

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

ORIGINAL

PRINTED: 10/27/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/15/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MOBRIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 4TH AVENUE EAST POST OFFICE BOX 937 MOBRIDGE, SD 57601
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F 000	<p><i>*Addendums noted with an asterisk per 11/5/15 per telephone with facility DON. KW/SDDOH/EL</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 26632 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 10/14/15 through 10/15/15. Golden LivingCenter - Mobridge was found not in compliance with the following requirements: F176, F241, F274, F281, F323, F431, F441, and F514.</p>	F 000	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.	
F 176 SS=D	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>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.</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 obtain a physician's order to self-administer medications for one of one sampled resident (13). *To follow one of one sampled resident (13) assessments for self-administration of medications. Findings include:</p> <p>1. Observation and interview on 10/14/15 at 1:50 p.m. of resident 13 in his room revealed: *He was applying Biofreeze (pain relieving medication) to his left shoulder. *He had a "bad shoulder." *After applying he placed the bottle of roll-on Biofreeze on his bedside table.</p>	F 176		

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

TITLE

(X6) DATE

Rich Freeman **ED** 11-5-15

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 176	<p>Continued From page 1</p> <p>Further observation and interview on 10/15/15 at 10:00 a.m. of resident 13 in his room revealed he:</p> <ul style="list-style-type: none"> *Had the Biofreeze bottle and a bottle of saline nasal spray on his dresser. *Therapy had given him the Biofreeze about six months ago, and he used it for his shoulder. *He used the saline nasal spray, because his "nose gets dry." <p>Review of resident 13's medical records revealed:</p> <ul style="list-style-type: none"> *He had been admitted on 8/21/14. *On 9/30/15 the IDT had completed a self-administration of medication assessment. *That assessment revealed he was not appropriate to do his own medications for the following reasons: - "Poor compliance." - Unable to apply topical ointments, creams, or transdermal patches according to procedure. *There had not been physician's orders for medication self-administration or to keep medications at his bedside. *He did not have a physician's orders for the Biofreeze or saline nasal spray. <p>Interview on 10/14/15 at 4:43 p.m. with LPN I regarding resident 13 revealed he:</p> <ul style="list-style-type: none"> *Was not supposed to self-administer his own medications. *Should not have medications in his room. *Did not have a physician's order for the Biofreeze. <p>Interview with the director of nursing regarding resident self-administration of medications revealed:</p> <ul style="list-style-type: none"> *Assessments were completed to see if the resident was safe to self-administer medications and keep medications in their rooms at the 	F 176	<p>F 176</p> <ol style="list-style-type: none"> 1) Re-educate staff for resident #13 that the resident may not self-administer medication, including but not limited to Biofreeze or nasal spray, without a physician order and until completion of an assessment by the Interdisciplinary Team (IDT) has determined the resident is appropriate to self administer medications. 2) All residents that have the potential to obtain medications from family or any other external source have the potential to be affected. <i>*Every resident's room was checked right after survey for presence of ointments, topicals, etc, etc.</i> 3) Review facility policy titled "Self-Administration of Medications". Re-educate staff regarding policy and re-educate staff responsible for medication administration that medications cannot be left in resident rooms for staff convenience. 4) The Director of Nursing Services (DNS) or designee will monitor resident rooms for inappropriate presence of medications weekly x4 and monthly x2. Results will be communicated immediately to the DNS or Executive Director (ED). <i>*Three rooms audited each week. HW/SDDO/HJL</i> 	<i>* 11/11/15 HW/SDDO/HJL</i>	

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F 176	Continued From page 2 bedside. *They should have had physicians' orders to keep medications in their rooms if they wanted to self-administer them. *She agreed resident 13: -Did not have physician's orders to keep the above medications at his bedside. *Had an assessment that deemed him unable to self-administer medications. Review of the provider's May 2012 Self-Administration of Medications policy revealed: **"In order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer." **"E. If the resident demonstrates the ability to safely self-administer medications, a further assessment of the safety of bedside medications storage is conducted."	F 176	F 176 (continued) If concerns are identified immediate corrective action will be implemented. The DNS will submit a report of the QA monitoring to the QA committee at each scheduled meeting and necessity of further monitoring will be determined. 5) Corrective action will be completed on or before November 11, 2015. <i>*QA meets monthly. hw/sddo/H/L</i>	
F 241 SS=G	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: 23059 Surveyor: 36413	F 241		<i>*11/11/15 hw/sddo/H/L</i>

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F 241	<p>Continued From page 3</p> <p>Based on observation, interview, and policy review, the provider failed to give care and services in a dignified manner for 1 of 18 sampled residents (2) during personal care. Findings include:</p> <p>1a. Observation on 10/14/15 at 5:20 p.m. of certified nursing assistant (CNA) F providing personal care for resident 2 revealed: *He was being lifted in a stand assist sling (Sara lift). *His pants were hanging around his ankles, and he was not wearing an incontinence (loss of bowel/bladder control) brief. *He was in the process of having a bowel movement while standing. *There was no commode available in the room. *The resident was not taken into the bathroom. *CNA F obtained dry, brown paper towels from above the sink. -With those paper towels he wiped the resident's bottom approximately fifteen times. -Those paper towels had not been moistened. -Liquid soap had been applied to some of the dry towels. *While the resident was in the sling and his bottom was being wiped he grimaced and stated "Ouch." *The resident continued having a bowel movement on the floor while in the Sara lift. *At no point was he taken to the bathroom. *The resident had not been able to support himself and was hanging by the sling under his arms in Sara lift.</p> <p>Review of the provider's 1/26/15 Perineal (private area) Care policy revealed: *Equipment needed: -Bed protector.</p>	F 241	<p>F 241</p> <p>1) CNA F is no longer employed in the facility. Re-educate staff for resident #2 regarding the necessity of observing fabric recliner for indications of it being wet or soiled and re-educate them that the facility does use soaker pads in recliners when necessary.</p> <p>2) All residents have the potential to be affected. <i>*Multiple Peri-care audits were completed right after, no other residents were affected.</i></p> <p>3) Review facility policy titled "Dignity". Re-educate all staff regarding the policy titled "Dignity" and what constitutes providing care and services in with dignity and respect for individuals. Educate nursing staff regarding the policy titled "Perineal Care". Educate nursing staff regarding the necessity of observing fabric recliners for indications of being wet or soiled, the preference of having the resident use a toilet or commode, and the requirement of having a nurse assess the resident for appropriate lift use;</p> <p>4) The DNS or designee will monitor staff for appropriately completing</p>	

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F 241	<p>Continued From page 4</p> <ul style="list-style-type: none"> -Bedpan. -Basin of warm water and soap or perineal cleansing solution. -Towels. -Disposable gloves. -Toilet tissue. <p>*The procedure for male perineal [private area] care was:</p> <ul style="list-style-type: none"> -If resident is soiled with feces [bowel movement], place him on side and clean perineum and rectal area. -Change water and discard soiled linen appropriately. -Change gloves. -Turn resident on his back. -Ask resident to separate his legs and flex knees. If he is unable to spread his legs and flex knees, the perineal area can be washed with the resident on the side with legs flexed. -Gently wash pubis and penis. -Ask resident to bend and separate knees. Help resident if required. Wash scrotum carefully. -Rinse and pat dry. -Help position resident onto back. -Remove protective pad under buttocks, remove gloves. -Replace top bed linen. -Make resident comfortable. -Place call light in reach." <p>b. Observation on 10/14/15 at 5:40 p.m. revealed resident 2's recliner seat was soaking wet. Pressure was applied to that cushion with a gloved finger and a yellowish liquid pooled in that area. A strong urine odor was noted at that time.</p> <p>Interview on 10/14/15 at 2:15 p.m. with resident 2's wife revealed: *She thought high turnover in staff resulted in the</p>	F 241	<p>F 241 (continued)</p> <p>perineal cares, observe fabric recliners for indications of being wet or soiled, monitor toileting of residents that use a mechanical lift and monitor compliance of all staff with the policy titled "Dignity" weekly x4 and monthly x2. Results will be communicated immediately to the DNS or ED. If concerns are identified immediate corrective action will be implemented. The DNS will submit a report of the QA monitoring to the QA committee at each scheduled meeting and necessity of further monitoring will be determined.*1</p> <p>5) Corrective action will be completed on or before November 11, 2015</p> <p>→ All staff have been educated on proper peri-care, we will be monitoring 3 residents each week, QA meets monthly. KW/SDD/H/EL</p>	

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F 241	<p>Continued From page 5</p> <p>CNAs not knowing the residents' needs.</p> <p>*Towels and wash cloths were not picked up or replaced in resident 2's room daily.</p> <p>*She felt the shortage of staff on weekends resulted in her husband sleeping all day in his reclining chair.</p> <p>*She stated his recliner had been repeatedly soiled and not cleaned.</p> <p>c. Interview on 10/15/15 at 10:00 a.m. with the director of nursing (DON) confirmed:</p> <p>*Using brown paper towels was not acceptable for providing personal care for residents.</p> <p>*The resident should have been provided a commode or taken to the toilet for his bowel movement.</p> <p>*Allowing the resident to have a bowel movement on the floor while standing in the lift was not an acceptable practice.</p> <p>*The above care was not provided in a manner to maintain the resident's dignity.</p> <p>*The CNA should have called for assistance.</p> <p>*Soaker pads were not recommended for use in recliners. She stated she felt those pads could impact skin integrity.</p> <p>*Housekeeping staff were responsible for cleaning residents' furniture as needed. She confirmed the amount of moisture noted above would have taken a long time to create a puddle.</p>	F 241	<p>F 274</p> <p>1) IDT will complete a comprehensive care plan review for Resident #1 and 3 to be certain the care plan accurately reflects current needs of these residents.</p> <p>2) Any resident that experiences a significant change in health status has the potential to be affected. <i>*QA meets monthly. KW/SDD/H/EL</i></p> <p>3) Educate MDS nurse and all staff who complete the MDS on how to access the current RAI manual within Point Click Care computer software. Each weekly Medicare meeting will contain a brief discussion of residents who may have a significant change in status.</p> <p>4) The DNS or designee will audit MDS's for appropriate MDS completion weekly x4 and monthly x2. Results will be communicated immediately to the DNS or ED. If concerns are identified immediate corrective action will be implemented. DNS will submit a report of the QA monitoring to the QA committee at each scheduled meeting and necessity of further monitoring will be determined.</p>	
F 274 SS=D	<p>483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE</p> <p>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change</p>	F 274	<p>*11/11/15 <i>KW/SDD/H/EL</i></p> <p><i>See next page</i></p>	

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F 274	<p>Continued From page 6</p> <p>means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on record review, interview, and Resident Assessment Indicator (RAI) manual review, the provider failed to determine a significant change in condition had been coded on the Minimum Data Set (MDS) assessments for 2 of 18 sampled residents (1 and 3). Findings include:</p> <p>1. Review of resident 3's medical record revealed MDS assessments had been completed on the following dates: *7/7/15 a quarterly assessment. *9/29/15 an annual assessment.</p> <p>Review of the above MDS assessments for the resident revealed the following activities of daily living (ADL) (assistance with bathing, dressing, eating, and grooming) areas were coded as follows: *Walking in her room: -On 7/7/15 that activity did not occur. -On 9/29/15 that activity occurred only once or twice. *Locomotion (moving about) in the resident's room on the unit: -On 7/7/15 she needed extensive assistance of one staff member.</p>	F 274	<p>F 274 (continued)</p> <p>5) Corrective action will be completed on or before November 11, 2015.</p> <p><i>*residents that have experienced a change (improvement or decline) are being discussed at the weekly Medicare meeting to see if a sig change MDS is actually warranted. QA meets monthly. kw/sddotfel.</i></p>	

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F 274	<p>Continued From page 7</p> <p>-On 9/29/15 that activity occurred only once or twice.</p> <p>*Locomotion within the corridor on the same floor as her room:</p> <p>-On 7/7/15 she needed extensive assistance of one staff member.</p> <p>-On 9/29/15 that activity occurred only once or twice.</p> <p>*Range of motion (movement of arms and legs):</p> <p>-On 7/7/15 she had no impairment of the arms and legs on either side of the body.</p> <p>-On 9/29/15 she had impairment (damage) of the arms and legs on both sides of the body.</p> <p>*Moods and behavior frequency (how often those occur):</p> <p>-On 7/7/15 she had little interest or pleasure in doing things occurring more than half of the time frame.</p> <p>-On 9/29/15 the little interest or pleasure in doing things had increased to nearly every day.</p> <p>-On 7/7/15 she felt tired or had little energy occurring more than half of the time frame.</p> <p>-On 9/29/15 she felt tired or had little energy occurring nearly every day.</p> <p>*Depression score:</p> <p>-On 7/7/15 she scored a nine (mildly depressed).</p> <p>-On 9/29/15 she scored an eleven (moderately depressed).</p> <p>Interview on 10/15/15 at 10:00 a.m. with the MDS assessment coordinator confirmed the above MDS assessments should have been coded as a significant change in condition. She used the May 2013 Resident Assessment Instrument (RAI) manual as a reference. She had been informed at that time there was a more current manual on the Center for Medicare and Medicaid Services (CMS) website.</p>	F 274			

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F 274	<p>Continued From page 8</p> <p>Surveyor: 29162</p> <p>2. Review of resident 1's medical record revealed MDS assessments had been completed on the following dates: *12/5/14 an admission assessment. *2/24/15 a quarterly assessment.</p> <p>Review of the above MDS assessments for resident 1 revealed the following ADLs were coded as follows: *Bed mobility: -On 12/5/14 she needed extensive assistance of one staff member. -On 2/24/15 she needed extensive assistance of two staff members. *Eating: -On 12/5/14 she needed supervision of one staff member. -On 2/24/15 she needed limited assistance of one staff member. *Toilet use: -On 12/15/14 she needed extensive assistance of one staff member. -On 2/24/15 she needed extensive assistance of two staff members.</p> <p>Interview on 10/15/15 at 1:42 p.m. with the MDS coordinator confirmed resident 1 should have had a significant change in status assessment completed on 2/24/15.</p> <p>Surveyor 32572</p> <p>3. The provider confirmed they did not have a resident assessment policy.</p> <p>Review of the RAI manual, Version 3.0, October 2014, page 2-20, revealed the definition of a significant change in a resident's status as: *"A decline or improvement of a resident's status</p>	F 274		
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F 274	Continued From page 9 that: -Will not normally resolve itself without intervention by staff or by implementing standard disease related interventions, is not self-limiting. -Impacts more than one area of the resident's health status. -Requires interdisciplinary review and/or revisions of the care plan."	F 274	F 281		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Surveyor: 32572 Surveyor: 35237 A. Based on observation, interview, record review, and policy review, the provider failed to ensure: *Physicians' orders had been followed for 3 of 5 sampled residents (3, 9, and 13) with oxygen therapy. *Physician's orders had been clarified for 1 of 18 sampled residents (11) who self-administered her medications. Findings include: 1. Review of resident 3's medical record revealed: *Physician's orders signed on 7/30/15, 9/1/15, and 9/30/15. *Those physician's orders stated "Oxygen	F 281	1) Re-educate staff for resident #3, 9, & 13 regarding the necessity of administering oxygen at the flow rate per physician order. Educate staff for resident #11 to clarify physician orders when said order conflicts with IDT assessment, specifically when IDT assessment has determined that the resident is unable to self-administer medication and the physician has ordered that the resident may self administer medications. Educate staff for resident #11 and 14 regarding appropriate delegation of tasks to CNA's, specifically that CNA's cannot determine the type of mechanical lift that is appropriate for a resident at any given time on any given day. Refer to F 176 POC 2) Any resident that has oxygen ordered has the potential to be affected.	*11/11/15 KW/SDDO/H/L	

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F 281	<p>Continued From page 10 concentrator 2 liter [L] in both nostrils every shift."</p> <p>Review of resident 3's medication administration records (MAR) revealed: *The February, March, September, and November 2015 MARs stated "Oxygen concentrator 2 liter in both nostrils every shift." *The February, March, September 2015 MARs had been signed on every entry the resident had received oxygen therapy at 2 L every day. *The October MAR had been signed on every day from the first through the thirteenth.</p> <p>Review of resident 3's 8/26/13 care plan revealed: *A focus area of "Alteration in respiratory status due to chronic obstructive pulmonary disease [breathing problems] and lung cancer. Is at risk for ineffective airway clearance and SOB [shortness of breath]." *An intervention of "Administer O2 [oxygen] per Dr. [doctor] order."</p> <p>Review of resident 3's nursing progress notes revealed entries on: *3/4/15 Resident vital signs (temperature, pulse, respiration, and blood pressure, along with oxygen saturation [how much oxygen is in the blood]) and "2.5 L NC [liters per nasal canula]." *3/5/15 Resident vital signs, "O2 sat on 3L per nasal canula." *9/25/15 "O2 con't [continue] at 4 lpm via n/c [liters per minute per nasal canula]."</p> <p>Random observations on 10/14/15 and 10/15/15 revealed resident 3 receiving oxygen per nasal canula at 3L.</p> <p>2. Review of resident 9's medical record</p>	F 281	<p>F 281 (continued)</p> <p>Any resident that has a physician order to self-administer medications has the potential to be affected.</p> <p>Any resident that transfers with the use of a mechanical lift has the potential to be affected.</p> <p>3) Review facility policy titled "Oxygen Administration". Educate all nursing staff on the policy titled "Oxygen Administration" and the necessity of administering oxygen at the flow rate per physician order, and the necessity of clarifying physician orders when needed.</p> <p>Review facility policy titled "Safe Patient Handling". Educate all nursing staff on the policy titled "Safe Patient Handling" and the requirement for a nurse or therapist to assess the resident initially regarding the appropriate mechanical lift for the resident and the requirement for a nurse or therapist to subsequently assess the resident to determine the need for a change in the type of mechanical lift used.</p>		

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F 281	<p>Continued From page 11 revealed: *A 9/16/15 signed transfer sheet from the hospital stating "O2 0.5 L per NC." *A physician's order signed 9/29/15 for "Oxygen concentrator 0.5 liter in both nostrils every shift."</p> <p>Review of resident 9's September and October 2015 MARs revealed: **"Oxygen concentrator 0.5 liter in both nostrils every shift." *The September 2015 MAR had been signed on every entry stating the resident received that dose. *The October 2015 MAR had been signed on every entry from the first through the thirteenth.</p> <p>Review of resident 9's nurses progress notes revealed twenty-two of thirty-four notes stated resident 9 had received O2 from 1 to 3L per nasal canula.</p> <p>Review of resident 9's initiated 9/29/15 care plan revealed: *A focus area of "Alteration in respiratory status due to congestive heart failure [fluid around the heart] and edema [swelling]." *Listed as interventions were: -"Administer oxygen as needed per Physician order." -"Monitor oxygen flow rate and response."</p> <p>Random observations on 10/14/15 and 10/15/15 revealed resident 9 receiving oxygen per nasal canula at 1.5 L.</p> <p>Surveyor: 35237 3. Observation and interview on 10/15/15 at 10:00 a.m. of resident 13 in his room revealed: *He was receiving oxygen per nasal canula at 4L.</p>	F 281	<p>F 281 (continued)</p> <p>Review job descriptions for RN, LPN and CNA, specifically where nurses must assess resident status and implement a plan of care, and where CNA's must provide care as directed and provide input to the nurses for development of plan of care.</p> <p>Refer to F 176</p> <p>4) The DNS or designee will monitor that oxygen flow rates are being administered per physician order weekly x4 and monthly x2. Results will be communicated immediately to the DNS or ED. If concerns are identified immediate corrective action will be implemented. DNS will submit a report of the QA monitoring to the QA committee at each scheduled meeting and necessity of further monitoring will be determined. <i>*We are auditing 3 residents every week. QA meets monthly. HHS/SDDOT/TEL</i></p> <p>The DNS or designee will monitor that any resident with a physician order to self-administer medication has a completed IDT assessment which determines that the resident is</p>	
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F 281	<p>Continued From page 12</p> <p>*He wore oxygen all the time. *He stated it should have been at 3L.</p> <p>Review of resident 13's printed 10/8/15 care plan revealed: *A focus area of "Alteration in respiratory status due to Chronic Obstructive Pulmonary Disease [COPD - breathing disorder], Congestive Heart failure, cough and wheezing." *Interventions for that area included: -"Administer oxygen as needed per Physician order. Monitor oxygen saturations on room air and/or oxygen. -Monitor oxygen flow rate and response."</p> <p>Review of his last signed 10/3/15 physician's orders revealed he should have received oxygen at 2L every shift.</p> <p>Surveyor: 32572 4. Interview on 10/15/15 at 9:45 a.m. with the director of nursing (DON) revealed she would have expected the physician's orders to have been followed or the order clarified with the physician.</p> <p>Review of the provider's 1/26/15 reviewed Oxygen Administration policy revealed: *"Check the physician's order for liter flow and method of administration." *"Set the flow meter to the rate ordered by the physician."</p> <p>Surveyor: 26632 5. Review of resident 11's 9/30/15 physician's orders update revealed she could self-administer: *Nebulizer treatments after set-up by the nurse. *Arthricare double ice pain gel and have at her bedside.</p>	F 281	<p>F 281 (continued)</p> <p>able to do so weekly x4 and monthly x2. Results will be communicated immediately to the DNS or ED. If concerns are identified immediate corrective action will be implemented. The DNS will submit a report of the QA monitoring to the QA committee at each scheduled meeting and necessity of further monitoring will be determined.</p> <p>The DNS or designee will monitor that a nurse or therapist has completed an initial assessment for mechanical lift use and an additional assessment any time a resident requires a mechanical lift change weekly x4 and monthly x2. Results will be communicated immediately to the DNS or ED. If concerns are identified immediate corrective action will be implemented. The DNS will submit a report of the QA monitoring to the QA committee at each scheduled meeting and necessity of further monitoring will be determined.</p>	

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F 281	<p>Continued From page 13</p> <p>*Cough drops lozenge and have at her bedside.</p> <p>Interview on 10/14/15 at 4:20 p.m. with the DON revealed:</p> <p>*Resident 11's physician's order should have been clarified with her physician.</p> <p>*Resident 11 was not able to self-administer medications due to her memory loss and poor safety awareness.</p> <p>B. Based on observation, interview, record review, and job description review, the provider failed to ensure safe delegation of resident transfer assessments for two of six sampled residents (11 and 14). Findings include:</p> <p>1. Review of resident 14's medical record revealed:</p> <p>*A lift/mobility assessment for residents had been completed on 6/4/15 and 9/1/15.</p> <p>-Those assessments had been completed by the Minimum Data Set (MDS) assessment nurse.</p> <p>-Those assessments indicated using the Sara Lift (sit-to-stand lift device where resident has to participate in transfers).</p> <p>-Those assessments also indicated the use of the Marisa Lift (total lift device where the resident does not have to participate in the transfer process).</p> <p>Review of the 9/1/15 care plan revealed:</p> <p>*A focus area with a start date of 6/23/11 of "Potential for falls related to impaired mobility [moving or transferring], and the use of a mechanical lift for transfers."</p> <p>*An intervention area of "Hoyer [for total assistance] lift or sara lift for transfers."</p> <p>2. Review of resident 11's medical record</p>	F 281	<p>F 281 (continued)</p> <p>5) Corrective action will be completed on or before November 11, 2015.</p>	

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F 281	<p>Continued From page 14 revealed:</p> <p>*A lift/mobility assessment for the resident had been completed on 5/26/15 and 8/21/15. -Those assessments had been completed by the MDS assessment nurse. -Those assessments indicated use of the Sara Lift.</p> <p>Review of resident 11's 3/04/11 care plan revealed: *A focus area of "Potential for falls related to history of falls, morbid obesity [overweight], general disability, shoulder and hand pain, and the use of psychotropic [mood altering] medications." *An intervention area of "Transfer with mechanical lift as needed."</p> <p>Interview on 10/15/15 at 1:00 p.m. with the DON revealed the did have a ttransfer policy Review of the provider's 9/25/14 certified nurse assistant (CNA) job description revealed an "Essential job duty of provide resident care as directed by care plan and/or nursing staff."</p> <p>Review of the providers 9/10/14 charge nurse job description revealed and "General purpose was to be responsible for the independent supervision of the delivery of care to a group of residents in a nursing unit. Assess resident needs, develop individual care plans, administer nursing care, evaluate nursing care. "</p> <p>Review of the manufacturer's recommendations for use guidelines for the Sara and Marisa lifts did not indicate specific guidelines for when and when not to use that equipment.</p> <p>Interview on 10/15/15 at 10:20 a.m. with the DON</p>	F 281		

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F 281	Continued From page 15 revealed she was aware the lifts needed a nursing assessment. She felt that "Certified nursing assistants (CNA) were able to decide which lift to use for that particular time for the resident." Observation and interview on 10/15/15 at 10:10 a.m. with CNA B revealed she would determine which lift would be used based on the resident's weight bearing status at that time.	F 281	F 323 1) CNA F no longer works in the facility. Educate staff for resident #2 and 11 that appropriate lift assessments must be completed initially by a nurse or therapist and at any time there is a need to change the type of mechanical lift in use.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Surveyor: 36413 Surveyor: 26632 Based on observation, interview, record review, and job description review, the provider failed to ensure: *Safe transfers had been completed for two of six sampled residents (2 and 11). *An environment free from potential accident hazards for one of one counter top electric convection oven in the advanced Alzheimer's care unit (AACU) dining room.	F 323	2) Any resident that transfers with the use of a mechanical lift has the potential to be affected. *Every resident that transfers with a lift, a new lift assessment 3) Review Safe Patient Handling policy. Educate all nursing staff on the policy titled "Safe Patient Handling" and that an appropriate lift assessment must be completed by a nurse or therapist prior to a mechanical lift being used or changing the type of mechanical lift being used. Educate all staff that countertop convection oven has been permanently removed from service. 4) The DNS or designee will monitor that residents transferring with the use of a mechanical lift have an initial lift assessment completed by a nurse or therapist and that a	*11/11/15 KW/SDD/H/EL care plans were updated, all staff have been educated. KW/SDD/H/EL

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F 323	<p>Continued From page 16</p> <p>Findings include:</p> <p>1. Observation on 10/14/15 from 10:15 a.m. through 10:40 a.m. revealed resident 11 was assisted by certified nursing assistant (CNA) D from her wheelchair to the toilet and then to her bed. A Sara Lift (sit-to-stand device, resident has to participate in transfers) was used. During those transfers resident 11 was noted to be in a sitting position with her feet on the lift platform and the blue lift sling under her arms. She did not bear any weight on her legs and was not able to pull herself to a standing position.</p> <p>Review of resident 11's Lift/Mobility Assessment for Residents form revealed three assessments had been completed by the Minimum Data Set (MDS) assessment coordinator. Those assessments had been completed on 3/2/15, 5/26/15, and 8/21/15. All of those assessments indicated using the Sara lift with the large green sling.</p> <p>Review of resident 11's 3/04/11 care plan revealed: *A focus area of "Potential for falls related to history of falls, morbid obesity [overweight], general disability, shoulder and hand pain, and the use of psychotropic [mood altering] medications." *An intervention area of "Transfer with mechanical lift as needed."</p> <p>Interview on 10/15/15 at 10:00 a.m. with the MDS assessment coordinator revealed she: *Would complete the lift assessments for each resident by interviewing the staff. *Rarely was able to observe a lift for the assessment.</p>	F 323	<p>F 323 (continued)</p> <p>subsequent assessment is completed by a nurse or therapist prior to changing the type of mechanical lift used for transfers. The DNS or Designee will monitor weekly x4 and monthly x2. Results will be communicated immediately to the DNS or ED. If concerns are identified immediate corrective action will be implemented. The DNS will submit a report of the QA monitoring to the QA committee at each scheduled meeting and necessity of further monitoring will be determined.</p> <p>5) Corrective action will be completed on or before November 11, 2015.</p>	
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**All residents were initially monitored and 3 are being audited each week, QA meets monthly.*
KW/SDP/H/EL

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F 323	<p>Continued From page 17</p> <p>*Was not aware resident 11 could not transfer in a standing position with the Sara lift.</p> <p>Surveyor: 36413 Surveyor: 23059</p> <p>2. Observation on 10/15/15 at 5:20 p.m. of CNA F providing care for resident 2 revealed he was being assisted with a Sara lift with a sling under his arms. He was unable to stand straight and bear weight on his legs. He was slouched and his arm pits were held up by the lift sling. He was grimacing and saying "ouch" during that time.</p> <p>Review of his medical record revealed no assessment was found to determine which mechanical lift would have been most appropriate for him to use.</p> <p>Interview on 10/15/15 at 1:00 p.m. with restorative CNA J revealed resident 2 was on the list for therapy to evaluate him for lift sling usage.</p> <p>Interview on 10/15/15 at 1:35 p.m. with the director of nursing (DON) revealed her expectation would have been the MDS assessment coordinator should have assessed him for appropriate type of lift used. She stated the MDS assessment coordinator was the one responsible for those assessments.</p> <p>Surveyor: 26632 Interview on 10/15/15 at 1:00 p.m. with the DON revealed the provider did not have a transfer policy. Review of the provider's 9/25/14 CNA job description revealed an "Essential job duty of provide resident care as directed by care plan and/or nursing staff."</p> <p>Review of the provider's 9/10/14 charge nurse job</p>	F 323		
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F 323	Continued From page 18 description revealed "General purpose was to be responsible for the independent supervision of the delivery of care to a group of residents in a nursing unit. Assess resident needs, develop individual care plans, administer nursing care, evaluate nursing care. " Review of the manufacturer's recommendations for use guidelines for the Sara and Marisa lifts did not indicate specific guidelines for when and when not to use that equipment. 3. Observation on 10/14/15 from 9:30 a.m. through 10:30 a.m. revealed a counter top electric convection oven in the AACU dining room. It was on the countertop and was plugged in. During the observation the memory care activity assistant had the oven on and was baking brownies. After the brownies had finished baking she left the dining room area. She took a pan of the brownies to the Alzheimer's care unit. The sides of the oven were still hot when touched. There was an unidentified resident in the dining room. Interview on 10/15/15 at 3:30 p.m. with the administrator revealed he was not aware that oven should not have been left plugged in. He had not realized it would still be hot for a while after use.	F 323	F 431 1) Educate nursing staff on the North and South Hall that pouches of Xopenex must be dated when the manufacturers seal is initially broken. - Educate nursing staff on the South hall that insulin pens and vials must be dated when the manufacturers seal is initially broken. Educate nursing staff on the North and South hall that expired medications and medications such as Xopenex and Insulin that are opened but un-labeled with the open date must be discarded. 2) All residents have the potential to be affected. 3) Review "Expiration Dating" policy. Educate all nursing staff on the policy titled "Expiration Dating" and specifically that pouches of Xopenex and insulin pens and vials must be dated when the manufacturer's seal is initially broken. Educate all staff that expired medications as well as un-dated but opened vials of medication, insulin		
F 431 SS=D	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	F 431		*11/11/15 KVV/SDD/HJL	

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F 431	<p>Continued From page 19 controlled drugs is maintained and periodically reconciled.</p> <p>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 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: 23059 Based on observation, interview, and policy review, the provider failed to ensure: *Two of two outdated medications had been removed from one of two observed medication carts (North Hall). *One of three Lantus insulin flexpens (device to administer insulin) and two of two in-use insulin vials had been dated when opened in one of two</p>	F 431	<p>F 431 (continued)</p> <p>pens, and Xopenex must be discarded.</p> <p>4) The DNS or designee will monitor that medications are dated when opened and that expired medications are discarded. Such audits will be conducted weekly x4 and monthly x2. Results will be communicated immediately to the DNS or ED. If concerns are identified immediate corrective action will be implemented. The DNS will submit a report of the QA monitoring to the QA committee at each scheduled meeting and necessity of further monitoring will be determined.*</p> <p>5) Corrective action will be completed on or before November 11, 2015.</p> <p>* All of the medications and medication cart are monitored in each of the audits, QA meets monthly. KW/SDDO/H/EL</p>	

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F 431	<p>Continued From page 20 medication carts (South Hall) *Six of six opened foil pouches of Xopenex (breathing treatment) had been dated when opened in two of two observed medication carts (North and South Hall). Findings include:</p> <p>1. Observation on 10/15/15 at 9:30 a.m. of the North Hall medication cart revealed: *One container of Vitamin B-6 with an expiration date of 9/2015. *One container of ibuprofen 200 milligrams with an expiration date of 8/2015. *Four of four opened foil pouches of Xopenex nebulizer solution without an opened date. The Xopenex would have expired fourteen days after the foil pouch had been opened.</p> <p>2. Observation on 10/15/15 at 10:15 a.m. of the South Hall medication cart revealed: *Two of two opened foil pouches of Xopenex without an opened date. *One of three Lantus insulin flexpens without an opened date. That medication would have expired twenty-eight days after opening. *Two of two opened vials of insulin without an opened date. Those vials would have expired twenty-eight days after opening.</p> <p>3. Interview on 10/15/15 at 10:15 a.m. with the director of nursing (DON) revealed staff had been taught to date all insulins including flexpens when first opened. She stated she did not think Xopenex needed to have been dated when the foil pouch was opened when it was given on a scheduled basis. She confirmed there was no way to know how long those foil pouches had been opened. She stated the assistant DON and the pharmacist were responsible for going</p>	F 431		
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F 431	Continued From page 21 through the medication carts and removing outdated medications. Review of the provider's 5/2012 Storage of Medications policy revealed: *Outdated medications were to have been immediately removed from the medication supply. *Medication storage was monitored on a monthly basis by the consultant pharmacist. *Medications, including multi-dose vials, once opened required an expiration date. *When the original seal of a manufacturer's container or vial was initially broken it should have been dated.	F 431	F 441 1) Educate Nurse A and the staff for resident #22 and 23 on appropriate hand hygiene, glove use, proper administration of eye medication, and proper storage and transportation of eye medication. Educate Nurse A and staff for resident #5 regarding hand hygiene and appropriate glucometer decontamination.		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (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.	F 441	Educate LPN A that ointments must be applied with an appropriate applicator stick. Educate LPN C that a dropped oral medication onto the medication cart top is considered contaminated. Relocate blanket warmers to an area where clean and soiled linens do not mix. Educate all staff that clean items such as lift slings and boots may not be stored on the floor. 2) All residents have the potential to be affected.	*11/11/15 KW/SDDOK/EL	

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F 441	<p>Continued From page 22</p> <p>(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.</p> <p>(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: 23059 Based on observation, interview, and policy review, the provided failed to maintain adequate infection control practices for: *Two of two random residents' (22 and 23) eye drop administration by one of one observed nurse (A). *One of one sampled resident's (5) blood sugar testing by one of one observed nurse (A). *One of one sampled resident's (5) insulin administration by one of one observed nurse (A). *One dropped pill out of thirty-two observed administrations of oral medications. *One of two observed resident's (5) treatments by one of two nurses (A). *Four of four blanket warmers stored in the soiled utility rooms. *A mechanical lift sling and a gray lift boot stored on the floor of the clean linen room beside the laundry area. Findings include:</p>	F 441	<p>F 441 (continued)</p> <p>3) Review "Handwashing/Hand Hygiene" policy. Educate all nursing staff on the policy titled "Handwashing/Hand Hygiene".</p> <p>Review the policy titled "Eye Medication, Administration of". Educate all nursing staff on the policy titled "Eye Medication, Administration of".</p> <p>Review "Blood Glucose Monitor Decontamination" policy. Educate all nursing staff on the policy titled "Blood Glucose Monitor Decontamination".</p> <p>Review "Topical Medication Administration" policy. Educate all staff that administer medications regarding the policy titled "Topical Medication Administration".</p> <p>Review Linen handling and storage policy titled "Departmental (Environmental Services) – Laundry and Linen". Educate all staff on policy titled "Departmental (Environmental Services) – Laundry and Linen".</p>	
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F 441	<p>Continued From page 23</p> <p>1a. Observation on 10/14/15 at 11:35 a.m. revealed licensed practical nurse (LPN) A prepared to administer Refresh Tears eye drops to resident 22. She removed the eye drop package from the medication cart and placed the eye drop container in her pocket. She put on gloves and locked the medication cart. She had not washed her hands or used hand sanitizer prior to putting on those gloves. She entered resident 22's room and with her gloved hands removed the eye drop container from her pocket. With those same gloved hands she pulled down on the resident's lower eyelid to administer the drops. She removed her gloves and left the resident's room. She did not wash her hands prior to leaving the room.</p> <p>b. Observation on 10/14/15 at 11:50 a.m. revealed LPN A prepared to administer Pred Forte eye drops (for treating swelling in the eyes) for resident 23. Without washing her hands or using hand sanitizer she put on a pair of gloves and did the following: *Opened the medication cart. *Obtained the eye drop container. *Shut and locked the medication cart. *Knocked on resident 23's door. *Pulled down on the resident's lower eyelid and administered the eye drop. She then removed her gloves and did not wash her hands or use hand sanitizer after removing them.</p> <p>c. Observation on 10/14/15 at 11:52 a.m. revealed LPN A obtained the glucose meter (device to check the level of sugar in the blood) from the medication cart. She put gloves on and took the glucose meter and an alcohol wipe into</p>	F 441	<p>F 441 (continued)</p> <p>4) The DNS or designee will monitor staff for appropriate handwashing/hand hygiene, proper administration of eye drops, correct decontamination of the blood glucose machine, proper administration of topical medications and appropriate storage and separation of clean and dirty linens. The DNS or Designee will monitor weekly x4 and monthly x2. Results will be communicated immediately to the DNS or ED. If concerns are identified immediate corrective action will be implemented. The DNS will submit a report of the QA monitoring to the QA committee at each scheduled meeting and necessity of further monitoring will be determined. <i>*All residents were initially monitored and 3 are being audited each week. QA meets monthly.</i></p> <p>5) Corrective action will be completed on or before November <i>KWISDDOIVEL</i> 11, 2015.</p>	
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F 441	<p>Continued From page 24</p> <p>resident 5's room. With those same gloves on she:</p> <ul style="list-style-type: none"> *Placed the testing strip into the glucose meter. *Used a lancet (sharp device to puncture the skin) and drew a drop of blood. *Obtained the blood sugar reading. *Returned the glucose meter to the medication cart. *Obtained a bleach wipe and disinfected the meter. <p>She removed her gloves and did not wash her hands or use hand sanitizer. She then removed the insulin flexpen (device to administer insulin) from the drawer and dialed the required amount of insulin. Without washing her hands or using hand sanitizer she put on gloves and did the following:</p> <ul style="list-style-type: none"> *Pushed resident 5 in his wheelchair back to his room. *Lifted up his shirt to administer the insulin into his stomach area. <p>Then she removed her gloves and did not wash her hands or use hand sanitizer after removing them.</p> <p>d. Interview on 10/14/15 at 12:05 p.m. with LPN A revealed all of the above were her usual practices.</p> <p>2. Observation on 10/15/15 at 8:06 a.m. revealed LPN C dropped an oral medication on the top of the medication cart. She used a spoon to pick up that medication and put it in the cup with the rest of the medications. She gave those medications to the resident.</p> <p>Interview at that time with LPN C revealed she would have discarded that oral medication if it had fallen on the floor. She felt the top of her</p>	F 441		
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F 441	<p>Continued From page 25</p> <p>medication cart would not have been considered a contaminated surface. She confirmed multiple items had been in contact with that medication cart that could have made it unclean.</p> <p>3. Interview on 10/15/15 at 10:15 a.m. with the director of nursing revealed her expectation was hand hygiene should have been completed before and after every glove use. She confirmed: *The nurse should not have put on gloves until she was ready to perform the specific task. *Touching multiple items could have contaminated those gloves prior to the administration of eye drops or insulin. *Medications dropped on top of a medication cart should have been discarded and not given to a resident.</p> <p>Surveyor: 29162</p> <p>4. Observation on 10/14/15 at 1:40 p.m. of LPN A while she completed a treatment for resident 5 revealed she: *Changed her left glove four times during the observation. All four of those times she had not completed hand hygiene (washing or using hand sanitizer) before putting on the clean glove. *Uncovered and examined the resident's right fourth and fifth toes with gloved hands. She then dipped that same soiled right gloved finger into hydrophor ointment (moisturizing ointment). She applied that ointment to the resident's toes.</p> <p>Interview on 10/15/15 at 2:00 p.m. with the DON revealed she agreed LPN A had not used appropriate hand hygiene and infection control practices for ointment application.</p> <p>Review of the provider's revised August 2014 Handwashing/Hand Hygiene policy revealed:</p>	F 441		
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F 441	<p>Continued From page 26</p> <p>*All personnel were to have followed the handwashing/hand hygiene procedures to help prevent the spread of infection.</p> <p>*An alcohol-based hand rub (hand sanitizer) or soap and water was to have been used:</p> <ul style="list-style-type: none"> -Before and after direct contact with residents. -Before preparing or handling medications. -Before performing any non-surgical invasive procedures (blood glucose monitoring). -Before and after handling an invasive device (lancet for puncturing a finger). -Before moving from a contaminated body site to a clean body site during a resident's care. -Before and after using gloves. <p>*The use of gloves did not replace handwashing/hand hygiene.</p> <p>*Glove use along with hand hygiene was recognized as the best practice for preventing healthcare-associated infections.</p> <p>Review of the provider's November 2011 Topical Medication Administration policy revealed an appropriate applicator to remove medication from the container was to have been used.</p> <p>Surveyor: 32572</p> <p>5. Random observations on 10/14/15 through 10/15/15 revealed four blanket warmers had been stored in the soiled utility room.</p> <p>Interview on 10/15/15 at 9:45 a.m. with the DON confirmed the blankets in the warmers were clean items that were stored in the soiled utility room. She stated "That is not the optimal placement for clean items."</p> <p>Review of the manufacturer's recommendations for use did not reveal where the device was to have been placed. The provider did not have a</p>	F 441		

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F 441	Continued From page 27 policy on the blanket warmers. 6. Random observations on 10/14/15 through 10/15/15 revealed a mechanical lift sling and a gray lift boot were stored on the floor of the clean linen room beside the laundry area. Interview on 10/15/15 at 8:10 a.m. with laundry aides N and O confirmed items on the floor were no longer considered clean. Those items on the floor would need to be re-washed and hung up. Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, MO., 2005, p 786, revealed "Clean techniques includes procedures used to reduce and prevent the spread of microorganisms [germs]."	F 441	F 514 1) Educate staff for resident #12 that accurate and complete recording of resident condition must include documentation of resident findings. 2) Any resident with a change in condition has the potential to be affected. *Residents that have experienced a change (improvement or decline) are being discussed at weekly Medicare meeting. QA meets monthly. 3) Review "Condition Change of the Resident (Observing, Recording and Reporting)" policy. Educate all nurses on the policy titled "Condition Change of the Resident (Observing, Recording and Reporting)", specifically that documentation must include observation of findings. 4) The DNS or designee will monitor for complete and accurate documentation when a resident experiences a change in condition. The DNS or Designee will monitor weekly x4 and monthly x2. Results will be communicated immediately to the DNS or ED. If concerns are identified immediate corrective action will be implemented. The DNS will submit a report of the QA monitoring to the QA committee at each scheduled meeting and	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by:	F 514		KW/SDD/H/EL *11/1/15 KW/SDD/H/EL

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F 514	<p>Continued From page 28 Surveyor: 35237 Based on observation, interview, record review, and policy review, the provider failed to ensure adequate documentation was present in the medical record for one of one sampled resident (12) who had a change in skin condition. Findings include:</p> <p>1. Observation and interview with certified nursing assistant (CNA) K on 10/14/15 at 7:50 a.m. outside resident 12's room revealed: *The resident's door was closed. *There was a cart with gowns and gloves in the hallway by his room. *He had a rash to his abdomen, chest, and back. *He was on isolation (precautions for an infection). *She was unsure if it was for scabies (an infection of the skin caused by mites) or a reaction to the laundry detergent.</p> <p>Observation and interview on 10/14/15 at 9:55 a.m. of resident 12 in his room revealed: *His rash started after he had been admitted from the hospital. *He was living with family prior to that hospitalization. *He felt the rash could have been caused by the facility laundry detergent since he had allergies to laundry detergents in the past. *He lifted his shirt and was scratching his abdomen. -There were scattered red blotchy areas to his abdomen, chest, and back. -Some areas were scratched open from his itching. *He stated they had a conference with a doctor on Monday who thought it was scabies. -He was unsure how he could have gotten</p>	F 514	<p>F 514 (continued)</p> <p>necessity of further monitoring will be determined.</p> <p>5) Corrective action will be completed on or before November 11, 2015.</p>	
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F 514	<p>Continued From page 29</p> <p>scabies.</p> <p>-They applied the treatment to his skin on Monday and showered that medication off yesterday.</p> <p>-They took all his clothes out to wash them and made him stay in his room for twenty-four hours.</p> <p>-He was unsure if that treatment was helping with the rash and itching yet.</p> <p>Review of his medical record revealed:</p> <p>*He was admitted on 9/8/15.</p> <p>*His 9/8/15 admission skin assessment did not mention a rash.</p> <p>*He was alert and oriented with no memory issues.</p> <p>*His admission physician's orders included hydrocortisone (for itching, redness, and swelling) cream twice daily with no specified reason for using.</p> <p>*His last signed 9/29/15 physician's orders included hydrocortisone cream twice daily for itching.</p> <p>*A 10/12/15 LTC (Long Term Care) Progress Note from a tele-med (uses audio/visual equipment to communicate with another provider) appointment stated:</p> <p>-Details: "Resident is evaluated via audio/visual telecommunication at the request of the facility nurse for rash which has been present for 3-4 weeks. He has been using hydrocortisone cream for the past 3 weeks with no success. States otherwise is feeling well. Facility has had a case of scabies which was in August that was treated."</p> <p>-Current location: "Generalized."</p> <p>-Location at onset: "Left back."</p> <p>-Skin symptoms: "Pruritus [itching]."</p> <p>-Skin eruptions: "Description (Wide spread papules with black endpoints and burrowing)."</p> <p>-Assessment/Plan: "Scabies."</p>	F 514		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/15/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MOBRIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 4TH AVENUE EAST POST OFFICE BOX 937 MOBRIDGE, SD 57601		
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F 514	<p>Continued From page 30</p> <p>-Additional Plan Details: "1. Discontinue hydrocortisone. 2. Permethrin [medicated cream for treatment of scabies] apply 5% X [times] 1 at bedtime, from neck to toes. Shower off in the morning. 3. Limit visitors today. 4. Call if any concerns or worsening of symptoms. Facility was educated to wash clothes worn recently in hot water, separate from other residents. They will also need to change bedding tomorrow after treatment and wash that in hot water, separate from other linens."</p> <p>Review of his interdisciplinary progress notes from his 9/8/15 admission through 10/15/15 revealed:</p> <p>*On 9/8/15, He arrived to the facility at 3:15 p.m. "Skin assessment completed & [and] documented on admission assessment." -There was no mention of a rash present at that time.</p> <p>*On 9/9/15 - "...skin check tonight resident presented [9/8/15] with a pressure (injured area of skin) area on right heal [heel] and multipl [multiple] bruisis [bruises] on the antior [anterior -front] and posteriour [posterior - back] of arms and abrasion on the front of his right leg. There is no oter [other] skin issues to report at this time." *On 9/18/15 - "He c/o [complains of] itching to left abdomen [abdomen] and left flank. Red rash noted to site. Hydrocortisone cream applied. Personal care rendered [done] as needed. Pleasant and cooperative with care. Will cont. [continue] to monitor." *On 10/12/15 - "...Resident was seen by elong term care [tele-med] and new orders were written..." -There was no mention of: --Why he was seen by tele-med. --An assessment of his skin or the rash.</p>	F 514			

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F 514	<p>Continued From page 31</p> <p>--What orders or instructions the tele-med physician had given.</p> <p>*There were no other progress notes that addressed his rash, itching, worsening of the rash, physician involvement, or precautions/instructions that were started as a result of the tele-med consultation.</p> <p>Review of resident 12's 9/22/15 printed care plan related to the focus area for "Altered skin integrity non pressure related to: redness and an abrasion to my right leg and itching. I have multiple bruises to my upper body and skin tears to my arms" revealed:</p> <p>*Interventions for that area had been initiated on 9/21/15 and last revised on 9/22/15. They included:</p> <p>- "Conduct weekly skin inspection."</p> <p>- "Monitor for signs and symptoms of infection such as swelling, redness, warm, discharge, odor notify physician of significant findings."</p> <p>- "Treatments as ordered."</p> <p>*There was no mention of a rash to his skin.</p> <p>*There were no documented changes in interventions for his skin.</p> <p>Interview on 10/14/15 at 8:30 a.m. with the director of nursing regarding resident 12 revealed:</p> <p>*The nurses had been applying hydrocortisone cream as ordered to his skin since admission on 9/8/15.</p> <p>*She thought he had been admitted with the rash, and it had gotten worse all of a sudden on Monday (10/12/15). They had updated his physician at that time.</p> <p>*When the rash worsened:</p> <p>- They updated his physician who ordered the tele-medicine (tele-med) consultation.</p>	F 514			

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F 514	<p>Continued From page 32</p> <p>-The tele-med consultation was completed. -He was diagnosed with scabies and ordered a treatment. -That treatment had been completed. *She agreed the documentation in his medical record did not mention the rash being present on admission, continued presence of a rash, or that it had worsened all of a sudden. *She confirmed there was minimal documentation about the rash or nursing assessments of it in his progress notes. *They did not have a general documentation policy.</p> <p>Interview on 10/14/15 at 5:50 p.m. of licensed practical nurse (LPN) L regarding resident 12 revealed: *His rash had been there for two or three weeks. *The nurses had been applying hydrocortisone cream as ordered. *They would have documented on the medication administration record the site to which it had been applied . *Skin assessments were done weekly and should have been documented in the progress notes. *She thought his rash could have been a reaction to the laundry detergent. *Laundry was "checking into it." *His rash had improved since last week, and she did not feel that was related to the recent treatment on Monday.</p> <p>Interview on 10/15/15 at 9:30 a.m. with the staff development/infection control nurse revealed: *She monitored all infections daily, helped report them to staff during stand-up meetings, and tracked/trended them monthly for the provider. *She was aware of resident 12's rash and recent treatment for scabies.</p>	F 514			

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F 514	<p>Continued From page 33</p> <p>*She stated tele-med had diagnosed him with scabies, but there had been no laboratory test to confirm that it was actually scabies.</p> <p>*Once resident 12 was diagnosed with scabies: -Staff had completed the treatments and orders as directed. -He was in isolation until the medication was showered off. -His clothes had been sent to laundry as directed. -His room had been thoroughly cleaned by housekeeping.</p> <p>*She confirmed there was minimal documentation in his medical record regarding the onset, duration, worsening, or treatment of his rash.</p> <p>*She agreed there should have been assessments of the rash and worsening of it in his progress notes.</p> <p>Interview on 10/15/15 at 1:00 p.m. with laundry supervisor L regarding resident 12 revealed: *She was aware of his recent infection. *Housekeeping completed a thorough cleaning of his room. *Laundry washed all of his clothes as directed. *They were not aware of his complaint of a possible reaction to the provider's laundry detergent. *She was not aware of his history of allergies to laundry detergents.</p> <p>Further interview on 10/15/15 at 1:30 p.m. with resident 12 in his room revealed: *He was unsure if he had told laundry of his past allergies to detergents. *He felt his rash and itching were better today.</p> <p>Review of the provider's 3/24/15 Clinical Health Status - Change of Condition Guideline policy revealed:</p>	F 514			

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F 514	<p>Continued From page 34</p> <p>*For Clinical Health Status: "This process will assist in driving a thorough evaluation of resident/patient conditions on admission, quarterly, and with significant change of condition. The tool will guide and assist in identifying risk and appropriately establishing a Plan of Care."</p> <p>*For Change of Condition - SBAR: -"The process for identification of change of condition includes gathering objective data and documenting assessment findings, resident/patient response, and physician and family notifications." -"Communication both written and verbal, are integral part of actions needed for change of condition."</p> <p>*For Monitoring/Compliance: "Documentation in the electronic record supports MD [medical doctor]/family notification is completed timely."</p>	F 514		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435052	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/14/2015
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K 000	<p><i>*Addendums noted with an asterisk per 11/23/15 per telephone with facility administrator. LF/SPD/H/EL</i></p> <p>INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 10/14/15. Golden LivingCenter-Mobridge was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p>	K 000	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.	
K 069 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334 Based on document review and interview, the provider failed to ensure the commercial kitchen fire protection system was maintained in accordance with NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations during the required semi-annual inspection. Findings Include:</p> <p>1. Document review at 9:30 a.m. on 10/14/15 of the semi-annual commercial kitchen hood inspection report dated September 2015 revealed missing information. That report was prepared by Armstrong Extinguisher Service Inc. That report did not provide information that the commercial kitchen hood fire suppression system was tied to</p>	K 069		

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

TITLE

(X6) DATE

Rich Freeman **ED** 11-5-15

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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K 069	Continued From page 1 the building fire alarm signaling system. That report did not provide any information the annunciation device activating the building alarm fire alarm signaling system was being tested on a semi-annual basis. The commercial kitchen hood shall upon activation of the fire suppression system activate the building fire alarm signaling system. Document review of the semi-annual fire alarm inspection report dated September 8, 2015 prepared by Automatic Building Controls Inc. revealed they also did not provide any indication the commercial kitchen hood fire suppression system annunciation device was being tested. As Armstrong Extinguisher Service was the liable service company ensuring the commercial kitchen hood was in compliance with NFPA 96. They should have ensured that annunciation device was installed, tested, and maintained as part of that commercial kitchen hood inspection. Interview with the maintenance supervisor during the exit interview at 2:15 p.m. on 10/14/15 revealed he was sure the kitchen hood suppression system was tied to the building fire alarm signaling system. He was not sure why Armstrong Extinguisher Service had not indicated on their bi-annual report of that requirement or that the device was being tested.	K 069	K 069 1) Educate staff regarding the necessity of commercial hood fire suppression annunciation being tied into the facility fire suppression system. 2) All residents have the potential to be affected. 3) The commercial kitchen hood fire suppression annunciation system will be tied directly into the facility fire suppression system, so if the hood fire suppression system should activate the fire suppression annunciation system in the facility will also activate. 4) Educate Dietary staff regarding changes 5) Corrective action will occur on or before November 11, 2015.	*11/4/15 LF/SDDO#EL
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072	*6) Testing of the fire suppression system annunciation device will be included with the bi-annual preventative maintenance kitchen hood inspection. LF/SDDO#EL	

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K 072	<p>Continued From page 2</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure the means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency in two of five egress corridors (north west corridor and south west corridor). Findings include:</p> <p>1. Observation at 1:30 a.m. on 10/14/15 during a fire drill revealed wheelchairs, medicine carts, and resident lift equipment were obstructing the clear corridor width. That was found in two locations the north west wing and the south west wing. Those items should have been cleared from the corridor to ensure the means of egress was clear and unobstructed. All items not in-use should have been removed from the corridor.</p> <p>Interview with the director of continuing education just after the fire drill was conducted revealed she was aware of that requirement. She indicated those items were usually removed during the fire drills. Review of the provider's fire plan policy indicated the corridor should have been cleared of obstructions during a fire situation.</p>	K 072	<p>* Meeting and the necessity of further monitoring will be determined. 5) corrective action will occur on or before November 11, 2015. LF/SPDOH/EL</p>	

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10656	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/15/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MOBRIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 4TH AVENUE E POST OFFICE BOX 937 MOBRIDGE, SD 57601
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S 000	Compliance/Noncompliance Statement Surveyor: 32334 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Medical Facilities, requirements for nursing facilities, was conducted from 10/14/15 through 10/15/15. Golden LivingCenter - Mobridge was found not in compliance with the following requirement: S410.	S 000	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.	
S 410	44:73:12:11 Dietary Department Construction, equipment, and installation of the dietary department shall comply with or exceed the minimum standards in §§44:02:07:01, 44:02:07:02, and 44:02:07:04 to 44:02:07:95, inclusive, the Food Service Code. The installation shall comply with §44:04:13:05 unless a commercially prepared dietary service, meals, or disposables are used. If a commercial service is used, dietary areas and equipment shall meet the requirements for sanitary storage, processing, and handling. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure ventilation equipment was provided to effectively remove steam, heat, cooking vapors and grease from food production areas at one randomly observed location (Alzheimer's care unit dining area). Findings include: 1. Observation at 11:50 a.m. on 10/14/15 revealed a dining room in the Alzheimer's care unit. Further observation revealed a table top convection cooking oven near the sink in that room. That oven was capable of cooking	S 410		

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

TITLE

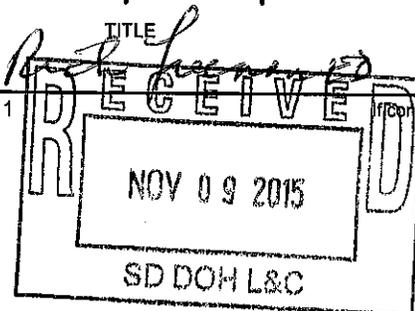
(X6) DATE

STATE FORM

6899

HZU911

Continuation sheet 1 of 2



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10656	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/15/2015
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S 410	<p>Continued From page 1</p> <p>operations up to 450 degrees Fahrenheit. That oven was not provided with proper exhaust ventilation to remove excessive heat, steam, and potential smoke produced from cooking.</p> <p>Interview with the maintenance supervisor and executive director during the exit interview at 2:15 p.m. on 10/14/15 revealed they were unaware exhaust ventilation was required for that table top convection oven. They indicated that oven had been in-use for a few years for light cooking.</p>	S 410	<p>S 410</p> <ol style="list-style-type: none"> 1) The table-top convection cooking oven has been removed from the facility. 2) Residents in the Alzheimer's Unit had the potential to be affected. 3) Educate staff that the table-top convection oven has been permanently removed from service. 4) No follow up monitoring is necessary 5) Corrective action has already occurred. 	<p>*11/2/15 LF/SPDD/HCL</p>