 7 on 6/22/15 from 4:30 p.m. until 6:30 p.m. and on 6/23/14 at random times throughout the day revealed she: *Required a two person assist to transfer her from a wheelchair to another surface. *Was severely confused and unable to carry on an appropriate conversation. *Did not wander around the secured unit where she resided. *Remained wherever staff sat her without trying to get up. *Ate with plastic silverware, and needed extensive cueing to eat.	F 280	1. Resident #7 care plan was revised by dietician including current diet on 7/10/15, nursing services on 7/11/15 including dc of wandering intervention, new goal for mobility, new interventions for loose stools, use of plastic silverware, preference for shower, and history of falls; and by social services on 7/13/15 including ability to converse/discuss feelings.		

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F 280	<p>Continued From page 5</p> <ul style="list-style-type: none"> -At times she needed to be fed. *Was not offered a cookie at an afternoon snack with staff saying "She could not have a cookie" when another resident asked about that. *Did not wear glasses. <p>Review of resident 7's medical record revealed:</p> <ul style="list-style-type: none"> *She had a history of falls, having four falls in February and March 2015. *She received Mirtazapine (a medication for depression). <p>Interview with certified nursing assistant (CNA) I on 6/23/15 at 5:20 p.m. regarding resident 7 revealed she:</p> <ul style="list-style-type: none"> *Could not have nuts due to choking. *Always required two people to assist with transfers. *Did not wander anymore. *Preferred showers, but could become combative during them. *Had problems with loose stools. *Used plastic silverware because she might hit someone with it. <p>Review of resident 7's 5/29/15 care plan revealed:</p> <p>*Problems:</p> <ul style="list-style-type: none"> -Supportive therapy to allow resident time to express feelings/concerns. -Monitor for safety during times of wandering - offering to take for walks with resident during episodes of restlessness or diversion. -Eating: Supervision/set up help - extensive assist of one. <p>*Her care plan was not current regarding:</p> <ul style="list-style-type: none"> -Wandering. -Having loose stools. -Her ability to discuss feelings. 	F 280			

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F 280	<p>Continued From page 6</p> <ul style="list-style-type: none"> -The need for plastic silverware. -Her preference for a shower. -Her history of falling. <p>2. Review of resident 9's medical record revealed: *She had been admitted from the hospital on 2/5/14. *She was alert and oriented, with no memory problems. *Social services progress notes from 6/1/15 through 6/22/15 revealed: -The resident was very adamant about her desire to go home. -She had become very agitated and upset with others when demanding that she return to her home. -Her physician did not support her decision to go home, and the resident had been told she would leave against medical advice if she left.</p> <p>Review of resident 9's 5/14/15 care plan revealed: *It had not addressed her desire to return to her home. *It had not addressed how staff were going to assist her in adjusting and accepting the long term nature of this placement.</p> <p>3. Observation of resident 1 on 6/22/15 at supper and on 6/23/15 at breakfast, dinner, and supper revealed: *He was angry and upset and refused to come out of his room for meals. *His meals were brought to him in his room. *He ate very little at these meals when he was upset.</p> <p>Interviews on 6/22/15 at 4:30 p.m. and 6/23/15 at</p>	F 280	<p>2. Resident #9 care plan was revised by Social Services on 7/13/15 including her desire to return home and how staff are going to assist her in adjusting and accepting long term placement.</p> <p>3. Resident #1 care plan was revised by nursing services on 7/11/15 including new intervention for behavior affecting intake, update of wake time after interview with day shift aide on 7/9/15; revised by social services on 7/13/15 including communication through German language and how mood impacts intake/meals. Care plan revised by dietician on 7/14/15 including diet and interventions to maintain weight.</p>		

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F 280	<p>Continued From page 7</p> <p>5:30 p.m. with certified nursing assistant I regarding resident 1 revealed:</p> <ul style="list-style-type: none"> *He became angry like that quite frequently. -It was best to let him be when he was upset. *When he was upset they brought his food to him, but he would not eat very much. *They did not ever know what triggered his being upset. *He spoke fluent German and sometimes she could talk to him in German and he would respond, but not always. *He became combative and swung at people. *He did not like a lot of noise, such as the noise during the mealtime with all the residents. *She had to have a male nurse come and help her get him cleaned up earlier in the afternoon because he had a bowel movement, and would not allow her to help him. <p>Review of resident 1's dietary intake record during the week of 6/10/15 through 6/17/15 revealed ten out of twenty-one meals he ate less than 50% of the food he had been offered.</p> <p>Interview with the dietary manager on 6/23/15 at 11:10 a.m. regarding resident 1 revealed:</p> <ul style="list-style-type: none"> *He was at nutritional risk because he had dementia, and had not always eaten real well. *He had snacks in his room which consisted of cookies and candy. <p>Review of resident 1's registered dietitian assessments revealed on 3/31/15 and 6/17/15 she documented: "Eats fair, per staff - some have commented he sometimes doesn't eat very well, can snack in his room, and that he likes to sleep in (until around 1000) [10:00 a.m.] then will eat peanut butter and toast in his room."</p>	F 280		

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F 280	<p>Continued From page 8</p> <p>Review of resident 1's 1/20/14 care plan revealed:</p> <p>*Focus: "The resident has an ADL [activity of daily living] self-care performance R/T [related to] Alzheimer's type dementia E/B [evidenced by] impaired cognition and the need for close supervision with assistance as needed for appropriate completion of ADL's."</p> <p>*Interventions: "EATING: Independent with set up help - supervision as needed. Encourage fluids at mealtimes and with each resident contact. Per _____ [name of physician] resident should drink 6-8 glasses daily. Offer snacks as resident will likely not initiate asking for them himself."</p> <p>-It had not addressed that his mood and behavior frequently interfered with his eating.</p> <p>-It had not addressed how they monitored he met his estimated nutritional needs if he was not eating.</p> <p>-It had not addressed how they monitored that he received the amount of fluids recommended by the physician.</p> <p>**Focus: "The resident is resistive to cares at times with physical aggression at times r/t [related to] dementia."</p> <p>-There were no interventions specific to this resident to manage his behaviors based on his Personal Assessment which included that he spoke German and staff may be able to talk to him in German. He may also respond to a male caregiver.</p> <p>*Focus: "Wake and sleep time preferences to follow resident routine."</p> <p>-Interventions: "Preferred wake time is 7:00 a.m."</p> <p>Interview on 6/24/15 at 10:30 a.m. with registered nurse/Minimum Data Set coordinator H regarding resident 1 revealed:</p> <p>*His care plan had not been individualized.</p>	F 280		
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F 280	<p>Continued From page 9</p> <p>*It had not addressed the extent of the behaviors he exhibited.</p> <p>Surveyor: 34030</p> <p>4. Random observations from 6/23/15 through 6/24/15 revealed resident 4 either in bed or up in her wheelchair. She had not been observed walking.</p> <p>Review of resident 4's medical record revealed: *Admission on 4/5/11. *Diagnoses that included Alzheimer's (a gradual decline in mental and physical functioning).</p> <p>Review of resident 4's 4/7/15 MDS quarterly assessment revealed: *A decline in her mental and physical functioning compared to her 1/13/15 yearly assessment. -She needed extensive assistance of one to two staff to move. -She no longer walked.</p> <p>Review of resident 4's undated care plan currently in use revealed: *An entry from "Nursing Rehab/Restorative: Walking Program." -Date initiated: 7/25/14. -Revision on: 7/25/14.</p> <p>Interview on 6/24/15 at 2:30 p.m. with the MDS coordinator revealed: *She thought therapy was responsible to update their entries on the care plan. *She agreed resident 4 no longer walked and the care plan had not been updated to reflect that.</p> <p>Interview on 6/24/15 at 2:40 p.m. with restorative aide L revealed:</p>	F 280	<p>4. Resident #4 care plan was revised by nursing services on 7/11/15 including resolution of restorative walking program intervention and new intervention regarding ambulating short distances in her room.</p> <p>Care Plan policy was reviewed on 7/9/15 by DON. Policy includes page 1, #5, "The care plan is individualized and specific." and page 1, #7, "The care plan is reviewed, updated, and revised with change of resident condition. The care plan is reviewed, revised, and updated at least quarterly at the scheduled care plan conference."</p> <p>Staff-specific education was completed by the DON with MDS Coordinators (RN (H)) and interdisciplinary team on 7/13/15. Education consisted of individualizing and updating care plans according to resident's current status, addressing behaviors effect on ADLs/cares, change in mobility, participation in restorative programs, falls, utensil use, bathing/showering, review of wake/sleep times and bowel medication regimen/loose stools.</p> <p>Education of all facility staff by DON occurred on 7/21/15. Education consisted of review of Care Plan Policy. Staff are instructed to report changes to the interdisciplinary team, MDS Coordinator, DON and charge nurse for care plan updates between MDS assessments and care conferences. <i>sw/saooH/JJ</i></p> <p><i>*will be done with each MDS assessment</i></p> <p>QA audits to ensure care plans are updated to reflect current resident status and are individualized/specific will be done weekly for 2 months. If substantial compliance is achieved, QA audits will be done monthly for an additional 3 months and then quarterly for another 6 months. <i>* [redacted] QA sw/saooH/JJ</i></p> <p>audits will be conducted by the DON or her designee. The DON will report audit findings to the QA committee monthly.</p>	7/21/15

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F 280	Continued From page 10 *Resident 4 had not been walking for "two or three months." *He agreed she had not been taken off the restorative program. *The physical therapist usually handled that but was not currently in the facility. Interview on 6/24/15 at 2:00 p.m. with the director of nursing (DON) and administrator revealed the DON agreed resident 4's care plan had not been updated to reflect her current level of activity. Review of the provider's 4/13/15 Care Plan policy revealed: **"The care plan is individualized and specific." **"The care plan is reviewed, updated, and revised with change of resident condition. The care plan is reviewed, revised, and updated at least quarterly at the scheduled care plan conference."	F 280			
F 325 SS=D	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 by: Surveyor: 26180	F 325			

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F 325	<p>Continued From page 11</p> <p>Based on record review, interview, and policy review, the provider failed to ensure one of six sampled residents (1) at nutritional risk, were monitored for appropriate nutritional intake. Findings include:</p> <p>1. Review of resident 1's weight record revealed: *His weight varied three pounds (lb) in 5 months, from 162 lb in January 2015 to 159 lb on 6/22/15. *His weights varied two to four pounds every week.</p> <p>Observation of resident 1 on 6/22/15 at supper and on 6/23/15 at breakfast, dinner, and supper revealed: *He was angry and upset and refused to come out of his room for meals. *His meals were brought to him in his room. *He ate very little at these meals when he was upset.</p> <p>Interviews on 6/22/15 and 6/23/15 with certified nursing assistant I regarding resident 1 revealed: *He became angry like that quite frequently. -It was best to let him be when he was upset. *When he was upset they brought his food to him, but he would not eat very much. *They did not ever know what triggered his being upset. *They did not record any food intake or supplements of residents. *If the nurses wanted them to record a resident's intake, they posted it on the refrigerator and they would keep track of it for a week. *It was not the week they would record how much he ate.</p> <p>Review of resident 1's dietary intake record during the week of 6/10/15 through 6/17/15</p>	F 325	<p>1. Maintain Nutrition Status Unless Unavoidable</p> <p>Resident #1 care plan was revised by: nursing on 7/11/15 including new intervention for behavior affecting intake, update of wake time after interview with aide on 7/9/15; social services on 7/13/15 including communication through German language and how mood impacts intake/ meals; dietitian on 7/14 including diet, weight loss interventions and increased protein. Weight is stable at 163.5# on 6/15/15. Admission weight on 3/23/11 was 169.9# with slow weight decrease of 7# over 4 years. Primary physician discontinued fluid recommendation and supplement ordered on 7-14-15.</p> <p>Resident #1 intake is being monitored at each meal as of 7/13/15. If meal is refused equivalent alternate food/fluid is offered. Consultant dietitian will review and develop an appropriate plan as intake changes over time. Current intake plan includes Supplemental protein scheduled as well as additional high protein drink if eats less than 50%. To be noted: Historically, dietitians have used the serum protein value albumin to evaluate nutritional status, however, it is now accepted practice that this, along with other serum hepatic proteins, including Total Protein, as cited in the 2567, are not indicators of nutritional status and do not accurately measure nutritional status, as they are affected by a number of factors, including Chronic Kidney Disease, which Resident #1 has, at stage 3. In addition to this, extra protein is not indicated in people with Stage 3 (and above) CKD, and Resident #1 had a normal albumin level. The definition (continued on page 13 of 29)</p>		

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F 325	<p>Continued From page 12</p> <p>revealed: *Ten out of twenty-one meals he ate less than 50% of the food he was offered. -Seven of those meals he ate less than 25%. *Six times he drank very little of his supplement.</p> <p>Review of resident 1's 5/6/15 laboratory report revealed: *His total protein (amount of protein in blood) was low at 6.2 (normal is 6.4 - 8.9 gram (g)/dL(deciliter) (a unit of measure). *His albumin (main protein in blood) was 3.6 which was in the normal range of 3.5-5.7 g/dL.</p> <p>Review of resident 1's dietitian assessments revealed: *3/31/15 - "Eats fair, per staff - some have commented he sometimes doesn't eat very well, can snack in his room, and that he likes to sleep in, then will eat peanut butter and toast. -Weight 156.2 # [pounds]. -Estimated needs: 1760-2000 kcals/d (calories/day), 65 gm [gram] protein/day, 2000 cc [cubic centimeters] fluids/day. No major nutritional concerns." *6/17/15 - "Eats fair, per staff - some have commented he sometimes doesn't eat very well, can snack in his room, and that he likes to sleep in, then will eat peanut butter and toast. -Weight 163.2 #." -"Estimated needs: 1760-2000 kcals/d, 65 gm protein/day, 2000 cc fluids/day. No major nutritional concerns." *She had not addressed how they would have monitored for receiving adequate nutrition when he was not eating very well.</p> <p>Interview on 6/24/15 at 10:30 a.m. with registered nurse/MDS coordinator H regarding resident 1</p>	F 325	<p>Continued from page 12</p> <p>of protein status in F371 is specific to albumin, and the reference also noted in F371 is from 2003. The following are two up-to-date current practice guidelines on protein markers, malnutrition, and nutrition status.</p> <p>Jensen GL, Mirtallo J, Compher C, et al; International Consensus Guideline Committee. Adult starvation and disease-related malnutrition: a proposal for etiology-based diagnosis in the clinical practice setting from the International Consensus Committee. JPEN J Parenter Enteral Nutr. 2010;34:156-159.</p> <p>White JV, Guenter P, Jensen G, et. al. Consensus statement of the Academy of Nutrition and Dietetics/American Society for Parenteral and Enteral Nutrition: Characteristics recommended for the identification and documentation of adult malnutrition (undernutrition). J Acad Nut Diet. 2012;112:730-738. doi: 10.1016/j.jand.2012.03.012. Accessed January 19, 2015.</p> <p>Abnormal Nutritional Status policy reviewed. All residents at nutritional risk as identified by the consultant dietitian on 7/2/15 are being monitored for intake as of 7/3/15. Consultant dietitian will review and develop an appropriate plan as needed for each resident. Care plan will be updated by dietitian to reflect current status.</p> <p>Education of all facility staff by DON occurred on 7/21/15. Review of Abnormal Nutritional Status policy; specifically addressed monitoring intake at nutritional risk, providing adequate protein, weight loss interventions and how behaviors can affect intake.</p> <p>QA audit to ensure care plans are updated to reflect current resident status are individualized/specific regarding interventions for weight loss will be done weekly for 2 months. If substantial compliance is achieved, QA audits will be done monthly for an additional 3 months then</p> <p>(continued on page 14 of 29)</p>	

on care plans of those residents identified at nutritional risk by RD. SW/S000H/KJ

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F 325	<p>Continued From page 13 revealed:</p> <ul style="list-style-type: none"> *She was aware he got upset and refused to come out of his room and eat. *She confirmed they do not track food intake and supplement intake routinely. *They also monitored intake of residents at risk, because the nurses were supposed to document on that. *A review of the nursing documentation on 6/23/15 throughout the three meals revealed the nurse had not documented anything regarding the resident eating so poorly. <p>Interview on 6/23/15 at 11:10 a.m. with the dietary manager revealed:</p> <ul style="list-style-type: none"> *They only monitored food intake of residents when they were in the seven day window for completing their Minimum Data Set (MDS) assessment. *She confirmed resident 7 had not been eating well during the MDS assessment window. *He was at nutritional risk because he had dementia, and had not eaten real well. *He had snacks in his room which consisted of cookies and candy. *Nurses were supposed to notify her if he was not eating well. She thought he was doing okay because she had not heard anything different. *She agreed he might have been maintaining his weight, but might not have had a nutritionally sound diet. <p>Review of resident 1's 1/20/14 care plan revealed:</p> <ul style="list-style-type: none"> *Focus: "The resident has an ADL [activity of daily living] self-care performance R/T [related to] Alzheimer's type dementia E/B [evidenced by] impaired cognition and the need for close supervision with assistance as needed for 	F 325	<p>Continued from page 13 quarterly for another 6 months. <i>* SW/SADH/JJ</i></p> <p>QA audits will be conducted by the Dietary Manager or her designee. The Dietary Manager will report audit findings to the QA committee meeting <i>monthly. SW/SADH/JJ 7/21/15</i></p>		

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F 325	Continued From page 14 appropriate completion of ADL's." *Interventions: "EATING: Independent with set up help - supervision as needed. Encourage fluids at mealtimes and with each resident contact. Per ___ [name of physician] resident should drink 6-8 glasses daily. Offer snacks as resident will likely not initiate asking for them himself." *It had not addressed his mood and behavior frequently interfered with his eating. *It had not addressed how they had monitored he met his estimated nutritional needs if he was not eating. *It had not addressed how they had monitored he received the amount of fluids recommended by the physician.	F 325			
F 431 SS=D	Review of the provider's 2/7/12 Abnormal Nutritional Status policy revealed: "Patients/Residents who have abnormal nutritional conditions will have alterations in their diet made to promote good nutritional status." 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431			

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F 431	<p>Continued From page 15 applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, and policy review, the provider failed to ensure accountability (number of medications were correct) was maintained for schedule IV (government controlled) medications as needed (PRN) for two of two randomly reviewed residents (2 and 18). Findings include:</p> <p>1a. Observation on 6/24/15 at 10:00 a.m. of the provider's medication cart with the director of nursing (DON) revealed: *Resident 2 had one cassette that contained PRN Tramadol (controlled pain medication). *The pharmacy had sent the medication on 5/8/15. *The cassette held a total of eight tablets.</p>	F 431	<p>1a. Resident #2 Tramadol was counted and documented on Narcotic Administration Sheet on 6/29/15. Nursing staff educated to sign in medication from pharmacy and sign out medication as given.</p>	

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F 431	<p>Continued From page 16</p> <p>*There were four tablets missing from the cassette.</p> <p>*Review of resident 2's May 2015 and June 2015 medication administration records (MAR) revealed he had taken a total of ten tablets.</p> <p>Interview on 6/24/15 at the time of the observation with the pharmacist revealed:</p> <p>*For resident 2 he had dispensed on:</p> <p>-5/2/15 eight Tramadol tablets.</p> <p>-5/8/15 eight Tramadol tablets.</p> <p>*No Tramadol tablets had been dispensed for resident 2 during June 2015.</p> <p>*From 5/2/15 through 6/23/15 he had dispensed a total of sixteen tablets for resident 2.</p> <p>Resident 2's May 2015 and June 2015 MARs, cassette, and with the interview of the pharmacist revealed the provider had been unable to account for one of his Tramadol tablets.</p> <p>b. Observation on 6/24/15 at 10:10 a.m. of the provider's medication cart with the DON revealed:</p> <p>*Resident 18 had two cassettes that contained PRN lorazepam (controlled medication for nervousness).</p> <p>*The pharmacy had sent the medication on 5/1/15.</p> <p>*One of the cassettes was full with eight tablets. The other cassette had one tablet left out of eight tablets.</p> <p>*Review of resident 18's May 2015 and June 2015 MARs revealed she had taken a total of fifty tablets.</p> <p>Interview on 6/24/15 at the time of the observation with the pharmacist revealed:</p> <p>*For resident 18 he had dispensed on:</p> <p>-5/1/15 eight lorazepam tablets.</p>	F 431	<p>b. Resident #18 Lorazepam was counted and documented on Narcotic Administration Sheet on 6/29/15. Nursing staff educated to sign in medication from pharmacy and sign out medication as given.</p> <p>Review of Controlled Medications policy page 1, #4 states "Schedule medication given on PRN basis must be accountable on PRN Administration Sheet." All PRN controlled III and IV medications for all residents were counted and documented on Narcotic Administration Sheet on 6/29/15.</p> <p>Individual nurse/medication aide education occurred between 6/29/15 and 7/14/15; specifically addressed all controlled medications that are ordered PRN must be accountable on a Narcotic Administration form for each resident.</p> <p>(continued on page 18 of 29)</p>	

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F 431	Continued From page 17 -6/1/15 eight lorazepam tablets. -6/8/15 eight lorazepam tablets. -6/16/15 eight lorazepam tablets. -6/23/15 eight lorazepam tablets. *From 5/1/15 through 6/23/15 he had dispensed a total of forty tablets. *Any empty cassettes would have been removed from the medication cart every week. *He had not assisted the provider with the accountability for any of the controlled medications. Resident 18's May 2015 and June 2015 MARs, two cassettes, and with the interview of the pharmacist revealed the provider had been unable to account for the discrepancy of ten lorazepam tablets. c. Interview on 6/24/15 at the time of the observation with the DON revealed: *They had no formal process in place to account for the PRN controlled scheduled III and IV medications. *They had not performed an actual individual count on each PRN scheduled III and IV medication. *The nurses had only been required to account for the scheduled II medications. Review of the provider's 3/27/08 Controlled Medications policy and procedure revealed: *Purpose "To ensure safe storage and administration of controlled medication." *The provider had no procedure in place to account for the administration of PRN controlled IV medications.	F 431	Continued from page 17 Education of nursing staff by DON occurred on 7/21/15. Staff not in attendance on 7/21/15 will meet individually with DON. Education consisted of review of Controlled Medications policy and use of Narcotic Administration form to account for PRN III and IV medications. <i>* fall swlsdpoH/jj</i> QA audits of PRN Controlled III and IV Medication Reconciliation to be completed by DON or her designee weekly for 2 months. If substantial compliance is achieved, QA audits will be done monthly for an additional 3 months then quarterly for another 6 months. <i>* swlsdpoH/jj</i> [REDACTED] QA data will be reviewed at the monthly QI meeting. <i>* swlsdpoH/jj</i> QA audit completed by [REDACTED] DON on 7/10/15; 100% compliance, count accurate.	7/21/15
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	<p>Continued From page 18</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</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>	F 441		
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F 441	<p>Continued From page 19</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180</p> <p>Surveyor: 32355</p> <p>Based on observation, interview, and policy review, the provider failed to ensure sanitary conditions were maintained for:</p> <ul style="list-style-type: none"> *One of one sampled resident (2) who received catheter (tube that removes urine from the bladder) care by one of one certified nursing assistant (CNA) (D). *Two of two sampled residents (2 and 7) who received personal care by three of three CNAs (D, I, and K). *One of one sampled resident (6) who received a dressing change by one of one registered nurse (RN) (C). *The cleansing of one of one nebulizer chamber by one of one RN (C). *The process after disinfecting one of two shower room and chair after resident use by one of one CNA (D). *The set-up process for the administration of insulin (medication to stabilize blood sugar levels) to three of three randomly observed residents (15, 16, and 17) by one of one RN (6). *The storage of four of five observed transfer aides (mechanical lifts used to transfer residents) in two of two soiled utility rooms (Northview and 200 wing). <p>Findings include:</p> <p>1. Observation on 6/23/15 at 7:40 a.m. of CNA D during catheter care for resident 2 revealed: *The resident had been sitting in his recliner with a blanket covering his legs. *He had a catheter and in the morning the staff had assisted him with removing a large drainage</p>	F 441	<p>1. Resident #2 - Catheter Tubing: C.N.A. (D): Catheter Care policy page 2 states "For Changing to Leg Bag, c) Disconnect the catheter and drainage tubing. Do not put them down or allow them to touch anything. d) Place a sterile cap or sterile alcohol packet over the exposed end of the drainage tube." (continued on page 21 of 29)</p>	

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F 441	<p>Continued From page 20 bag from the catheter tubing and attach a smaller drainage bag. The smaller drainage bag attached to one of his lower legs for privacy. *CNA D sanitized her hands and put on clean gloves. *With those clean gloves she had: -Retrieved a small leg bag and an alcohol wipe package. -Adjusted the blanket covering the resident's legs to expose the connection site for the drainage bags to the catheter tubing. -Opened a white strap that was attached to the resident's right leg. That strap had been used to secure the catheter tubing in place. -Disconnected the large drainage bag from the catheter tubing. -Laid the large drainage bag on his bed. -Opened the alcohol package wipe and cleansed the opening of the catheter tubing. -Attached the small drainage bag to the catheter tubing. *During the entire above process she had been <i>swabbing</i> holding the tip and connection site area of the small drainage bag in her left hand. That tip of the small drainage bag was not covered and had been touching the resident's back. *She had not cleansed the tip and connection site of the small drainage bag prior to attaching it to his catheter tubing.</p> <p>2. Continued observation on 6/23/15 at 8:00 a.m. of CNA D revealed: *After she had switched the catheter drainage bags she provided personal cares for resident 2. *She had removed her soiled gloves and sanitized her hands. With those clean hands she had: -Readjusted his catheter. -Assisted the resident with putting on his</p>	F 441	<p>Continued From page 20 Staff-specific education was completed by the DON with C.N.A. (D) on 7/14/15. Education consisted of review of Gloves, Hand Hygiene and Catheter Care policies and Your 5 Moments for Hand Hygiene. Observation of catheter care given to Resident #2 by C.N.A. (D) was observed on 7/14/15 by DON and Infection Control Coordinator.</p> <p>Education of nursing staff by DON occurred on 7/21/15. Staff not in attendance on 7/21/15 will meet individually with DON. Education consisted of review of Gloves, Hand Hygiene and Catheter Care policies; Catheter Care policy: page 2 states "For Changing to Leg Bag, c) Disconnect the catheter and drainage tubing. Do not put them down or allow them to touch anything. d) Place a sterile cap or sterile alcohol packet over the exposed end of the drainage tube.", and Your 5 Moments for Hand Hygiene.</p> <p>QA audits to ensure infection control is met will be done weekly for 2 months. If substantial compliance is achieved, QA audits will be done monthly for an additional 3 months then quarterly for another 6 months. <i>swabbing</i> QA audits will be conducted by the DON or her designee. The DON will report audit findings to the QA committee monthly.</p> <p>7/21/15</p> <p>2. Resident #2 - Personal Care C.N.A. (D): A) Gloves policy states "When to Use Gloves: When touching secretions, excretions, blood or body fluids, resident's food." B) Hand Hygiene policy page 1 states "Use an Alcohol-Base Hand Rub: Before and after direct patient contact, After contact with patient's intact skin, After removing gloves, After contact with objects and equipment in (continued on page 22 of 29)</p>	7/21/15
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F 441	<p>Continued From page 21 underwear and pants. -Retrieved his shoes and put them on his feet. She had touched both soles of the shoes which had been sitting directly on the floor. -Assisted the resident to stand up. -Put on a clean pair of gloves without sanitizing or washing her hands. With those clean gloves she had: -Opened the bathroom door and retrieved a package of wet wipes. Those wet wipes had been sitting on a shelf above the toilet. -Opened the package of wet wipes and washed the bottom of the resident. *She took off her gloves and without sanitizing or washing her hands had assisted the resident into his wheelchair (w/c). With those soiled hands she had: -Pushed the resident up to the sink, touched the handles on the faucet, and turned on the water. -Set the resident up to wash his hands. *After the resident had finished washing his hands she had: -Turned the water off with her bare hands. -Pushed the resident in the w/c out of his room. -Sanitized her hands.</p> <p>Surveyor: 26180 3. Observation on 6/23/15 at 11:15 a.m. of resident 7 revealed: *CNA I and K brought the resident to her room to toilet her. *They pulled her slacks down as they transferred her to a commode. *CNA I removed the resident's soiled brief and disposed of it. *Without performing any handwashing she: -Moved the resident's wheelchair. -Retrieved a clean pair of disposable briefs to put on the resident.</p>	F 441	<p>Continued From page 21) the patient's immediate vicinity, When moving from a contaminated body site to a clean body site during care." C) Hand Hygiene policy page 2 states "Hand washing: #8 Turn off the faucets with clean paper towel."; faucets are recognized as contaminated surface. Staff-specific education was completed by the DON with C.N.A. (D) on 7/14/15. Education consisted of review of Gloves and Hand Hygiene policies and Your 5 Moments for Hand Hygiene. Observation of personal care given to Resident #2 by C.N.A. (D) was observed on 7/14/15 by DON. Education of all staff by DON occurred on 7/21/15. Staff not in attendance on 7/21/15 will meet individually with DON. Education consisted of review of Gloves and Hand Hygiene policies and Your 5 Moments for Hand Hygiene. QA audits to ensure infection control is met will be done weekly for 2 months. If substantial compliance is achieved, QA audits will be done monthly for an additional 3 months then quarterly for another 6 months. s.w. 5/20/15 [redacted] QA audits will be conducted by the DON or her designee. The DON will report audit findings to the QA Committee monthly.</p> <p>3. <u>Resident #7 - Personal Care C.N.A. (I) and C.N.A. (K):</u> A) Gloves policy states "When to Use Gloves: When touching secretions, excretions, blood or body fluids, resident's food." B) Hand Hygiene policy page 1 states "Use an Alcohol-Base Hand Rub: Before and after direct patient contact, After contact with patient's intact skin, After removing gloves, After contact with objects and equipment in the patient's immediate vicinity, When moving from a contaminated body site to a clean site during care." (continued on page 23 of 29)</p>	7/21/15
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F 441	<p>Continued From page 22</p> <ul style="list-style-type: none"> -Completely removed the resident's slacks. -Put on a pair of disposable gloves. -Got some disposable wash cloths. -Assisted CNA K with standing the resident up. -Washed the bottom of the resident. -Pulled her brief and slacks up. -Took her gloves off. -Opened her door and pushed the resident in a wheelchair into the dining room and sat her at the table. -Removed her gait belt and laid it on the table. -Went to the cupboard to get some hand gel and then sanitized her hands. <p>Interview on 6/23/15 at 5:20 p.m. with CNA I revealed she should have performed hand hygiene after she removed resident 7's soiled brief and again when she washed her bottom. She had not done that.</p> <p>Interview on 6/24/15 at 11:40 a.m. with the infection control nurse and the director of nurses (DON) confirmed the above technique used to provide catheter care had not been been sanitary. They would have expected the staff to follow the provider's policy and procedure for catheter care.</p> <p>Review of the provider's 4/28/99 Catheter Care policy and procedure revealed "The tips of the tubing must be covered to reduce contamination and invasion of microorganism (bacteria) into the urinary tract."</p> <p>Surveyor: 32355</p> <p>Interview on 6/24/15 at 11:00 a.m. with the infection control nurse and the DON revealed:</p> <ul style="list-style-type: none"> *They had performed random audits throughout the year on proper handwashing and glove use. *They confirmed the above process for personal 	F 441	<p>Continued from Page 22</p> <p>C) Hand Hygiene policy page 2 states "Hand washing: #8 Turn off the faucets with clean paper towel"; faucets are recognized as contaminated surface.</p> <p>Staff-specific education was completed by the DON with C.N.A. (K) on 7/10/15 and C.N.A. (I) on 7/13/15. Education consisted of review of Gloves and Hand Hygiene policies and Your 5 Moments for Hand Hygiene.</p> <p>Education of all staff by DON occurred on 7/21/15. Staff not in attendance on 7/21/15 will meet individually with DON. Education consisted of review of Gloves and Hand Hygiene policies and Your 5 Moments for Hand Hygiene.</p> <p>QA audits to ensure infection control is met will be done weekly for 2 months. If substantial compliance is achieved, QA audit will be done monthly for an additional 3 months then quarterly for another 6 months. [REDACTED] QA audits will be conducted by the DON or her designee. The DON will report audit findings to the QA committee monthly.</p>	7/21/15

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F 441	<p>Continued From page 23</p> <p>care had not been sanitary. *The process above provided the potential for cross-contamination of bacteria to the resident and others.</p> <p>Review of the provider's 9/11/13 Hand Hygiene policy and procedure revealed: *Purpose: -"To prevent the spread of infection and disease to other residents." -"To keep hands free from potentially infectious material." *"Use an alcohol-based hand rub: -Before and after direct patient contact. -After contact with patient's intact skin. -After removing gloves. -When moving from a contaminated body site to a clean body site during patient care."</p> <p>4. Observation on 6/23/15 at 8:30 a.m. of RN C during a dressing change for resident 6 revealed: *He had retrieved a container with supplies for a dressing change and a box of gloves. *He entered the resident's room and set the container and box of gloves directly on top of a bed pad on the resident's bed. No protective barrier had been placed between the two surfaces to prevent the potential of cross-contamination. *RN C retrieved several packages, tape, and a spray bottle of wound cleanser from the container. He placed those supplies directly on the resident's bed pad without a protective barrier. *The resident had been sitting in a recliner with her feet elevated. *RN C put on clean gloves without sanitizing or washing his hands. With those clean gloves he had:</p>	F 441	<p>4. Resident #6 - Clean Wound Dressing Change by RN (C):</p> <p>A new policy entitled Clean Wound Dressing Change was drafted/approved by the DON on 7-9-15. Policy includes establishing a clean field to place dressing change materials on, states when to sanitize/wash hands, apply/remove gloves and to use Q-tip to apply ointment/medication.</p> <p>Staff-specific education was completed by the DON with RN (C) on 7/13/15. Education consisted of review of Gloves, Hand Hygiene and new Clean Wound Dressing Change policies and Your 5 Moments for Hand Hygiene.</p> <p>Education of nursing staff by DON occurred on 7/21/15. Staff not in attendance on 7/21/15 will meet individually with DON. Education consisted of review of Gloves, Hand Hygiene and Clean Wound Dressing Changes policies and Your 5 Moments for Hand Hygiene.</p> <p>(continued on page 25 of 29)</p>		

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F 441	<p>Continued From page 24</p> <ul style="list-style-type: none"> -Pushed the resident's pants up on her right leg to expose the wound. -Opened a package of gauze. -Retrieved the spray bottle of wound cleanser. -Sprayed some of the wound cleanser onto the gauze. -Cleansed the wound on her right leg with that wet gauze. *After RN C had cleansed the wound he removed his soiled gloves. *Without sanitizing or washing his hands he put on a clean pair of gloves. With those clean gloves he had: <ul style="list-style-type: none"> -Opened a plastic bag and retrieved a tube of ointment. -Opened the ointment and placed some on his fingers. -Applied that ointment directly to the resident's open wound on her right leg. -Recapped the ointment and replaced it inside of the plastic bag. -Retrieved another package that had been laying directly on the resident's bed pad and opened it. -Retrieved the medicated dressing and applied it to the open wound. -Retrieved another package of gauze and opened it. -Wrapped the dressing and wound with this gauze. -Applied ace wraps to both of her legs. -Retrieved the roll of tape laying directly on the resident's bed pad and secured the ace wraps with it. *Removed his gloves and with his soiled hands replaced the tape and spray bottle of wound cleanser into the container. *Washed his hands. *Retrieved the container with the dressing supplies and box of gloves. Placed both of these 	F 441	<p>Continued from page 24</p> <p>QA audits to ensure infection control is met will be done weekly for 2 months. If substantial compliance is achieved, QA audits will be done monthly for an additional 3 months then quarterly for another 6 months. QA audits will be conducted by the DON or her designee. The DON will report audit findings to the QA committee monthly.</p>	7/21/15
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F 441	<p>Continued From page 25</p> <p>items on the counter in the clean utility room.</p> <p>Interview on 6/24/15 at 11:05 a.m. with the infection control nurse and the DON confirmed the above technique used to provide a dressing change had not been done in a sanitary manner. The DON had reviewed the process for a dressing change that morning with RN C. They would have expected the staff to follow the provider's policy and procedure for dressing changes.</p> <p>Review of the provider's 5/21/99 Dressing Change policy and procedure revealed: *Procedure: -"Wash your hands." -"Assemble equipment." -"Wash your hands. Open packages of dressing supplies, ointments, solutions, and cut tape." -"Wash your hands. Put on gloves. Remove old dressing." -"Wash your hands." Put on gloves and re-dress the wound." -"Wash your hands."</p> <p>5. Observation on 6/24/15 at 9:20 a.m. of RN C revealed he prepared and set-up resident 11 to do a nebulizer treatment (medication to improve breathing). After the resident had completed his nebulizer treatment RN C had put on clean gloves and with those clean gloves he had: -Disconnected the mouth piece from the medication chamber and went over to the sink. -Turned on the faucet handles to start the water and rinsed out the medication chamber. -Turned off the faucet handles and placed the rinsed medication chamber inside of the nebulizer machine.</p>	F 441	<p>5. <u>Resident #11 - Nebulizer by RN (C):</u> Hand Hygiene policy page 2 states "Hand washing: #8 Turn off the faucets with clean paper towel."; Faucets are recognized as contaminated surface.</p> <p>Staff-specific education was completed by the DON with RN (C) on 7/13/15. Education consisted of review of Hand Hygiene policy and Your 5 Moments for Hand Hygiene.</p> <p>Education of nursing staff by DON occurred on 7/21/15. Staff not in attendance on 7/21/15 will meet individually with DON. Education consisted of review of Gloves and Hand Hygiene policies and Your 5 Moments for Hand Hygiene. (continued on page 27 of 29)</p>	
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F 441	<p>Continued From page 26</p> <p>Interview on 6/24/15 at 10:45 a.m. with the infection control nurse and the DON confirmed RN C should have used a paper towel to turn the faucet handles on and off. Those faucet handles had not been considered a clean surface.</p> <p>6. Observation on 6/23/15 at 10:00 a.m. of CNA D revealed she had prepared to disinfect the shower room and chair after a resident's use. *Without the use of gloves she had: -Sprayed the entire area and chair with Virex 256 one-step disinfectant cleaner. -Left all the surfaces wet for 10 minutes as instructed by the manufacturer. *After the required 10 minute wait time she had prepared to scrub and rinse all the surfaces that were sprayed. Without the use of gloves she had: -Touched the faucet handle to turn on the water. -Retrieved a large handled scrub brush and scrubbed all of the sprayed surfaces on the floor and shower chair. She had touched several areas on the shower chair, including the seat. -Rinsed the entire shower room area and chair after she finished scrubbing. -Touched the faucet handle and turned off the water. -Opened the shower/tub room door and left. *She had not been observed washing her hands or using gloves during the entire process above.</p> <p>Interview on 6/24/15 at 11:10 a.m. with the infection control nurse and the DON confirmed the CNA should have: *Used gloves during the entire disinfecting and scrubbing process. *Washed her hands when she had completed the disinfecting of the shower room and chair.</p> <p>7. Observation on 6/23/15 at 5:00 p.m. of RN G</p>	F 441	<p>Continued from page 26</p> <p>QA audits to ensure infection control is met will be done weekly for 2 months. If substantial compliance is achieved, QA audits will be done monthly for an additional 3 months then quarterly for another 6 months. * [redacted] QA SW/5000H/JJ</p> <p>audits will be conducted by the DON or her designee. The DON will report audit findings to the QA committee monthly.</p> <p>7/21/15</p> <p>6. <u>Disinfecting Shower Equipment by C.N.A. (D):</u> Shower policy revised by DON on 6/29/15 to include donning of gloves to disinfect equipment- page 2, #38. Hand hygiene dispensers have been placed in tub and shower rooms on 7/14/15.</p> <p>Staff-specific education was completed by the DON with C.N.A. (D) on 7/14/15. Education consisted of review of Gloves, Hand Hygiene and Shower policies and Your 5 Moments for Hand Hygiene. Observation of disinfection of shower equipment by C.N.A. (D) was observed on 7/14/15 by DON.</p> <p>Education of nursing staff by DON occurred on 7/21/15. Staff not in attendance on 7/21/15 will meet individually with DON. Education consisted of review of Gloves, Hand Hygiene and Shower policies and Your 5 Moments for Hand Hygiene.</p> <p>QA audits to ensure infection control is met will be done weekly for 2 months. If substantial compliance is achieved, QA audits will be done monthly for an additional 3 months then quarterly for another 6 months. [redacted] QA audit will be conducted by the DON or her designee. The DON will report audit findings to the QA committee monthly.</p> <p>7/21/15</p> <p>7. <u>Insulin Draws by RN (G):</u> Insulin injection policy revised by DON on 7/13/15 to include using separate alcohol wipe for each vial; wipe is not to touch any surface before use on vial. (continued on page 28 of 29)</p>	7/21/15
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F 441	<p>Continued From page 27</p> <p>revealed she had prepared to administer insulin to residents 15, 16, and 17. She had:</p> <ul style="list-style-type: none"> -Retrieved an alcohol wipe and opened the package. -Retrieved a bottle of insulin required for resident 15 and wiped the top of the bottle off with the alcohol wipe. -Placed the used alcohol wipe directly on the counter top surface in the medication room. -Drawn up the required amount of insulin for the resident. -Retrieved another bottle of insulin for resident 16 and re-used the same alcohol wipe that was laying on the counter top to wipe of the insulin bottle. -Again placed the used alcohol wipe directly on the counter top surface. -Drawn up the required amount of insulin from the bottle for resident 16. -Repeated the same process as above for resident 17. <p>Interview on 6/23/15 at the time of the above observation with RN G confirmed she should have used a new alcohol wipe for each insulin vial. She had agreed the counter top had not been considered a clean surface.</p> <p>Interview on 6/24/15 at 11:00 a.m. with the infection control nurse and the DON further confirmed the RN should have used a new alcohol wipe for each insulin vial.</p> <p>8. Observation on 6/22/15 at 4:30 p.m. of two transfer aides (mechanical lifts to assist with transfers) on the Northview unit revealed: *They had been located inside of a soiled utility room.</p>	F 441	<p>Continued from page 27</p> <p>Staff-specific education was completed by the DON with RN (G) on 7/14/15. Education consisted of review of Insulin Injection policy. Observation by the DON of insulin draws by RN (G) occurred on 7/14/15.</p> <p>Education of nursing staff by DON occurred on 7/21/15. Staff not in attendance on 7/21/15 will meet individually with DON. Education consisted of review of Insulin Injection policy.</p> <p>QA audits to ensure infection control is met will be done weekly for 2 months. If substantial compliance is achieved, QA audits will be done monthly for an additional 3 months then quarterly for another 6 months. _____ QA audits will be conducted by the DON or her designee. The DON will report audit findings to the QA committee monthly.</p> <p>8. <u>Mechanical Lifts Storage:</u> DON drafted/approved new policy entitled "Mechanical Life Storage" on 7/14/15. All Mechanical Lifts will be stored in an alcove or tub/shower room when not in use. (Continued on page 29 of 29)</p>	7/21/15	

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F 441	<p>Continued From page 28</p> <p>*They were pushed up against: -A hopper used to rinse out soiled linens. -A soiled bedside commode used for residents to go to the bathroom. -The soiled linen cart.</p> <p>Interview on 6/22/15 at 4:50 p.m. with licensed practical nurse (LPN) E revealed: *The mechanical lifts should: -Not have been stored in the soiled utility room. -Have been stored in the clean utility room. *She agreed neither the clean utility room or soiled utility rooms were appropriate storage places for the mechanical lifts. There had been potential for cross-contamination of bacteria to the residents.</p> <p>Observation on 6/23/15 at 9:00 a.m. of two mechanical lifts on the 200 wing revealed the same observation as above.</p> <p>Interview on 6/23/15 at 10:20 a.m. with CNA D revealed the mechanical lifts should have been stored in the clean utility room.</p> <p>Interview on 6/24/15 at 11:15 a.m. with the infection control nurse and the DON confirmed the mechanical lifts should have been stored in the clean utility room. They had agreed that neither the soiled utility rooms or the clean rooms were appropriate storage areas for the mechanical lifts. Their storage space had been limited.</p>	F 441	<p>Continued from Page 28</p> <p>Staff education was completed by DON through report on 7/14/15. Charge nurse is to continue to instruct C.N.A.s to store all mechanical lifts in alcove, shower or tub rooms through report and during shifts.</p> <p>QA audits to ensure infection control is met will be done weekly for 2 months. If substantial compliance is achieved, QA audits will be done monthly for an additional 3 months then quarterly for another 6 months. * [REDACTED] QA SW/SOON/JJ audits will be conducted by the DON or her designee. The DON will report audit findings to the QA committee monthly.</p>	7/14/15
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ORIGINAL

PRINTED: 07/07/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435112	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/24/2015
NAME OF PROVIDER OR SUPPLIER OAKVIEW TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 510 E 8TH ST POST OFFICE BOX 370 FREEMAN, SD 57029		
(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	
K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 6/24/15. Oakview Terrace was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000			

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

TITLE

(X8) DATE

Nicholas R. Brandon

CEO

7-13-15

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.

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10621	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/24/2015
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NAME OF PROVIDER OR SUPPLIER OAKVIEW TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 510 E 8TH ST POST OFFICE BOX 370 FREEMAN, SD 57029
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 000	<p>Initial Comments</p> <p>Surveyor: 34030 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 6/22/15 through 6/24/15. Oakview Terrace was found in compliance.</p>	S 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Nicholas R. Brandner</i>	TITLE <i>CEO</i>	(X6) DATE <i>7-15-15</i>
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