

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435060</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/09/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - BELLA VISTA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>302 ST CLOUD STREET RAPID CITY, SD 57701</b>
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F 000	INITIAL COMMENTS  Surveyor: 26180 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/7/15 through 4/9/15. Golden Living Center - Bella Vista was found not in compliance with the following requirements: F221, F224, F278, F280, F281, F309, F314, F323, F325, F327, F371, F425, F428, F441, F490, and F520.	F 000	STATEMENT OF COMPLIANCE: The following represents the plan of correction for the alleged deficiencies cited during the survey that was conducted on April 9, 2015. Please accept this plan of correction as the living center's Credible Allegation of Compliance with the completion date of May 29, 2015. The completion and execution of this plan of correction does not constitute an admission of guilt or wrong doing on the part of the living center. This plan of correction is completed in good faith and as the living center's commitment to quality outcomes for the residents. In addition, this plan of correction is completed as it is required by law.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS  The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.  This REQUIREMENT is not met as evidenced by: Surveyor: 32355 A. Based on observation, interview, record review, and procedure review, the provider failed to properly assess one of one sampled resident (7) with a raised wheelchair (w/c) seat cushion. Findings include:  1. Observation on 4/7/15 at 3:05 p.m. in resident 7's room revealed: *Certified nursing assistants (CNA) H and I assisted resident 7 to transfer from the recliner to the w/c. *Inside of resident 7's w/c was a saddle cushion with a raised area in the middle that came up between the resident's legs. *The CNAs secured her in the w/c by sitting her behind the raised area on the cushion.	F 221	<b>F 221D Right to be free from physical restraints</b>  Resident #7 has had the seat cushion evaluated by RN and OT designee and determined it was required for positioning. Residents residing in the facility using similar type cushions have the potential to be affected in a similar manner.	5/29/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Marquita Prince</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>4/30/15</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	<p>Continued From page 1</p> <p>Review of resident 7's medical record revealed: *An admission date of 7/30/14. *Diagnoses of left hip fracture (broken bone) and dementia (forgetfulness). *A physician's order for physical therapy (PT) and occupational therapy (OT) for strengthening and transfer training. *There was no initial or quarterly assessments completed for the use of a saddle cushion. *The 1/9/15 quarterly Minimum Data Set (MDS) assessment revealed: -A Brief Interview for Mental Status (BIMS) score of 8. A score of 8 indicated moderate memory impairment. -Required extensive assistance by the staff for bed mobility (moving and repositioning) and transfers. -Was not steady during transfers when moving between locations. -Physical restraints was marked as not used.</p> <p>Review of resident 7's 8/2/14 care plan with multiple revision dates revealed: *A focus area of "At risk for falls related to: New environment, history of a fall with fracture." *On 9/2/14 "Encourage proper positioning in w/c." *On 10/20/14 "Encourage line of sight when in w/c." *No intervention was in place that indicated the resident required the use of a raised w/c cushion for safety or positioning.</p> <p>Review of resident 7's 9/10/14 PT progress notes revealed no documentation to support the use of a saddle cushion to assist the resident with proper upper body control and positioning in her w/c.</p>	F 221	<p>Executive Director, Director of Nursing and Interdisciplinary team have reviewed the Golden Living 'Restraint Guideline'</p> <p><del>Licensed nursing staff have been re-educated on the Golden Living 'Restraint Guideline' and appropriate interventions to deal with aggressive and/or catastrophic reactions of resident's and caregiver stress.</del> <i>See below.</i></p> <p>Director of Nursing or designee will complete <sup>four (4)</sup> random audits weekly x 4 weeks then monthly x 2 months to ensure appropriate restraint evaluations have been completed. Results will be reviewed at the monthly QAPI meetings for further recommendations. <i>ED/DNS or designee will report audit findings to QAPI.</i></p> <p><i>The Director of Clinical Education re-educated the IDT, licensed nurses and all staff on restraint guideline and appropriate interventions and/or catastrophic reactions of residents and caregiver stress on April 30, 2015.</i></p>	<p><i>dim</i></p> <p><i>dim</i></p> <p><i>dim</i></p> <p><i>dim</i></p>
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F 221	<p>Continued From page 2</p> <p>Interview on 4/8/15 at 9:10 a.m. with the director of nursing (DON) and MDS coordinator regarding resident 7's saddle cushion revealed:</p> <ul style="list-style-type: none"> <li>*The MDS coordinator had been responsible for the assessing and documenting on any devices that could have restricted movement or were considered a restraint.</li> <li>*She confirmed:             <ul style="list-style-type: none"> <li>-The therapy department would have initiated the use of the saddle cushion in the resident's w/c.</li> <li>-She had been aware of the cushion in resident 7's w/c but unsure of the exact date when it was initiated.</li> <li>-She had not completed any formal restraint assessment prior to or after the placement of the raised cushion.</li> <li>-She had not considered the cushion a restraint due to the size.</li> <li>-Resident 7 would not have been able to transfer herself out of the w/c without staff assistance with that cushion in place.</li> <li>-The use of the saddle cushion had not been documented on the resident's current care plan.</li> <li>-There should have been an assessment completed to support the use of that w/c cushion.</li> </ul> </li> </ul> <p>Review of the provider's 1/5/15 Physical Restraints Review procedure revealed:</p> <ul style="list-style-type: none"> <li>*Guideline statement: "To ensure that the medical record of any resident who has a physical restraint contains documentation of the appropriateness and necessity of physical restraint use."</li> <li>*Process:             <ul style="list-style-type: none"> <li>-"Ensure that the restraint assessment was completed and that documentation shows that the least restrictive restraint device was chosen."</li> <li>-"Care plan should reflect current restraint use."</li> <li>-"Review the most current MDS section P0100 to</li> </ul> </li> </ul>	F 221		
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F 221	<p>Continued From page 3</p> <p>ensure that the type of restraint listed matches the assessment/care plan/observation of restraint being used by resident."</p> <p>B. Based on record review, interview, and policy review, the provider failed to ensure all employees were trained on appropriate interventions to safely handle aggressive residents for one of one sampled resident (5). Findings include:</p> <p>1. Review of resident 5's medical record revealed: *An admission date of 11/3/12. *Diagnoses of Alzheimer's (memory loss), dementia (forgetfulness) with behaviors, depression (sadness), and macular degeneration (poor eyesight). *He was exit seeking with a history of successful elopement out of the facility. *He had a history of aggression and combativeness (hitting) towards the staff and residents.</p> <p>Review of resident 5's 3/25/14 progress note revealed: *Describe behavior/mood: "Resident noted to be agitated after supper. Resident obsessed with getting the locked double doors open. Resident noted to be verbally abusive to staff, aggressive, and belligerent [hostile]. At 1945 (7:45 p.m.) resident then struck me [staff member name] in the left ear with a closed fist punch. Safety takedown [technique used to calm an aggressive person] used to subdue [resident's name]. No injuries noted. Resident then assisted by other care staff to his room."</p> <p>Review of resident 5's 11/16/12 care plan with</p>	F 221			

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F 221	<p>Continued From page 4</p> <p>multiple revision dates revealed:</p> <p>*A focus area: "I sometimes have behaviors which include hitting during care, resisting care, yelling or cursing when agitated."</p> <p>*No intervention documented to support a safety takedown to subdue (calm down) the resident during episodes of combativeness.</p> <p>Interview on 4/8/15 at 12:10 p.m. with the DON and MDS coordinator revealed:</p> <p>*They had not been:</p> <ul style="list-style-type: none"> <li>-Properly trained on safety takedowns for combative residents.</li> <li>-Sure of the correct procedure to do a safety takedown.</li> </ul> <p>*They had been aware of the above occurrence between the resident and staff member.</p> <p>*Safety takedowns for aggressive residents had not been a part of the staff orientation or training.</p> <p>*They confirmed the staff member should not have performed that type of procedure without proper training by the provider.</p> <p>*Safety takedowns had not been a part of the facility's policy and procedures.</p> <p>Interview on 4/9/15 at 9:55 a.m. with registered nurse (RN) L revealed:</p> <p>*He confirmed he had performed the safety takedown procedure on resident 5.</p> <p>*He had done that procedure on resident 5 twice.</p> <p>*Resident 5 had become combative during both occurrences requiring RN L to walk behind the resident and firmly wrap his arms around resident 5. The resident would not have been able to move during that procedure.</p> <p>*He would have continued that procedure until the resident had calmed down.</p> <p>*He had not been trained by the provider on that procedure or maneuver. He had been trained to</p>	F 221		
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F 221	<p>Continued From page 5</p> <p>do that procedure during nursing school.</p> <p>*He had not considered a safety takedown as a restraint. He used that procedure as a subduing technique.</p> <p>*He confirmed that procedure had not been a part of the provider's current policy and procedures or behavioral management program.</p> <p>*He confirmed he would have continued to perform that procedure without a proper policy and procedure or training by the provider prior to the interview with this surveyor.</p> <p>Interview on 4/9/15 at the same time as the above interview with the administrator revealed:</p> <p>*She confirmed the provider had no current policy and procedure for the staff to follow on safe behavioral management of aggressive residents.</p> <p>*RN L should not have performed that procedure or maneuver on resident 5 without proper training by the provider or an outside source.</p> <p>*For two years she had been actively searching for an appropriate program to train the staff on safe behavioral management of aggressive residents.</p> <p>Review of the provider's 12/18/14 Reporting and Investigation of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property policy revealed "During orientation training shall include appropriate interventions to deal with aggressive and/or catastrophic reactions of residents and caregiver stress."</p>	F 221		
F 224 SS=E	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN</p> <p>The facility must develop and implement written</p>	F 224		

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F 224	<p>Continued From page 6</p> <p>policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, interview, and resident rights review, the provider failed to ensure personal care for 1 of 1 randomly observed resident (18) and 1 of 14 sampled residents (2) were provided as needed. Findings include:</p> <p>1. Random observation on 4/7/15 at 5:20 p.m. revealed there was an odor of bowel movement (BM) in the shared room of residents 1 and 18. Both residents were in bed and appeared to have been sleeping.</p> <p>Observation on 4/7/15 at 5:40 p.m. revealed certified nursing assistant (CNA) A brought resident 1 out of the room in her wheelchair and brought her to the dining room for supper. Interview at 5:48 p.m. with CNA A revealed he had noted the BM odor in her room, but denied she had a BM. Further observation until 6:05 p.m. revealed CNA A had not reentered the room of resident 18.</p> <p>Observations and interview of CNA B on 4/7/15 at 6:15 p.m. revealed: *CNA A was walking in the hall and was not attending to another resident. *CNA B entered resident 18's room, and then requested another unidentified CNA to assist her</p>	F 224	<p><b>F 224 E Prohibit Mistreatment/Neglect/Misappropriation</b></p> <p><i>The past care for resident 1 and 18 can not be corrected. dem</i></p> <p>Residents will be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. Residents have the right to exercise his/her resident rights.</p> <p>Executive Director, Director of Nursing and Interdisciplinary team have reviewed the Abuse and Neglect policy and procedure.</p> <p><i>On April 30, 2015 the Director of Clinical Education re-educated all staff.</i></p> <p><i>dem</i> Staff will be reeducated on Abuse and Neglect policy and procedure appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown origin and misappropriation of resident property and to ensure that all alleged violations of Federal or State laws which involve mistreatment, neglect, abuse, injuries of unknown origin and misappropriation of resident property ("alleged violations").</p>	5/29/15

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F 224	<p>Continued From page 7</p> <p>in getting the resident out of bed. *After the resident was up and had been brought to the dining room she confirmed resident 18 had been soiled with BM and needed to have been cleaned up.</p> <p>Another interview on 4/7/15 at 6:20 p.m. with CNA A revealed: *He confirmed he had noted the odor hen he entered resident 1 and 18's room. *He could not explain why he had not returned to that room after bringing resident 1 to the dining room. *He said he thought maybe another CNA had gone in there but had not verified that and sometimes residents had "bad gas."</p> <p>Interview on 4/8/15 at 11:00 a.m. with the director of nurses confirmed if a CNA thought a resident was in need of toileting the CNA should have assisted the resident immediately.</p> <p>Review of the provider's undated Long-Term Care Facilities Resident's Bill of Rights given to all residents at the time of admission revealed: *You are entitled to quality of life. A facility must provide care in an environment that contributes to your quality of life including: -Freedom from theft of personal property; verbal, sexual, physical or mental abuse; and involuntary seclusion, neglect or exploitation imposed by anyone." Surveyor: 22452 2. Observation on 4/7/15 from 11:05 a.m. through 11:30 a.m. of resident 2 revealed: *Licensed practical nurse (LPN) P and certified nursing assistant (CNA) Q changed his soiled incontinent (lacking control of bowel and bladder) brief and provided perineal (private area) care.</p>	F 224	<p><i>ALL dim</i></p> <p>Staff will be reeducated on the Long Term Care Facilities Resident's Bill of Rights provided by the SD Department of Social Services Adult Services and Aging: Ombudsman Program.</p> <p>Residents residing in the facility have the potential to be affected in a similar manner.</p> <p>ED and/or DNS will complete <i>and observations of residents dim</i> Resident and staff interviews, weekly x 8 weeks to ensure residents are free verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion and residents feel they have the right to exercise his/her resident rights. The results of these interviews will be brought to the monthly QAPI committee for <i>by ED or DNS monthly dim</i> further review and recommendations.</p>	

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F 224	<p>Continued From page 8</p> <p>*He was lying on his right side. They repositioned him from side-to-side to provide perineal care and change his adult brief.</p> <p>*His brief was saturated with urine, and his right hip was reddened.</p> <p>*LPN P changed the dressing to his left buttock pressure ulcer (sore).</p> <p>*LPN P wet a washcloth with water under the sink in the bathroom and wiped off his face.</p> <p>*LPN P and CNA Q sat him on the edge of the bed and transferred him into a wheelchair. They placed their arms under both his arms during the transfer and did not use a gait belt.</p> <p>*They put his clothes on him when he was in the wheelchair and did not provide any further personal hygiene.</p> <p>*He had a lot of facial hair on his face indicating he had not been recently shaved.</p> <p>*CNA Q rinsed the resident's dentures off with water in the bathroom sink and placed them in his mouth. There was no oral care done with the few natural teeth he had in his mouth.</p> <p>*CNA Q was able to find only one shoe in his closet for him, and put gripper socks on him.</p> <p>*He was assisted out to the dining room table in his wheelchair for lunch by CNA Q.</p> <p>Interview at that time with LPN P and CNA Q regarding resident 2 revealed he:</p> <p>*Usually did not want to get up for breakfast, and they honored his wishes.</p> <p>*Did not usually get anything to eat until lunch unless he woke up.</p> <p>*Was last repositioned and his disposable brief was changed between 6:30 a.m. and 7:00 a.m.</p> <p>*Was to receive morning medications at 8:00 a.m., but they were usually held until he got up for the noon meal. Most of the time he refused his medications.</p>	F 224		

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F 224	Continued From page 9 *Could be resistive with care especially shaving, oral care, and personal hygiene. *Usually tolerated being transferred without the use of a gait belt.	F 224	<b>F 278 E Assessment Accuracy/Coordination/Certifie</b>	<i>5/19/15</i>
F 278 SS=E	<b>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</b>  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.  Clinical disagreement does not constitute a material and false statement.  This REQUIREMENT is not met as evidenced by:	F 278	Resident's 1 and 8 most recent MDS 3.0 assessment has been reviewed and revised. Resident 1 MDS date of 2/19/15 was not reviewed or revised as they do not have an MDS for that date. Most recent MDS for this resident was reviewed and revised.  Residents residing in the facility have the potential to be affected in a similar manner.  Residents residing in the facility will have their assessments reviewed and revised to reflect the resident's current status with the next scheduled MDS assessment  Director of Nursing and Interdisciplinary team have reviewed the policy and procedure related to accurate assessment and care plan revision. <i>on April 30, 2015 dim</i>  MDS Coordinator has been re-educated on the Centers for	

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F 278	<p>Continued From page 10</p> <p>Surveyor: 26180</p> <p>Based on observation, record review, and interview, the provider failed to ensure the Minimum Data Set (MDS) assessments were completed accurately for 2 of 14 sampled residents (1 and 8). Findings include:</p> <p>1. Random review of resident 1's progress notes revealed she:</p> <p>*Had refused her medications on 1/14/15, 1/15/15, 2/4/15, 2/5/15, 2/17/15, 3/17/15, and 3/20/15.</p> <p>*1/7/15 - "Resident verbal and yelling peers, and staff in the dining room at supper. She shoved her plate away when offered supper."</p> <p>*1/9/15 - "Resident was hitting, kicking, hollering and scratching at staff this a.m. Refused to eat breakfast."</p> <p>Review of resident 1's 2/19/15 MDS assessment revealed she never rejected care.</p> <p>2. Random observations on 4/7/15 from 8:00 a.m. until 6:45 p.m. and on 4/8/15 from 7:30 a.m. until 6:00 p.m. of resident 8 revealed:</p> <p>*She resided in the secured unit (a locked unit within the whole secure building) also known as the Advanced Alzheimer Care Unit (AACU).</p> <p>*She was in bed and appeared to have been asleep with blankets pulled up around her face.</p> <p>*With the exception of going to the dining room she spent the entire day in her bed.</p> <p>*She refused to get out of bed for supper.</p> <p>*On 4/8/15 she came to the dining room for breakfast but returned to bed immediately after eating.</p> <p>Interview on 4/7/15 at 11:30 a.m. with certified nursing assistant S regarding resident 8 revealed:</p>	F 278	<p>Medicare/Medicaid resident assessment instrument 3.0 manual <i>dim</i> <i>by may 29, 2015.</i></p> <p>Director of Nursing or designee will <i>dim</i> complete <sup>5 (five)</sup> random audits weekly to correspond with the MDS schedule x 4 weeks then monthly x 2 months to ensure the MDS 3.0 assessment reflect resident's current status. Results will be reviewed at QAPI meetings for further recommendations. <i>by the DNS monthly. dim</i></p>	

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F 278	Continued From page 11 *She frequently refused to get out of bed. *She had a very strong personality, and staff never knew when she would get angry. *They just let her be when she said no, because she meant "no."  Interview on 4/7/14 at 4:00 p.m. with the Alzheimer's care unit (ACU) director regarding resident 8 revealed: *She might spend all day in bed sleeping. *Her personality ranged from being very sweet to calling staff the "B" word which happened frequently. *They had not pushed her, because if she did not want to do something, she would get very agitated and aggressive. *She frequently refused to come to meals or have other cares done for her.  Review of resident 8's 2/19/15 MDS assessment revealed she never rejected care.  A random review of resident 8's progress notes and interview on 4/8/15 at 11:00 a.m. with the social services designee (SSD) revealed she frequently had refused her medications. The SSD confirmed she had not reviewed things like nursing care or refusal of medications when she assessed the resident's behaviors. She confirmed the MDS assessments would not have been accurate for residents 1 and 8.	F 278			
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	F 280			

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F 280	<p>Continued From page 12 changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, record review, interview, and policy review, the provider failed to ensure care plans had been reviewed and revised to reflect the individual needs of 6 of 16 sampled residents (1, 2, 3, 7, 8, and 10). Findings include:</p> <p>1. Observation and interview on 4/8/15 at 8:15 a.m. during personal care and a dressing change for resident 2 with certified nursing assistants (CNA) M and N and registered nurse (RN) E revealed: *He had been incontinent (lacking control) of bowel and bladder at that time. *He had a pressure ulcer (an area of skin breakdown where something keeps rubbing or pressing on the skin) to his left ischial prominence (lower part of the buttocks) with slough (injured tissue that was tan or black</p>	F 280	<p><b>F 280 E Right to participate planning care – revise care plan</b></p> <p>Resident 1, 2, 3, 7, and 8 care plans have been reviewed and revised.</p> <p>Resident 10 is not in a wheelchair and does not receive Speech Therapy, care plan was reviewed, not revised.</p> <p>Residents residing in the facility have the potential to be affected in a similar manner.</p> <p>Residents residing in the facility will have their care plans reviewed and revised to reflect the resident's current status <del>with the next scheduled MDS assessment.</del> <i>by May 29, 2015 dem</i></p> <p>Director of Nursing and Interdisciplinary team have reviewed the policy and procedure related to accurate assessment and care plan revision. <i>on April 30, 2015 dem</i></p> <p>Licensed nursing staff have been re-educated on the Centers for Medicare/Medicaid resident</p>	<i>5/20/15</i>

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F 280	<p>Continued From page 13 colored) noted. *RN E completed the dressing change with the Santyl ointment (medication for debridement [to get rid of the injured tissue]) and the foam dressing as directed. -She stated the ulcer had been there a couple weeks.</p> <p>Review of resident 2's wound evaluation flow sheet revealed: *On 3/16/15 there was a new stage 2 pressure ulcer measurement noted to his left "glut" (gluteus [buttocks]). -They were using a foam dressing to the area. -Current preventative interventions were a wheelchair cushion and pressure redistribution mattress. *On 3/23/15 the ulcer continued to be a stage 2 with the same type of dressing. *On 3/30/15 the ulcer had deteriorated (gotten worse) to an unstageable (indicating full thickness of tissue loss covered by slough) pressure ulcer. -The nurse requested new orders for Alginate AG (medication for debridement). *On 4/6/15 the ulcer was listed as a stage 2 again, but checked that slough was present. -Wound (pressure ulcer) status/additional comments indicated the wound continued with slough and they would request new wound care orders. *On all the above entries there was a box checked that indicated the care plan had been reviewed.</p> <p>Review of resident 2's last revised 3/16/15 care plan revealed: *A handwritten entry on 3/16/15 indicated a stage 2 pressure ulcers to his left "glut." *No new interventions were added related to the</p>	F 280	<p>assessment instrument 3.0 manual pages 4-8 through 4-11. <i>by April 30, 2015</i> <i>by DNS.</i></p> <p>Director of Nursing or designee will <sup>(fourth)</sup> complete random audits weekly to correspond with the MDS schedule x 4 weeks then monthly x 2 months to ensure care plans reflect resident's current status. Results will be reviewed at monthly QAPI meetings for further recommendations. <i>The DNS or designee will report audit findings monthly to QAPI.</i></p>	<i>dim</i>

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F 280	<p>Continued From page 14 pressure ulcer. *No entries had mentioned the ulcer was an unstageable pressure ulcer currently. *No mention of the wheelchair cushion or pressure redistribution mattress.</p> <p>Interview on 4/8/15 at 10:00 a.m. with the director of nursing (DON) revealed: *The Minimum Data Set (MDS) assessment nurse was the main person in charge of resident care plans. *The interdisciplinary team made adjustments and additions to the care plans by handwriting them onto the current printed care plan. -The MDS nurse then added the handwritten entries into the computer when she did the resident's MDS assessment. *She agreed there were no interventions on resident 2's care plan specific to the pressure ulcer. *She agreed there should have been interventions on resident 2's care plan</p> <p>2. Review of resident 2's 12/2/14 Nutrition Data assessment revealed: *He had dementia which was a dehydration (not enough fluids) risk factor. *The summary section indicated: -He was at risk for dehydration due to dementia. -His hydration was monitored as needed (PRN).</p> <p>Review of resident 2's 12/2/14 and 2/20/15 progress notes by the certified dietary manager (CDM) revealed: *He was at risk for dehydration due to his dementia. *Hydration was monitored PRN.</p> <p>Review of resident 2's last revised 3/16/15 care</p>	F 280			

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F 280	<p>Continued From page 15</p> <p>plan revealed: *He was at nutritional risk due to dementia. *There was no specific mention of his risk for dehydration. *There were no specific interventions for hydration.</p> <p>Review of resident 2's 3/17/15 Nutrition Assessment by the dietitian revealed his estimated fluid needs (required for the body) were 1915 milliliters [(ml) liquid measurement] per day.</p> <p>Review of resident 2's I&amp;O (intake and output) by Day Report from 1/9/15 through 4/8/15 revealed 82 out of 90 days his fluid intake was less than 1915 ml.</p> <p>3. Review of resident 3's 2/20/15 Nutrition Data assessment done by the CDM revealed: *He had dementia which was a dehydration risk. *The summary section indicated: -He was at risk for dehydration due to the dementia. -His hydration was monitored PRN.</p> <p>Review of resident 3's 11/23/14 Nutrition Assessment by the dietitian revealed his estimated fluid needs were 2290 ml per day.</p> <p>Review of resident 3's I&amp;O Log from 1/10/15 through 4/10/15 revealed 90 out of 90 days his fluid intake was less than 2290 ml.</p> <p>Review of resident 3's 2/20/15 progress note by the CDM revealed: *He was at risk for dehydration due to his dementia. *Hydration was monitored PRN.</p>	F 280		

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F 280	<p>Continued From page 16</p> <p>Review of resident 3's last revised 3/25/15 care plan revealed: *He was at nutritional risk due to his dementia. *There was no mention of his risk for dehydration. *There were no specific interventions for hydration.</p> <p>Interview on 4/8/15 at 11:15 a.m. with the CDM revealed: *She agreed there was no mention of resident 2's risk for dehydration or interventions for hydration on his current care plan. *She stated if someone was identified at risk she did not always put it on the care plan. Surveyor: 26180.</p> <p>4. Random observations on 4/7/15 from 8:00 a.m. until 6:45 p.m. of resident 1 revealed: *She resided in the ACU. *She was in bed and appeared to sleep all morning. *She was brought out to the dining room for the lunch meal. *After lunch she was taken to her room and laid down in bed immediately and remained there until supper at 5:40 p.m.</p> <p>Observation on 4/8/15 of resident 1 from 8:00 a.m. through 6:00 p.m. revealed she sat in front of her television the entire day except when she was brought to the dining room for the meals.</p> <p>Review of resident 1's 2/19/15 MDS assessment revealed her daily preferences included music, pets, books, her personal belongings, religion, and being with groups of people.</p> <p>Review of resident 1's 4/14/15 care plan revealed: *"Focus:</p>	F 280			

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F 280	<p>Continued From page 17</p> <p>-Resident has diagnosis of Alzheimer's or related dementia. Due to cognitive loss (memory loss), diminished decision making capabilities, and safety and security issues, placement in the secured ACU with programs designed for that population is needed as evidenced by: Moderate to severe cognitive loss.</p> <p>-I require some assistance in participating in activities of my choice related to Needing extra time to communicate or follow cues (suggestions).</p> <p>-Potential for drug related complications associated with use of psychotropic medications (used to treat mental illness or reduce aggressive behaviors) related to anti-Depressant medication.</p> <p>*Interventions:</p> <p>-Allow resident to wheel throughout the ACU.</p> <p>-Provide environmental cues throughout the ACU to minimize effects of cognitive deficits, memory box, name and picture beside door.</p> <p>-Provide normalized programming based on patient [resident] assessment and interests: church choir, ___ [name of sorority] genealogy."</p> <p>*There were no specific interventions nor a therapeutic program (program individualized to her needs) outlined for her.</p> <p>*Her daily preferences were not incorporated into her plan.</p> <p>*It had not addressed the behaviors or the reason she was on the psychotropic medications related to: Antidepressant medication.</p> <p>*It had not addressed any behavior management plan to reduce the behaviors without the use of the medications.</p> <p>5. Random observations on 4/7/15 from 8:00 a.m. until 6:45 p.m. of resident 8 revealed: *She resided in the ACU. *She was in bed and appeared to sleep all</p>	F 280			

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F 280	<p>Continued From page 18</p> <p>morning and was brought to the dining room for lunch.</p> <p>-She slept through most of lunch and ate very little at that meal.</p> <p>*She was brought back to her room after lunch and was laid down in bed immediately and remained there all afternoon and into the evening.</p> <p>*She refused to get up for supper, and she received no supper in her room that evening.</p> <p>Review of resident 8's 2/19/15 MDS assessment revealed her daily preferences included staying up past 8:00 p.m. reading the news, music, attending activities with groups of people, religion, pet visits, and getting outside for fresh air when appropriate.</p> <p>Interview on 4/7/15 at 11:30 a.m. with certified nursing (CNA) S regarding resident 8 revealed:</p> <p>*She frequently refused to get out of bed.</p> <p>*She had a very strong personality, and staff never knew when she would get angry.</p> <p>*They just let her be when she said no, because she meant "no."</p> <p>Interview on 4/7/14 at 4:00 p.m. with the ACU director regarding resident 8 revealed:</p> <p>*She might spend all day in bed sleeping.</p> <p>*Her personality ranged from being very sweet to calling staff the "B" word which happened frequently.</p> <p>*They had not pushed her, because if she did not want to do something she would get very agitated and aggressive.</p> <p>*She frequently refused to come to meals and let staff assist her with other cares.</p> <p>Interview on 4/7/14 at 6:15 p.m. with CNA A regarding resident 8 revealed:</p>	F 280			

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F 280	<p>Continued From page 19</p> <p>*She had refused to come out for supper that night and frequently refused to do that. *If she refused you just let her be, because she could become very agitated or aggressive. -She frequently called staff the "B" word. *Some days she might spend all day in bed. *They would offer her a snack in the evening, such as goldfish crackers, the orange/peanut butter crackers or cookies. -They always had something to offer her to eat if she had wanted it.</p> <p>Review of resident 8's 3/11/15 care plan revealed: **Focus: -Resident has diagnosis of Alzheimer's or related dementia. Due to cognitive loss (memory loss), diminished decision making capabilities, and safety and security issues, placement in the secure ACU with programs designed for this population is needed as evidenced by: Moderately severe cognitive loss." -Potential for drug related complications associated with use of psychotropic medications (used to treat a mental illness or minimize aggressive behaviors)related to Anti-depressant medication, Anti-psychotic medication. **Interventions: -Allow resident to walk throughout the ACU at will. -Provide normalized programming based on patient assessment and interests, books, food related socials. -Strongly encourage resident to attend meals in the dining room." *Focus: "My level of activity participation changes due to: tiring easily, cognitive status." **Interventions: -If I become less involved in group activities, please offer me 1:1 [one-to-one] or independent activities.</p>	F 280			

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F 280	<p>Continued From page 20</p> <p>-If I'm unable to attend religious services, please ask clergy to come to my room."</p> <p>*There were no specific interventions or a therapeutic program outlined for her.</p> <p>*Her daily preferences were not incorporated into her plan.</p> <p>*It had not addressed:</p> <p>-A behavior management plan to reduce the behaviors without the use of the medications.</p> <p>-What would have been usual for her to spend many hours per day in bed.</p> <p>-How they attempted to meet her nutritional needs when she had not come out to the dining room since that was not an unusual practice for her.</p> <p>Surveyor: 22452</p> <p>6. Observation on 4/9/15 from 12:15 p.m. to 12:45 p.m. and from 6:15 p.m. to 6:30 p.m. of resident 10 revealed she:</p> <p>*Was in the dining room for the lunch and supper meals.</p> <p>*Was frequently restless and moved her wheelchair with her feet in attempts to leave the dining room.</p> <p>*Was pushed back to the table in the dining room and given cues to remain at the table and eat her food.</p> <p>*Was at a table where no staff member assisted with feeding.</p> <p>Review of resident 10's 3/29/15 speech therapy (ST) progress notes and updated plan of care revealed:</p> <p>*Start of care 1/22/15.</p> <p>*Bedside swallow. Patient (resident) very lethargic (sleepy) and not eating or swallowing. Resident requires one-on-one one for intakes.</p> <p>Review of resident 10's 11/6/14 care plan</p>	F 280			

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F 280	<p>Continued From page 21</p> <p>revealed no documentation to provide one on one staff assistance for food and fluid intake (eating).</p> <p>Interview on 4/8/15 at 4:00 p.m. with ST R regarding resident 10 revealed she:</p> <ul style="list-style-type: none"> <li>*Had been observing her at meals, and she had been consuming about 50 percent (%) of her meals without problems.</li> <li>*Was unsure why she was to have one-to- to one staff assistance with meals, and she was not aware that had been the recommendation.</li> <li>*Knew staff needed to intermittently cue her to remain at the table and return to eating her food.</li> <li>*Knew she did not eat at a table in the dining room that staff provided assistance to.</li> </ul> <p>Interview on 4/9/15 at 11:45 a.m. with the director of nursing regarding resident 10 revealed:</p> <ul style="list-style-type: none"> <li>*She was unaware of the 4/9/15 ST's recommendations.</li> <li>*If the ST's recommendation had been a physician's order then nursing would have been aware of the orders.</li> </ul> <p>Surveyor: 32355</p> <p>7. Review of resident 7's medical record revealed:</p> <ul style="list-style-type: none"> <li>*An admission date of 7/30/14.</li> <li>*Diagnoses of left hip fracture (broken bone) and dementia (forgetfulness).</li> <li>*She had required extensive assistance of two staff members for transfers.</li> <li>*She had been at risk for skin breakdown with a history of a stage II pressure ulcer (superficial opening of the skin) to her left heel.</li> </ul>	F 280			

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F 280	<p>Continued From page 22</p> <p>Observation on 4/7/15 at 3:05 p.m. in resident 7's room revealed:            *Certified nursing assistants (CNA) H and I prepared to transfer the resident from her recliner into the w/c.            *They retrieved a standing transfer aide (device to assist the resident with transferring) and had secured her to the lift prior to the transfer.            *Inside of resident 7's w/c was a black cushion with a raised area in the middle.            *The CNAs secured her in the w/c by sitting her behind the raised area on the cushion.</p> <p>Interview on 4/7/16 at 3:15 p.m. with CNA H revealed:            *She confirmed resident 7 had required staff assistance with all transfers.            *She would have done two different types of transfers with resident 7.            *She would have used:            -The Standing Transfer Aide when she had transferred the resident by herself.            -A gaitbelt (belt that secures around the waist of the resident to assist with transfer) when another staff member would have assisted her with the transfer.            *Today CNA I had preferred to use the transfer aide with two staff members.</p> <p>Review of resident 7's 1/29/15 care plan revealed:            *A focus area "I have physical functioning deficit related to self care impairment, mobility impairment."            *Interventions provided under that focus area were:            -"Transfer assistance of: extensive assist." There was no documentation to support how the</p>	F 280		

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F 280	<p>Continued From page 23</p> <p>resident was to have been transferred or the number of staff required to assist her. -"Assistive devices: uses a w/c for locomotion." There was no documentation to support resident 7 required a raised cushion in her w/c and the purpose. *A focus area "Pressure ulcer actual or at risk due to assistance required in bed, Braden score 18 or less, bowel incontinence, history pressure ulcers (Braden scores of 18 indicated high risk for pressure ulcers)." *There were no interventions provided under that focus area to support how often the staff were to have assisted her with repositioning.</p> <p>8. Interview on 4/7/15 at 11:45 a.m. with the DON and MDS coordinator revealed: *The MDS coordinator had been responsible for the reviewing and revising of the care plans. *They agreed all of the above areas of concerns should have been found on the residents' care plans.</p> <p>Review of the provider's undated care plan policy revealed: *"The care plan ensures that the resident attains or maintains the highest practicable physical, mental and psychosocial well-being. *The care plan includes any care or treatment that would otherwise be required for the provision of quality care, unless not provided due to a Residents right, including the right to refuse treatment. *The care plan must reflect the immediate step for each goal if identification of these steps will enhance th Resident's ability to meet the goal. *The interdisciplinary team will utilize the Care plan goals to monitor resident progress or lack of progress with meeting the established goals and</p>	F 280			

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F 280	Continued From page 24 will document this information in the Medical Record."	F 280	<p><b>F 281 E Services Provided Meet Professional Standards</b></p> <p>Resident 7, 10, 12 and 19 medical records have been reviewed and past medication administration concerns are unable to be corrected.</p> <p>Residents residing in the facility have the potential to be affected in a similar manner.</p> <p><i>all Residents' medication supplied in card form are being dated and initialed by nurse or med. aide at time of administration.</i></p> <p><i>Director of Nursing or designee will complete five (5) random audits weekly x 4 weeks then monthly x 2 months to ensure compliance with appropriate medication and oxygen administration. Results will be presented by DNS reviewed at monthly QAPI meetings for further recommendations.</i></p>	<b>5/29/15</b>	
F 281 SS=E	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, and interview, the provider failed to follow physicians' orders for: *Medication administration for three of three sampled residents (10, 12, and 19). *Oxygen (O2) administration for one of one sampled resident (7) who received O2. Findings include:</p> <p>1. Review of resident 10's April 2015 medication administration record (MAR) revealed "Duloxetine [antidepressant] 20 milligrams [mg] one capsule daily."</p> <p>Observation on 4/9/15 at 10:00 a.m. of resident 10's duloxetine medication cards revealed: *The medication card was filled by the pharmacy on 2/26/15 and contained thirty capsules. *There was documentation the first capsule was removed from the medication card on 3/4/15. *The last capsule was administered on 4/9/15. *There were two other duloxetine medication cards that were also filled by the pharmacy on 2/26/15 and each contained thirty capsules. *There should have been seven capsules removed from one of the other duloxetine</p>	F 281			

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F 281	<p>Continued From page 25</p> <p>medication cards if the duloxetine had been administered every day from 3/4/15 through 4/9/15 as was documented on the MAR. *There was documentation from 3/4/15 through 4/9/15 thirty-seven capsules of duloxetine had been administered. There were only thirty capsules of duloxetine removed from the medication cards.</p> <p>2. Review of resident 12's April 2015 MAR revealed "Montelukast [asthma] 10 mg one tablet daily."</p> <p>Observation on 4/9/15 at 10:10 a.m. of resident 12's montelukast medication card revealed: *The medication card was filled by the pharmacy on 3/15/15 and contained thirty tablets. *There was documentation the first tablet was removed from the medication card on 3/20/15. *There was documentation forty tablets had been administered from 3/20/15 through 4/9/15. *There were eighteen tablets left in the medication card. *There should have been nine tablets left in the medication card.</p> <p>3. Review of resident 19's April 2015 MAR revealed "Finasteride [prostate cancer prevention] 5 mg one tablet daily."</p> <p>Observation on 4/9/15 at 10:15 a.m. of resident 19's finasteride medication card revealed: *The medication card was filled by the pharmacy on 4/4/15 and contained thirty tablets. *There was documentation the first tablet was removed from the medication card on 3/21/15. *There was documentation twenty tablets had been administered from 3/21/15 through 4/9/15. *There were eight tablets left in the medication</p>	F 281			

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F 281	<p>Continued From page 26 card.</p> <p>*There should have been ten tablets left in the medication card.</p> <p>4. Interview on 4/9/15 at 10:30 a.m. with the director of nursing regarding the above medication cards revealed she:</p> <p>*Confirmed there were discrepancies of the amounts of capsules/tablets that had been removed from the medication cards and what had been documented as administered on the MARs.</p> <p>*Was unsure why the discrepancies existed unless the nursing staff had documented the wrong date the first pill had been removed from the medication cards, or a dose of medication had been refused or omitted for some reason.</p> <p>Surveyor: 32355</p> <p>4. Random observations on 4/7/15 from 2:30 p.m. through 6:00 p.m. of resident 7 revealed:</p> <p>*There was an oxygen concentrator in her room and an oxygen cylinder attached to her wheelchair (w/c).</p> <p>*When she was:</p> <p>-In her room she had received oxygen from that concentrator through a nasal cannula (tubing). The dial on the oxygen concentrator had been set at 2.5 liters per minute.</p> <p>*In her w/c she had received oxygen from the cylinder attached to the w/c. The dial on the oxygen cylinder had been set at 1 liter per minute.</p> <p>Review of resident 7's medical record revealed:</p> <p>*An admission date of 7/30/14.</p> <p>*She had been admitted after a fall with injury to her left hip.</p> <p>*She required the:</p> <p>-Use of oxygen continuously (all the time) to keep</p>	F 281		

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F 281	<p>Continued From page 27</p> <p>her oxygen saturation levels in her blood above 90 percent (%).</p> <p>-Staff were to monitor her oxygen saturation levels and ensure she was receiving the right amount of oxygen per her physician's orders.</p> <p>Review of resident 7's physician's orders from July 2014 through March 2015 revealed she had an order for oxygen to be delivered continuously by a nasal cannula at 1 liter per minute.</p> <p>Review of resident 7's treatment administration records from July 2014 through April 2015 revealed the nurses had documented for each shift the resident was receiving oxygen continuously at 1 liter per minute.</p> <p>Review of resident 7's progress notes from July 2014 through April 2015 revealed no documentation to support she had required a higher level oxygen than 1 liter per minute with physician notification.</p> <p>Random observations on 4/8/15 from 7:45 a.m. through 10:30 a.m. revealed the same as written above.</p> <p>Interview on 4/8/15 at 11:45 a.m. with the director of nursing and Minimum Data Set assessment coordinator revealed: *The certified nursing assistants had been responsible for the oxygen cylinder attached to her w/c. *The nursing staff were: -Responsible for monitoring the oxygen concentrator in her room for the appropriate level of oxygen. -To have checked the oxygen concentrator every shift.</p>	F 281		

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F 281	Continued From page 28 -To document on the treatment assessment record confirming the correct level of oxygen had been delivered to the resident for their shift. *They had expected the nursing staff to follow the physician's orders to ensure the correct level of oxygen had been delivered to the resident.  Observation on 4/8/15 at 3:30 p.m. of resident 7 revealed: *She had been resting in her bed. *She had been receiving oxygen by nasal cannula from the oxygen concentrator. *The dial on the oxygen concentrator continued to indicate she had been receiving 2.5 liters of oxygen instead of the 1 liter ordered by her physician.  5. Review of the provider's May 2012 Medication Administration-Preparation and General guidelines revealed: **"Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so." **"Medications are administered in accordance with written orders of the prescriber." **"If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time, the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record. If two consecutive doses of a vital medication are withheld, refused, or not available the physician is notified. Nursing documents the notification and physician response."	F 281		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	<p>Continued From page 29</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, observation, interview, and resident rights review, and policy review, the provider failed to ensure care and services to attain the highest practicable physical and psycho-social well-being according to their assessed needs and care plan for: *Assistance with eating for 2 of 4 sampled residents (8 and 10). *Assistance with bathing for 5 of 14 sampled residents (3, 4, 8, 9, and 10). Findings include:</p> <p>1a. Observation on 4/7/15 at the noon meal revealed resident 8: *Sat at a table with two other residents in the main dining room who were being fed by a staff person. *Took a couple of bites of food and then fell asleep. *In a forty-five minute period she slept most of it. *Was not encouraged to eat or purposefully woke up during the mealtime. *Ate less than 25 percent (%) of her meal.</p> <p>Observation on 4/7/15 at the supper meal revealed she refused to get out of bed to come</p>	F 309	<p><b>F 309 E Provide Care/Services for highest well being</b></p> <p>Residents 8 and 10 receive assistance with eating.</p> <p>Residents 3, 4, 8, 9 and 10 receive assistance with bathing based on preferences, bathing schedule and care plan updated by 5/29/2015. dem</p> <p>Residents residing in the facility have the potential to be affected in a similar manner. All resident or family interviewed to establish bathing preference, bath schedule and care plan. Nursing staff have been reeducated on assisting residents according to the updated care plan to include dining assistance and bathing by 5/29/2015 dem</p> <p>Director of Nursing or designee will complete five (5) random audits weekly x 4 weeks then monthly x 2 months to ensure compliance with providing residents care and services according to care plan. Results will be reviewed at monthly QAPI meetings for further recommendations, presented by DNS or designee monthly. dem</p>	5/29/15

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F 309	<p>Continued From page 30 and eat.</p> <p>Review of resident 8's 2/19/15 Minimum Data Set assessment revealed she: *Weighed 141 pounds, and her weight was stable. *Required the extensive assistance of one person with eating.</p> <p>Review of resident 8's 3/15/15 care plan revealed she needed supervision with eating, and her goal was for intakes to return to 75% or more eaten most meals.</p> <p>Interview on 4/7/14 at 6:15 p.m. with CNA A regarding resident 8 revealed: *She had refused to come out for supper that night. *She frequently refused to do that. *If she refused you just let her be, because she could become very agitated or aggressive. -She frequently called staff the "B" word. *Some days she might spend all day in bed. *They would offer her a snack in the evening, such as goldfish crackers, the orange/peanut butter crackers or cookies. *They always had something to offer her to eat if she had wanted it.</p> <p>Review of resident 8's Resident Meals by Day Report revealed since 3/9/15: *Her average meal was less than 75% all but one day. *For the evening snack she only ate 100% of her snack only three out of thirty days. -The rest of the days she ate nothing as an evening snack.</p> <p>Interview on 4/8/15 at 8:30 a.m. with the dietary</p>	F 309		

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NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - BELLA VISTA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>302 ST CLOUD STREET RAPID CITY, SD 57701</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 31</p> <p>services manager regarding resident 8 revealed:</p> <ul style="list-style-type: none"> <li>*She was to have received encouragement to eat her meals</li> <li>*She sat at a table with two residents who were fed, so the staff person would encourage resident 8 to eat.</li> <li>-The staff person who sat at her table should have encouraged her to eat and stay awake.</li> <li>*She frequently refused to come out to meals.</li> <li>*They always had ham or peanut butter sandwiches that staff knew they could come and get when a resident refused to eat a meal.</li> <li>*Sometimes they even saved their tray, and staff would come and get it, and reheat it before bringing it to the resident.</li> <li>*She did not know why the CNA was unaware there were more substantial snacks available for residents.</li> </ul> <p>Surveyor 32355 Interview on 4/9/15 at 8:45 a.m. with the certified dietary manager revealed:</p> <ul style="list-style-type: none"> <li>*The CNAs were to have offered all residents a snack at bedtime from a snack cart prepared by the dietary department.</li> <li>*The snack cart had not contained any substantial foods.</li> <li>*The CNAs would have to retrieve a more substantial snack from the dietary department. The dietary department was available to assist with those snacks until 10:00 p.m. After 10:00 p.m. the CNAs would have had to go into the kitchen and prepare their own snacks.</li> <li>*She had no snack rotation plan or process in place to ensure those residents who consistently refused to eat a meal or required a more substantial snack for weight control concerns received one.</li> </ul>	F 309			

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F 309	<p>Continued From page 32</p> <p>Review of the provider's undated Nourishment policy revealed "Reference the HS (hour of sleep) snack rotation plan included in each menu packet."</p> <p>Surveyor: 22452</p> <p>1b. Review of resident 10's 2/7/15 dietitian's nutrition assessment revealed: *Total daily calorie needs 1385 calories. **"Underweight related to Alzheimer's dementia and increased energy expenditure due to wandering and inability to stay in dining room." *Weight loss 5 pounds (lb) last six months and a 2 lb weight loss past three months. *Weight on 1/26/15 was 114 lb. *Resident very manic (hyperactive) per staff and hard to get her to sit and eat. *Staff assisted with meal set-up. *She did best with finger foods and needs cues to stay on task. *She likes to sleep in so often does not eat breakfast. *Family not interested in any aggressive treatment. *She was at risk for malnutrition. *Offer smaller meal portions with snacks between meals.</p> <p>Review of resident 10's 1/19/15 through 4/5/15 weight summary revealed the following weights: *1/19/15- 112.0 lb. *1/25/15- 114.0 lb. *2/7/15- 114.0 lb. *2/8/15- 114.0 lb. *2/15/15- 129.0 lb. -There was a 15 lb weight gain in one week. *2/22/15- 128.0 lb. *3/8/15- 126.0 lb. *4/5/15- 125.0 lb.</p>	F 309			

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F 309	<p>Continued From page 33</p> <p>Review of resident 10's 2/27/15 through 4/7/15 daily meal report revealed:                      *There was no meal intake recorded for 22 of 120 meals..                      *There was a "1" documented for eleven of the breakfast meals.                      *There were two meals documented for 25 percent (%) intake.                      *There were nine meals documented for 50% intake.                      *There was zero documented for all forty days of evening snacks.</p> <p>Review of resident 10's 2/27/15 through 4/7/15 nursing progress notes revealed no documentation of increased edema (swelling).</p> <p>Interview on 4/8/15 at 11:30 a.m. with the dietary manager regarding to resident 10 revealed she:                      *Was not aware of the 15 lb weight increase.                      *Would have had them do a re-weight the next day with that much weight gain.                      *Would have had the dietitian reassess her when she had gained the 15 lb if she had been made aware of the weight.                      *Was not certain why she had a significant weight gain.                      *Knew she had been eating better even though it was not always reflected on her daily meal report.                      *The 1s that were documented for her breakfast meals meant she had refused the meal.                      *Had talked to the staff multiple times about not leaving blank spaces on meal intake records.                      *Agreed it was good she was gaining weight, but a 15 lb weight gain in a week did not seem realistic.                      *Was unsure if the scale could have been a</p>	F 309			

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F 309	<p>Continued From page 34 problem.</p> <p>Interview on 4/9/15 at 11:45 a.m. with the director of nursing regarding to resident 10 revealed she:</p> <ul style="list-style-type: none"> <li>*Was unaware of her weight fluctuations.</li> <li>*Was unsure why she would have gained 15 lb in one week.</li> <li>*Was unable to find any nursing documentation she had any increased edema.</li> <li>*Thought maintenance had calibrated the scales, since they had other weight fluctuations for some residents.</li> <li>*Was unsure if the physician had been updated of the significant weight gain as per their policy.</li> </ul> <p>Review of the provider's undated weight monitoring policy revealed:</p> <ul style="list-style-type: none"> <li>*Weight was recorded by the nursing department upon admission, monthly, and more often if risk had been identified.</li> <li>*All weights would be reviewed by the dietary manager, and the registered dietitian would be notified of any significant weight changes or trends.</li> <li>*When weight change was significant or severe the licensed nurse would notify the patients' (residents') physician, and obtain and carry out treatment orders if given.</li> </ul> <p>2a. Review of resident 10's 8/10/14 through 4/5/15 computerized bathing tracking record revealed the following time periods where a weekly bath had no been given:</p> <ul style="list-style-type: none"> <li>*8/10/14 to 8/24/14.</li> <li>*9/14/14 to 10/12/14.</li> <li>*11/11/14 to 11/30/14.</li> <li>*12/21/14 to 1/4/15.</li> <li>*3/22/15 to 4/5/15.</li> </ul>	F 309	

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F 309	<p>Continued From page 35</p> <p>Review of resident 10's undated care plan revealed she needed extensive assistive with bathing but not how often.</p> <p>Surveyor: 34030</p> <p>2b. Review of resident 4's entire medical record revealed:</p> <p>*Her care plan stated she needed assistance with personal hygiene, but it did not mention a preference for the type of bath or how often she would like one.</p> <p>*On her Bath/Weight Information sheet:</p> <p>-December 2014 she received four baths, or one bath a week.</p> <p>-January 2015 she received three baths.</p> <p>-February 2015 she received two baths.</p> <p>-March 2015 she received four baths.</p> <p>*A review of the resident's activities of daily living (ADL) log from the above time frame revealed an extra bath on 1/27/15 that had not been mentioned on the Bath/Weight Information sheet.</p> <p>2c. Review of resident 9's entire medical record revealed:</p> <p>*His care plan stated he needed limited assistance with personal hygiene, but it did not mention a preference for the type of bath or how often he would like one.</p> <p>*On his Bath/Weight Information sheet:</p> <p>-November 2014 he received two baths.</p> <p>-December 2014 he received two baths.</p> <p>-January 2015 he received four baths. (Two of those were noted on the ADL log.)</p> <p>-February 2015 he received two baths. (One of those was noted on the ADL log.)</p> <p>-March 2015 he received four baths.</p> <p>Surveyor: 35237</p> <p>2d. On resident 3's Bath/Weight information</p>	F 309		

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F 309	<p>Continued From page 36 sheet:</p> <ul style="list-style-type: none"> <li>*In Decemeber 2014 he had two baths.</li> <li>*In January 2015 he had three baths.</li> <li>*In February 2015 he had two baths.</li> <li>*In March 2015 he had two baths.</li> </ul> <p>Review of resident 3's ADL Flow Sheet Log from 1/1/15 through 4/8/15 revealed he had received a bath or shower :</p> <ul style="list-style-type: none"> <li>*Three times in January 2015.</li> <li>*One time in February 2015.</li> <li>*Two times in March 2015.</li> </ul> <p>Review of resident 3's revised 3/17/15 care plan revealed he:</p> <ul style="list-style-type: none"> <li>*Needed extensive assistance with personal hygiene.</li> <li>*He had functional incontinence (lacking control) with a goal to be clean, dry, and odor free without skin breakdown.</li> </ul> <p>Interview on 4/8/15 at 8:45 a.m. and again at 11:15 a.m. with the director of nursing (DON) revealed:</p> <ul style="list-style-type: none"> <li>*The provider should have had enough staff to give the baths the residents needed.</li> <li>*She was not aware of any concerns with baths.</li> <li>*If a resident refused a bath it would be documented in the care tracker or bath log book.</li> <li>*If a resident refused a bath staff would pass it on to the next shift.</li> <li>*Staff should have updated the nurse or family if a resident had refused a bath.</li> <li>*She would have expected bathing to be done once a week.</li> <li>-If it was longer than once a week she would have expected occupational therapy to be involved.</li> <li>*She agreed resident 3 had not received baths</li> </ul>	F 309			



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F 314	<p>Continued From page 38 and registered nurse (RN) E for resident 2 revealed: *He had been incontinent (lacking control) of bowel and bladder at that time. *He had a pressure ulcer to his left lower part of the buttocks with slough (injured tissue that was tan or black colored) noted. *RN E completed the dressing change with the Santyl ointment (debridement medication [to get rid of the injured tissue]) and the foam dressing as directed. *She stated the ulcer had been there a couple weeks. *He had a saddle type cushion in his wheelchair that appeared slightly worn. *He had a regular mattress on his bed.</p> <p>Review of resident 2's medical record revealed: *He had been admitted on 7/15/14. *He had a hip fracture in November 2014 and was hospitalized and had been re-admitted on 11/14/14. *A 2/9/15 Quarterly Interdisciplinary Resident Review indicated: -He had skin concerns. -A Braden Scale (measurement for predicting risk of pressure ulcers) score of 17 indicating he was at risk for them. *On 3/16/15 a pressure ulcer was noted to his left "glut" (gluteus [buttock]).</p> <p>Review of resident 2's wound evaluation flow sheet revealed: *On 3/16/15 there was a new stage 2 pressure ulcer measurement indicating partial thickness of tissue loss noted to his left "glut." -They were using a foam dressing to the area. -Current preventative interventions were a wheelchair cushion and pressure redistribution</p>	F 314	<p>the Golden Living Center Skin integrity guideline. and no revisions to the <i>dem</i> policy. and all facility staff <i>dem</i> Nursing staff, have been reeducated on the Skin integrity guideline. by Director of Clinical education on 4/30/2015. <i>dem</i></p> <p>Director of Nursing or designee will complete <del>random</del> <i>all residents</i> audits weekly x 4 weeks then monthly x 2 months to ensure compliance the skin integrity guideline. Results will be reviewed at monthly QAPI meetings for further recommendations, presented by DNS or designee. monthly. <i>dem</i></p> <p><i>pressure ulcers and 4 residents skin care plans. dem</i></p>	

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F 314	<p>Continued From page 39 mattress.</p> <p>*On 3/23/15 the ulcer continued to be a stage 2 with the same type of dressing.</p> <p>*On 3/30/15 the ulcer had deteriorated (gotten worse) to an unstageable (indicating more tissue loss covered by slough) pressure ulcer.</p> <p>-The nurse requested new orders from the physician for Alginate AG (medication used for debridment).</p> <p>*On 4/6/15 the ulcer was listed as a stage 2 again, but checked that slough was present.</p> <p>-Wound status/additional comments indicated the wound continued with slough, and they would request new wound care orders.</p> <p>*On all the above entries there was a box checked that indicated the care plan had been reviewed.</p> <p>Review of the March 2015 medication and treatment administration records (MAR/TAR) revealed:</p> <p>*Weekly skin reviews were done every Friday at 8:00 a.m.</p> <p>*There was no treatment or dressing for the pressure ulcer.</p> <p>Review of the April 2015 MARs and TARs revealed:</p> <p>*Weekly skin reviews were done every Friday at 8:00 a.m.</p> <p>*There was a treatment for Alginate AG to the wound bed covered with a tegaderm foam dressing that was initialed as being administered on 4/6/15 only.</p> <p>-That had an ordered date of 4/2/15 and discontinued date of 4/6/15.</p> <p>*There was a treatment for Santyl to the wound bed covered with a tegaderm pad.</p> <p>-That was to be changed daily, and had an</p>	F 314		
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F 314	<p>Continued From page 40 ordered date of 4/6/15.</p> <p>Review of resident 2's last revised 3/16/15 care plan revealed: *A handwritten entry on 3/16/15 indicated a stage 2 (measurement scale for pressure ulcers) to his left "glut." *No new interventions were added related to the pressure ulcer. *No entries had mentioned the ulcer was currently an unstageable pressure ulcer. *No mention of the wheelchair cushion or pressure redistribution mattress.</p> <p>Interviews on 4/7/15 at 4:00 p.m. and again at 4:55 p.m. with licensed practical nurse (LPN) D revealed: *The pressure ulcer was originally noted on 3/16/15. *She was the nurse who started the initial foam dressing treatment. -There was no order for that original treatment. *The current treatment of the Santyl was the third treatment for the ulcer. *The ulcer was not currently draining but was covered with slough. -She agreed it was an unstageable ulcer at this time. *She thought she had notified the physician by phone of the pressure ulcer on 3/16/15 but was unable to find that documentation. *She should have made a progress note about the notification of the physician at the time but had not.</p> <p>Review of resident 2's interdisciplinary progress notes revealed: *A 3/16/15 at 10:33 a.m. note that indicated: -An open area (pressure ulcer) was noted to his</p>	F 314			

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F 314	<p>Continued From page 41</p> <p>left lower buttocks.</p> <p>-It appeared his skin integrity (health) was compromised by breakdown associated with incontinence (lack of bladder or bowel control) combined with shearing (friction against the skin).</p> <p>-A wheel chair cushion was in place.</p> <p>-A message was left to notify his wife.</p> <p>*A 4/2/15 late entry note for 3/16/15 at 12:35 p.m. note that indicated:</p> <p>-Therapy had a discussion with nursing regarding the ulcer and type of mattress.</p> <p>-Due to his cognitive (memory) level, lack of ability to use the call light, and decline in awareness of his body location, the resident would be at more risk of falls out of bed with an air mattress.</p> <p>*A 3/16/15 at 12:53 p.m. note that indicated his wife was notified.</p> <p>*A 4/7/15 late entry note for 3/16/15 at 6:36 p.m. note that indicated:</p> <p>-The nurse had spoken to doctor (Dr.) ___ in the facility about the new ulcer.</p> <p>-The Dr verbalized an okay to continue the dry dressing per the provider's protocol.</p> <p>Interview on 4/8/15 at 11:05 a.m. with LPN D revealed:</p> <p>*She would have initiated the treatment for the pressure ulcer.</p> <p>*She usually did not put the treatment on the MARs or TARs until she received an order from the Dr.</p> <p>*Normal facility protocol would have been to change the foam dressing when soiled or dirty, because it could be left in place for more than one day.</p> <p>*She agreed there was no treatment indicated on the March 2015 MAR or TAR.</p> <p>-She agreed there was no way to prove he had</p>	F 314			

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F 314	<p>Continued From page 42</p> <p>received pressure ulcer care by the nurses in March.</p> <p>*She stated the charge nurses should have known from the communication book or report about the ulcer.</p> <p>Interview on 4/8/15 at 11:10 a.m. with RN E confirmed as a charge nurse they would use the MARs and TARs to know what treatment would be needed for a resident each day.</p> <p>Further interview on 4/8/15 at 3:50 p.m. with LPN D revealed:</p> <p>*She had worked in the facility about two and a half years.</p> <p>*She had been the wound nurse for the facility for the last several months.</p> <p>*She worked on wound care primarily one day a week.</p> <p>*She had not received formal training for wound care.</p> <p>-Her only training had been on-the-job with the previous wound nurse.</p> <p>-The previous wound nurse was the current director of nursing (DON).</p> <p>*She would have consulted the dietitian on new ulcers.</p> <p>*She thought the facility also had a consultant wound nurse but was unsure of where she was from or her name.</p> <p>-She stated she had never met the consultant wound nurse.</p> <p>*When a new pressure ulcer had been identified by her or the charge nurse she would have been expected to:</p> <p>-Assess the area.</p> <p>-Measure the area.</p> <p>-Fax a request to the Dr for orders.</p> <p>-Put interventions into place, such as a new</p>	F 314			

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F 314	<p>Continued From page 43</p> <p>mattress, booties, or something specific to the ulcer.</p> <p>*She agreed there was no specific repositioning or toileting schedule in place for resident 2.</p> <p>*She agreed the resident typically spent several hours a day sitting in his wheelchair.</p> <p>*She agreed he needed a new wheelchair cushion.</p> <p>*She confirmed the resident's pressure ulcer had declined since 3/16/15.</p> <p>Interview on 4/8/15 at 10:00 a.m. with the DON regarding resident 2 revealed:</p> <p>*The interdisciplinary team should have made adjustments and additions to the care plans by handwriting them onto the current printed care plan.</p> <p>-The MDS nurse should have then added the handwritten entries into the computer when she did the resident's MDS assessment.</p> <p>*She agreed there were no interventions on the resident's care plan specific to the pressure ulcer, and there should have been.</p> <p>*They would try to get the correct mattress and interventions in place for a resident at risk for pressure ulcer.</p> <p>*LPN D was the wound nurse in the facility and would have decided an initial treatment for a pressure ulcer.</p> <p>*She would have expected the Dr to be notified of a new ulcer on the same day.</p> <p>*She agreed there was no treatment for the resident's ulcer on his March MAR or TAR.</p> <p>*She agreed if the nurse did not work every day they might not have known about the pressure ulcer, and therefore would not have done a treatment to the area.</p> <p>*She stated the CNAs used different care sheets to know what care the resident needed.</p>	F 314		

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F 314	<p>Continued From page 44</p> <p>-She confirmed there was no mention of the resident's pressure ulcer on the CNA care sheet. *She agreed the resident did not have a specific repositioning or toileting schedule. *She confirmed there was no way to prove the resident had received pressure ulcer care in March. *She further stated if something was not documented then it was not done.</p> <p>Surveyor: 32355 2. Review of resident 7's medical record revealed: *An admission date of 7/30/14. *Diagnoses of left hip fracture (broken bone) with repair, dementia (forgetfulness), and a history of a stage II pressure ulcer (red, broken skin, over a bony prominence [bone]) to the left heel. *She had required extensive assistance with all of her mobility needs (transferring from location to location and moving in bed) and ADL needs.</p> <p>Review of resident 7's 7/30/14 Braden Scale Assessment revealed a score of a 13 indicating she was at moderate risk for developing pressure ulcers.</p> <p>Review of resident 7's 7/30/14 physician's admission orders revealed: *Two skin tears and a surgical wound to the left hip had been identified. *No other skin problems were documented on or identified by the hospital discharging physician.</p> <p>Review of resident 7's 7/30/14 admission head-to-toe physical assessment revealed: *Two skin tears to the upper portion of her left</p>	F 314			

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F 314	<p>Continued From page 45 arm.</p> <p>*Three red and blanchable (skin loses redness with pressure) areas to her left buttock.</p> <p>*Both of her heels were soft and red. The left heel had a scab on it.</p> <p>*There was no documentation regarding:</p> <ul style="list-style-type: none"> <li>- The size of the scab.</li> <li>-The appearance of the scab.</li> <li>-If there was drainage from the wound or not.</li> </ul> <p>*Prevalon boots (pressure relieving) were to have been used on both feel.</p> <p>Review of resident 7's nursing progress notes from 7/30/14 through 9/15/14 revealed:</p> <p>*On 9/9/15 the nursing staff had documented "RN (registered nurse) called to resident's room to change dressing as it was falling off on the left posterior (back) heel. Under the dressing was noted a 2 centimeter (cm) diameter superficial open area appearing red with minimal drainage. A Tegaderm (protective dressing) foam adhesive was applied after cleansing with sterile NS (normal saline)."</p> <p>*On 9/15/14 the nursing staff had documented:</p> <ul style="list-style-type: none"> <li>- "Weekly wound assessment - resident admitted to facility with areas of concern. Stage 2 pressure ulcer to left heel. Wound bed is pink and moist. Scan serosanguineous drainage noted."</li> <li>- "MD (medical doctor) notified via fax and wound care orders requested."</li> <li>- "Son was notified via phone."</li> </ul> <p>*No documentation to support the wound had been assessed for worsening or health conditions, and was free from signs and symptoms of infection until 9/9/14.</p> <p>*No documentation to support the physician and family had been aware of the wound until 9/15/14.</p> <p>Review of resident 7's physician's orders revealed</p>	F 314			

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F 314	<p>Continued From page 46</p> <p>the physician had not been notified of a stage 2 pressure ulcer to her left heel until 9/15/14. The nursing staff had requested a treatment for that wound at the same time of that notification.</p> <p>Review of resident 7's weekly pressure ulcer record revealed: *The wound evaluation flow sheet had not been initiated for her left heel until 9/15/14. That had been forty-seven days after the initial identification and documentation of her wound on 7/30/14. *She had a stage 2 pressure ulcer to her left heel with serosanguineous drainage (yellow in color with small amounts of blood).</p> <p>Review of resident 7's medication administration record (MAR) revealed from July 2014 through September 2014: *She had an order for a Tegaderm foam dressing to be applied to her left heel and to be changed every three days and as needed with a start date of 9/15/14. *No documentation to support the resident's left heel had a treatment or protective dressing in place until 9/15/14.</p> <p>Review of resident 7's 8/6/14 admission Minimum Data Set (MDS) assessment revealed the resident had: *Been at risk for pressure ulcers. *No pressure ulcers identified during that assessment period. *Not been placed on a repositioning program.</p> <p>There had been no MDS assessment identifying the pressure ulcer and skin issue to the resident's left heel until 9/24/14 with her change of therapy assessment.</p>	F 314			

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F 314	<p>Continued From page 47</p> <p>Review of resident 7's 8/6/14 MDS Comprehensive Area Assessment documentation revealed:                  *She had been at risk for obtaining pressure ulcers.                  *The following documentation:                  -"Triggered due to resident requires extensive assist with bed mobility, is frequently incontinent, and is at risk for pressure ulcers."                  -"She does have a history of ulcers."                  -"Skin was assessed on admission and will be assessed weekly by nursing staff."                  -"Staff assists with turning repositioning throughout the day."                  -"Goal is to avoid complications."</p> <p>Interview on 4/8/15 at 9:15 a.m. with the DON and MDS coordinator regarding resident 7 revealed:                  *They had not been aware of a wound to the resident's left heel at the time of admission.                  *The MDS coordinator would have reviewed all documentation regarding the resident from the time of admission through the MDS date of 8/6/14.                  *They confirmed there had been no documentation to support a pressure ulcer or wound to the resident's left heel after 7/30/14 until 9/9/14.                  *The staff should have assessed and documented weekly on the resident's left heel wound upon identification on 7/30/14 until it was healed on 12/18/14.                  *They were not able to locate any documentation to support the wound had been assessed weekly or monitored after identification on 7/30/14 until 9/9/14.</p>	F 314		
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F 323	<p>Continued From page 49</p> <p>by: Surveyor: 32355</p> <p>Based on observation, interview, and record review, the provider failed to have a policy and procedure in place to determine the type of transfer required for one of three sampled residents (7). Findings include:</p> <p>1. Review of resident 7's medical record revealed: *An admission date of 7/30/14. *Diagnoses of left hip fracture (broken bone) and dementia (forgetfulness). *She had required extensive assistance with two staff members to assist her with transfers.</p> <p>Observation on 4/7/15 at 3:05 p.m. in resident 7's room revealed: *Certified nursing assistants (CNA) H and I prepared to transfer the resident from her recliner into the wheelchair (w/c). *They retrieved a standing transfer aide (device to assist the resident with transferring) and had secured her to the lift prior to the transfer.</p> <p>Interview on 4/7/16 at 3:15 p.m. with CNA H regarding resident 7 revealed: *The resident had required staff assistance with all transfers. *She would have done two different types of transfers with the resident. *She would have used: -The Standing Transfer Aide when she had transferred the resident by herself. -A gaitbelt (belt that secured around the waist of the resident to assist with transfer) when another staff member would have assisted her with the transfer. *Today CNA I had preferred to use the transfer</p>	F 323	<p>ensure transfer techniques are being followed according to the resident's care plan. Results will be reviewed at monthly QAPI meetings for further recommendations, presented by DNS or designee monthly to QAPI.</p> <p><i>dim</i></p>		

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F 323	<p>Continued From page 50 aide with two staff members.</p> <p>Review of resident 7's updated 1/20/15 Lift/mobility Assessment for Residents revealed "No lift needed, unless off of floor."</p> <p>Review of resident 7's 1/29/15 care plan revealed: *A focus area of "I have physical functioning deficit (lack of) related to self care impairment, mobility impairment." *An intervention provided under that focus area was "Transfer assistance of extensive assist." *No documentation to support how the resident was to have been transferred or the number of staff required to assist her during a transfer.</p> <p>Interview on 4/8/15 at 9:30 a.m. with the director of nursing (DON) and the Minimum Data Set (MDS) assessment coordinator regarding resident 7 revealed: *They agreed resident 7's care plan had not reflected the type of transfer she required or how many staff members were needed to assist her with a transfer. *The therapy department had worked with resident 7 on transfers after her 7/30/14 admission. *The CNAs would have known the type of transfer to use on the resident from the training they received from the therapy department. *The MDS coordinator was responsible for the assessment, documentation, and care planning on transfers for the residents. She could not clarify the type of transfer the resident required. *The DON stated "The CNAs can use a lift if a resident is weak, tired, or unable to transfer safely. They should inform the charge nurse when that occurs."</p>	F 323			

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F 323	Continued From page 51 *The DON confirmed the CNAs should not have been determining the type of transfer for resident 7.  The 6/24/14 Facility - Lift/Mobility Assessment for Residents form had been what the provider used for their policy and procedure to use for determining the transfer type on all the residents. 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: 34030 Based on observation, interview, record review, and policy review, the provider failed to intervene in a timely manner to address a severe weight loss for one of seven sampled residents (12) with weight loss. Findings include:  1. Observations on 4/7/15 of the noon and evening meals with resident 12 revealed: *At the noon meal the resident was seated at the Rushmore dining room table. -From 11:45 a.m. to 12:00 noon a therapist was	F 323	<b>F 325G Maintain Nutritional Status unless unavoidable</b>  Resident 12 has been evaluated by Registered Dietician, interventions have been implemented and the care plan has been revised. <i>Review all resident weights and trends Residents outside of 5% parameter will be addressed per facility protocol by DSM by 5/29/2015 dim</i>  The Director of Nursing, Registered Dietician and Dietary Manager has reviewed the Golden Living Center Weight Loss guideline on 4/30/2015 <i>dim</i>  Dietary Manager has been reeducated with regard to notification of Registered Dietician with any significant weight change or trends. by <i>Executive Director, Interim by 5/29/2015. dim</i> Director of Nursing or designee will complete <sup>four (4)</sup> random audits weekly x 4 weeks then monthly x 2 months to ensure weight loss notifications are being completed in a timely manner. Results will be reviewed at monthly	5/27/15
F 325 SS=G		F 325		

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F 325	<p>Continued From page 52</p> <p>assisting her to eat then left her by herself. -The resident then sat at the table without eating. -At 12:20 p.m. the aide working in that dining area helped the resident eat a few bites of food, then left to assist other residents. -Nothing more was eaten by the resident. She had consumed about half of her meal. *At the evening meal the resident was seated at the Rushmore dining room table. -She took a few bites of food then just sat there with no staff helping her. -She appeared to be unsure of what to do for eating her meals. She sat there and looked around.</p> <p>Review of resident 12's medical record revealed: *She was admitted on 1/29/15. *Her diagnoses included Alzheimer's (a progressive disease that destroys memory and other mental functions) and depression. *An admission weight of 176 pounds (lb). *On 3/9/15 her weight had decreased from 176 lb to 166 lb and was currently at that weight. This was a 5.6 percent weight loss which was considered a severe loss. *A 2/10/15 nutrition note from the dietary manager including "refer to RD [registered dietician] for new admit". No other notes or mention of weight loss were made. *There was no RD assessment. *The physician had not been notified of the resident's weight loss.</p> <p>Review of resident 12's 1/29/15 Minimum Data Set assessment revealed a Brief Interview for Mental Status of 2, indicating a severe mental impairment.</p> <p>Review of resident 12's 2/10/15 care plan</p>	F 325	<p>QAPI meetings for further recommendations, presented by Executive Director or DNS Monthly to QAPI.</p> <p><i>dim</i></p>		

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F 325	<p>Continued From page 53</p> <p>revealed: *Resident is "at nutritional risk due to Alzheimer's" with the following interventions: -Regular diet order. -Will monitor labs [laboratory tests] per physicians orders. -Will monitor weight and meal intakes weekly. *There was no mention of weight loss or interventions for that had been found.</p> <p>Review of resident 12's 2/1/15 to 4/7/15 meal logs revealed: *Her meal intake had been decreasing, and she currently averaged between forty to fifty percent of her meals. *She had taken a bedtime snack only twice in that time period.</p> <p>Interview on 4/9/15 at 9:50 a.m. with the dietary manager regarding resident 12's weight loss revealed: *She agreed the RD had not seen the resident yet. *She had noticed the resident's decreasing meal intake, and had arranged for an assessment by occupational therapy to determine its cause. That assessment was currently being done. *She had not noticed the weight loss nor had checked into why the resident was not taking bedtime snacks. *She would wait until after the assessment to start any supplements or other interventions to address the resident's weight loss. It had been a month since resident 12's severe weight loss had happened.</p> <p>Review of the provider's 2011 Weight Monitoring policy revealed: **All weights will be reviewed by the DSM [dietary</p>	F 325		

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F 325	Continued From page 54 service manager] and the RD will be notified of any significant weight changes or trends through the referral process." *A weight loss of greater than five percent was considered to have been a severe loss. **"When weight change is significant or severe, the licensed nurse will notify the patient's physician, and obtain and carry out treatment orders if given. The licensed nurse will also notify the patient's family member or legal representative. Additionally, the LivingCenter will notify the dietician." **"A nutritional screen will be completed by the DSM and referred to the dietician for any patient needing additional nutritional interventions."	F 325	<b>F 327 E Sufficient Fluid to Maintain Hydration</b>	<b>5/29/15</b>
F 327 SS=E	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION  The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.  This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on record review, interview, and policy review, the provider failed to ensure adequate fluid intake for three of eight sampled residents (2, 3, and 13) who were at risk for dehydration (inadequate fluid intake). Findings include:  1. Review of resident 2's 12/2/14 Nutrition Data assessment revealed: *He had dementia (disease affecting the memory). -That was a dehydration risk factor. *The summary section indicated:	F 327	Resident 2, 3 and 13 hydration statuses have been reviewed by <i>Dietary Service Manager, dim</i> appropriate interventions implemented and care plans reviewed and revised to reflect resident's current status. <i>by 4/16/2015.</i>  Residents residing in the facility who are at risk for hydration have the potential to be affected in a similar manner.  Residents at risk for hydration concerns have been reviewed; <i>with daily monitor of intake documentation in care tracker and dim</i> appropriate interventions implemented and care plans reviewed and revised to reflect resident's current status. <i>by 5/29/2015.</i>  The Director of Nursing, Registered Dietician and Dietary Manager has reviewed the Golden Living Center Hydration guideline.  Nursing staff have been reeducated on the hydration policy <i>by Director of Clinical Education or designee by May 29, 2015. dim</i>	

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NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - BELLA VISTA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>302 ST CLOUD STREET RAPID CITY, SD 57701</b>
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F 327	<p>Continued From page 55</p> <ul style="list-style-type: none"> <li>-He was at risk for dehydration due to the dementia.</li> <li>-His hydration was monitored as needed (PRN).</li> </ul> <p>Review of resident 2's 12/2/14 and 2/20/15 progress notes by the certified dietary manager (CDM) revealed:</p> <ul style="list-style-type: none"> <li>*He was at risk for dehydration due to his dementia.</li> <li>*Hydration was monitored PRN.</li> </ul> <p>Review of resident 2's last revised 3/16/15 care plan revealed:</p> <ul style="list-style-type: none"> <li>*He was at nutritional risk due to dementia.</li> <li>*There was no mention of his risk for dehydration.</li> <li>*There were no specific interventions for hydration.</li> </ul> <p>Reivew of resident 2's 3/17/15 Nutrition Assessment by the dietitian revealed his estimated fluid needs were 1915 milliliters (ml [liquid measurement]) per day.</p> <p>Review of resident 2's Intake and Output (I&amp;O) by Day Report from 1/9/15 through 4/8/15 revealed 82 out of 90 days his fluid intake was less than the 1915 ml he required.</p> <p>2. Review of resident 3's 2/20/15 Nutrition Data assessment revealed:</p> <ul style="list-style-type: none"> <li>*He had dementia.</li> <li>-That was a dehydration risk factor.</li> <li>*The summary section indicated:</li> <li>-He was at risk for dehydration due to the dementia.</li> <li>-His hydration was monitored PRN.</li> </ul> <p>Review of resident 3's 11/23/14 Nutrition Assessment by the dietitian revealed his</p>	F 327	<p>Director of Nursing or designee will complete <sup>four (4)</sup> random audits weekly x 4 weeks then monthly x 2 months to ensure the hydration policy is being followed according to the resident's care plan. Results will be reviewed at monthly QAPI meetings for further recommendations, presented by ED/DNS or designee monthly.</p> <p><i>den</i></p>	

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F 327	<p>Continued From page 56 estimated fluid needs were 2290 ml per day.</p> <p>Review of resident 3's 2/20/15 progress note by the CDM revealed: *He was at risk for dehydration due to his dementia. *Hydration was monitored PRN.</p> <p>Review of resident 3's I&amp;O Log from 1/10/15 through 4/10/15 revealed 90 out of 90 days his fluid intake was less than the 2290 ml he required.</p> <p>Review of resident 3's last revised 3/25/15 care plan revealed: *He was at nutritional risk due to his dementia. *There was no mention of his risk for dehydration. *There were no specific interventions for hydration.</p> <p>Interview on 4/8/15 at 11:15 a.m. with the CDM revealed: *She agreed there was no mention of resident 2's risk for dehydration or interventions for hydration on his current care plan. *She stated if someone was identified at risk she did not always put it on the care plan. *She stated she would watch a resident more closely for dehydration when they had less than 750 ml of fluids for two consecutive days in a row. -That was per the instruction of their medical director. *She confirmed residents in the secured units of the building (100, 200, and 400) did not have water mugs in their rooms. -Only the residents on the 300 unit, that was outside of the secured unit, had water mugs in their rooms due to those residents had less severe dementia.</p>	F 327		

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F 327	<p>Continued From page 57</p> <p>*She confirmed residents would have received fluids during meals, at snack times, or at other times if given to them by staff members or visitors.</p> <p>*She stated sometimes residents would have received fluids that might not have been documented.</p> <p>*She agreed most of the the residents in the facility would have been at risk for dehydration due to their dementia.</p> <p>Surveyor: 22452</p> <p>3. Review of resident 13's 9/9/14 dietitian's nutritional assessment revealed estimated daily fluid needs 1375 cubic centimeters (cc).</p> <p>Review of resident 13's 2/11/15 through 4/7/15 twenty-four hour fluid intake sheet revealed there was:</p> <p>*No fluid intake recorded for 2/22/15, 3/22/15, and 3/23/15.</p> <p>*Zero (0) cc documented for 3/4/15.</p> <p>*Forty-one days were documented 60 cc to 960 cc fluid intake.</p> <p>*Eleven days were documented 1020 cc to 1560 cc.</p> <p>Review of resident 13's 8/28/14 care plan revealed no documentation related to her poor fluid intake.</p> <p>Interview on 4/9/15 at 11:50 a.m. with the director of nursing regarding resident 13 revealed:</p> <p>*She was unsure why there was no fluid intake recorded for 2/22/15, 3/22/15, and 3/23/15.</p> <p>*She thought maybe on 3/4/15 she had been resistive with fluids like she often was, or she had been out of the building.</p> <p>*There was no documentation on the behavior log or nurse's notes on 3/4/15 she had been resistive</p>	F 327		
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F 327	Continued From page 58 with fluids, or she had been out of the building. *They had just started a new computer system mid-January 2015 that might have been the problem with documentation. *She confirmed there was no documentation on the resident's care plan fluid intake was a problem, and she was often resistive with staff offering fluids.  4. Review of the provider's 2/3/15 Hydration policy revealed: *The dietitian calculates daily fluid requirements for all patients (residents) annually or with changes in condition. *The following are risk factors for dehydration: -Functional impairments making it difficult to drink, reach for fluids or communicate fluid needs. -Dementia in which patient forgets to drink. -Refusal of fluids.	F 327	<b>F 371 F Food /Store/Prepare/Serve - Sanitary</b>  Employees F and G have been reeducated on proper hand washing techniques  Food items have been audited to ensure use by dates have been documented and outdated food has been discarded  Kitchen floor has been cleaned  Air conditioner vents have been cleaned  Debris under the plastic tubs have been cleaned  Garbage cans have been moved away from food carts to an appropriate distance.  Bread crumb container has been cleaned  Kitchen dinette areas have been cleaned	5/29/15	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on record review, observation, interview,	F 371			

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F 371	<p>Continued From page 59</p> <p>and policy review, the provider failed to ensure sanitary conditions were maintained in the dietary department for the following:</p> <ul style="list-style-type: none"> <li>*Hand washing between tasks by two of two cooks (F and G).</li> <li>*While checking the food temperatures by two of two observed cooks (F and G).</li> <li>*During the cooling process of food by two of two observed cooks (F and G).</li> <li>*Two of thirteen observed ready-to-use gallon sized containers of juice with beyond use dates or undated.</li> <li>*The floor throughout the entire kitchen area was covered with spills, debri, and multiple areas of sticky residue.</li> <li>*Two of three air conditioner vents had been dirty with lint.</li> <li>*Four of four plastic tubs containing clean and ready-to-use dishes had debri underneath the dishes.</li> <li>*Two of two garbage cans had been located in the serving and preparation areas.</li> <li>*One of one bread crumb containers had been dirty.</li> <li>*Five of five kitchen dinette areas (Rushmore, Unit, Town Square, and two in the Main dining room) had not been clean.</li> </ul> <p>Findings include:</p> <p>1. Random observations on 4/7/15 from 10:40 a.m. through 12:40 p.m. of cook F during lunch preparation and serving revealed:</p> <ul style="list-style-type: none"> <li>*He washed his hands multiple times.</li> <li>-Each time he scrubbed his hands with soap and water for a total of five to eight seconds.</li> <li>-Twice he shut off the water faucet directly with his bare hands.</li> </ul> <p>Random observations on 4/7/15 at 5:05 p.m.</p>	F 371	<p>Residents residing in the facility have the potential to be affected in a similar manner.</p> <p>* The Registered Dietician and Dietary Manager have reviewed the procedures related to maintaining sanitary conditions and Safeserve requirements by 4/30/2015 <i>dim</i></p> <p>Dietary staff has been reeducated related to kitchen sanitation, procedures in properly obtaining food temperatures and appropriate hand washing techniques on 4/30/2015 <i>dim</i></p> <p>Dietary Services Manager or designee will complete <sup>four (4)</sup> random audits weekly x 4 weeks then monthly x 2 months to ensure kitchen sanitation, procedures in properly taking food temperatures and appropriate hand washing techniques are being followed. Results will be reviewed at monthly QAPI meetings for further recommendations, presented by ED <i>dim</i> monthly.</p> <p>* A cleaning schedule is in place and being followed; outdates checked daily; temperature documentation charts completed and audited by Executive Director, Interim. <i>dim</i></p>	
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F 371	<p>Continued From page 60 through 5:50 p.m. of cook G during supper preparation and serving revealed: *He washed his hands multiple times. -Each time he scrubbed his hands with soap and water for a total of five to eight seconds. -Multiple times he shut off the water faucet directly with his bare hands.</p> <p>Interview on 4/8/15 at 8:02 a.m. with the certified dietary manager (CDM) revealed: *She would have expected hand washing to be done properly. *Hand washing should have been at least 20 seconds of lathering with soap and water, then rinsed with water and dried with paper towels. *The water faucet should have been shut off using a paper towel.</p> <p>Review of the provider's 10/30/14 dietary in-service that included hand washing revealed: **"How to wash hands:" -"Wet hands and arms." -"Apply soap." -"Scrub hands and arms vigorously. Scrub them for 10 to 15 seconds." -"Rinse hands and arms thoroughly. Use running water." -"Dry hands and arms. Use a single-use paper towel or a hand dryer." **"If you are not careful, you can contaminate your hands after washing them. Consider using a paper towel to turn off the faucet and to open the door."</p> <p>Review of the providers 2011 Hand washing policy revealed: **"Dining Services employees must effectively clean hands at appropriate kitchen hands sinks with proper cleaning compounds prior to</p>	F 371		

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F 371	<p>Continued From page 61</p> <p>handling, preparing, serving and distributing food, working with clean utensils, dishes and equipment."</p> <p>*"Follow the steps below to properly wash hands:"</p> <p>- "Turn on water and run until warm."</p> <p>- "Wet hands and exposed forearms with antiseptic soap."</p> <p>- "Lather hands and exposed forearms with antiseptic soap."</p> <p>- "Wash hands with vigorous friction on the surfaces..."</p> <p>- "Rinse thoroughly with warm water - total time of hand washing procedure should be at least 20 seconds."</p> <p>- "Wipe hands dry with a single use, disposable paper towel..."</p> <p>- "Turn water off with paper towel and dispose of towel in the foot pedal controlled trash can."</p> <p>2. Random observations on 4/7/15 from 10:40 a.m. through 12:40 p.m. of cook F during lunch preparation and serving revealed:</p> <p>*He did not clean the thermometer each time he took it out of the plastic cover prior to starting.</p> <p>*He used a few different metal thermometers to take the temperatures of multiple food items.</p> <p>*He cleaned the thermometers with alcohol wipes between different foods.</p> <p>Observation on 4/7/15 at 2:38 p.m. of cook G during a recheck of a temperature on the rosemary potatoes revealed he stuck the digital thermometer probe directly through the aluminum foil and saran wrap into the potatoes to check the temperature.</p> <p>Interview on 4/8/15 at 8:02 a.m. with the CDM revealed:</p> <p>*Temperatures were taken on the food when they</p>	F 371			

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F 371	<p>Continued From page 62</p> <p>were put into the steam table, prior to being served, and after they were done serving. *Dietary staff had been trained to clean the thermometers with alcohol wipes. *She would have expected the thermometer to be cleaned prior to taking each temperature. *She agreed that it was not correct to stick the thermometer through the aluminum foil and saran wrap. That would have been a contamination issue.</p> <p>Review of the provider's 5/15/14 dietary in-service that included how to check temperatures revealed: *"You must know how to take a temperature correctly."</p> <p>Review of the provider's 2011 Food Thermometer Guidelines revealed: *"Follow this procedure to use a thermometer:" -"Wash, rinse, sanitize and air-dry the thermometer before each use. A sanitizing mixture or alcohol fabric wipe for food contact surfaces can be used." -"Insert the thermometer into the thickest part of the product... Do not let the sensor touch the bottom or sides of the pan."</p> <p>3. Observation on 4/7/15 at 11:00 am of cook F during preparation of the rosemary potatoes for the following day revealed he: *Checked the temperature of the potatoes. -It was 85 degrees Fahrenheit (F). *Separated them into three different pans. *Covered the pans with plastic wrap. *Then placed them on ice and left them on the table.</p> <p>Observation and interview on 4/7/15 at 12:25</p>	F 371			

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F 371	<p>Continued From page 63</p> <p>p.m. with cook F revealed: *He re-checked the temperature of the potatoes. -It was 76 degrees F. *He left them sitting on ice at that time. *He was unsure what the temperature needed to be after two and four hours of cooling. *He stated he would check the temperature again prior to putting the pans in the refrigerator.</p> <p>Interview on 4/7/15 at 2:35 p.m. with cook F revealed: *He stated he checked the temperature of the potatoes prior to putting them in the refrigerator. *He stated the temperature was 37 degrees F at that time.</p> <p>Observation and interview on 4/7/15 at 2:38 p.m. with cook G revealed: *He re-checked the temperature of the potatoes using an electronic thermometer. -It was 78.4 degrees F. *He stated the temperature of the potatoes should have been down to 40 degrees F by that time. *He agreed they would be unable to serve those potatoes since they had not cooled properly.</p> <p>Interviews on 4/7/15 at 8:00 a.m. and on 4/8/15 at 8:02 a.m. with the CDM revealed: *The dietary staff had been trained on cooling food properly. *They had five dietary staff currently ServSafe certified. *She agreed the potatoes were probably not ever at 37 degrees as cook F had indicated.</p> <p>Review of the provider's 5/15/14 dietary in-service that included cooling food revealed: **Pathogens grow well in the temperature danger</p>	F 371		

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F 371	<p>Continued From page 64</p> <p>zone. But they grow much faster between 125 degrees Fahrenheit (F) and 70 degrees F." -"Food must pass through this temperature range quickly to reduce this growth." *"First, cool food from 135 degrees F to 70 degrees F within two hours." *"Then cool it to 41 degrees or lower in the next four hours." *"If the food has not reached 70 degrees F within two hours, it must be thrown out or reheated and then cooled again."</p> <p>Review of the provider's 2011 Cooling policy revealed: *"The director of dining or designee must ensure that all food is cooled to proper temperature(s) and use proper techniques." *"Taking too long to chill PHF/TCS (potentially hazardous foods) has been consistently identified as one factor contributing to foodborne illness." *"9. Steps for handling food that does not reach safe temperature within the acceptable time:" -"Reheat food to 165 degrees F for 15 seconds and start the cooling process again (assure the quality of the product is not compromised." -"Discard the food as not being safe to serve."</p> <p>4. Observation and interview with the CDM on 4/7/15 at 10:30 a.m. revealed: *Two of thirteen gallon sized pitchers of juice were past the date to be used. -They should have been used by 4/6/15. *Two of thirteen gallon sized pitches of juice had no date listed of when to be used by.</p> <p>Review of the provider's 2011 Storing Prepared Foods policy revealed: *"Label each item with product name and "use</p>	F 371		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435060</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - BELLA VISTA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>302 ST CLOUD STREET RAPID CITY, SD 57701</b>		
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F 371	<p>Continued From page 65 by" date."</p> <p>Surveyor: 32355</p> <p>5. Observation on 4/7/15 from 7:45 a.m. through 8:30 a.m. of the floor in the storage, prepping/serving, and dishwasher kitchen areas revealed:</p> <ul style="list-style-type: none"> <li>*Multiple areas with dry, black, brown, and tan colored spots.</li> <li>*There had been several pieces of paper laying on the floor in all areas from opened packages.</li> <li>*Large amounts of tan, brown, and white specks along the sides and walking areas of the floor.</li> <li>*This surveyor's feet stuck to the floor in multiple areas when walking throughout the kitchen.</li> </ul> <p>Interview on 4/9/15 at 8:02 a.m. with the CDM revealed the floors were to have been cleaned twice a day. She had not listed the floor cleaning task on the daily cleaning schedule. That had been a part of the dietary staffs' daily duties.</p> <p>6. Observation on 4/7/15 at 8:05 a.m. of two air conditioning unit vents revealed a large build-up of dust.</p> <ul style="list-style-type: none"> <li>-One of those air conditioners was blowing directly over the mixer, blender, coffee maker, and microwave.</li> <li>-The other air conditioner had been blowing in the freezer, refrigerator, and dry food storage area.</li> </ul> <p>Interview on 4/9/15 at 8:10 a.m. with the CDM revealed the air conditioning units were to have been wiped down monthly or "anytime they are fuzzy."</p> <p>7. Observation on 4/7/15 at 10:45 a.m. of the storage rack that contained clean dishes</p>	F 371			

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F 371	<p>Continued From page 66 revealed:</p> <ul style="list-style-type: none"> <li>*That storage rack was located in the clean end of the dishwasher room.</li> <li>*There had been several plastic tubs sitting on the storage rack and filled with clean ready-to-use dishes.</li> <li>*Three of those tubs had black, brown, and tan colored specks on the bottom underneath the clean dishes.</li> <li>*Underneath a counter attached to the dishwasher was a plastic tub filled with clean bowls. The tub was sitting on the heating unit located by the digital temperature monitor for the dishwasher. Underneath the clean dishes had been black, brown, and tan colored specks.</li> </ul> <p>Interview on 4/9/15 at 8:15 a.m. with the CDM regarding the above observation of the plastic tubs revealed she had not been aware the plastic tubs containing clean dishes was dirty. She confirmed the plastic tub underneath the dishwasher counter area was not to have been placed there.</p> <p>8. Random observations on 4/7/15 from 10:30 a.m. through 12:30 p.m. in the serving and preparation area revealed:</p> <ul style="list-style-type: none"> <li>*Two large garbage cans with lids on them.</li> <li>*Those garbage cans had been used by the dietary staff for their waste products.</li> <li>*There had been a three tiered cart located inches from them. On the cart was several glasses of water.</li> <li>-Those glasses of water were served to the residents during the noon meal.</li> <li>*Multiple times during the preparation and serving process the dietary staff opened and closed those garbage cans to dispose of their waste products.</li> </ul>	F 371			

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F 371	<p>Continued From page 67</p> <p>Observation on 4/7/15 from 2:30 p.m. through 3:00 p.m. in the serving and preparation area revealed a three tiered cart located inches from the two garbage cans. On the cart were several small bowls filled with a dessert. Multiple times the dietary staff opened and closed those garbage cans to dispose of their waste products.</p> <p>Interview on 4/9/15 at 8:20 a.m. with the CDM revealed the process for storing the water glasses and desserts during preparation and serving of meals was not sanitary. She confirmed that process needed to be changed.</p> <p>9. Observation on 4/7/15 at 8:00 a.m. of a large storage bin containing bread crumbs revealed: *That storage bin had been sitting on the floor by the above storage rack. *The lid and entire container was dusty with multiple sticky gray colored areas. *There had been bread crumbs on the lid and on the floor in the surrounding area. *There had been a radio sitting on top of the bin. The radio was dirty with sticky gray colored areas on it.</p> <p>Interview on 4/9/15 at 8:25 a.m. with the CDM confirmed the crumb bin and surrounding area was dirty and should have been cleaned. She removed the radio. The radio should not have been placed on top of the storage bin.</p> <p>10. Random observations from 4/7/15 through 4/8/15 of five kitchen dinette areas revealed: *Two of three observed stoves (main and Alzheimer's unit dining rooms) had ovens and attached drawers. -Those ovens had several black, brown, and tan colored dried areas on all of their surfaces.</p>	F 371		

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F 371	<p>Continued From page 68</p> <p>-The drawers were dirty inside with multiple brown, black, and white colored specks and debris.</p> <p>*The stove drawer in the Alzheimer's unit dining room contained three cookie sheets. Those cookie sheets had been resting on top of the dirty surfaces written above.</p> <p>*All five kitchen dinette areas had multiple drawers and cupboards. Several of those drawers and cupboards had been dirty inside with brown dried spots and black/brown colored specks.</p> <p>*One of the cupboards in the Townsquare dining room had several cloth napkins and placemats. The shelves were observed to be dirty as written above. The residents had used those linens during their meals.</p> <p>*In the main dining room one of the kitchen dinette area had several cupboards and drawers.</p> <p>-Two of the cupboard doors had been sticky and covered in a black substance that appeared to be mold.</p> <p>-Several of the cupboards on the inside had a significant amount of peeling and exposed/unfinished wooden areas. Those exposed areas had created uncleanable surfaces.</p> <p>-There had been several water pitchers and their lids, glasses, and vases stored on those uncleanable surfaces.</p> <p>Interview on 4/9/15 at 8:35 a.m. with the CDM revealed:</p> <p>*The dietary department had been responsible for the cleaning of all five kitchen dinette areas.</p> <p>*The activities department occasionally would have used those kitchen dinette areas for cooking.</p> <p>*She had not been aware of all the areas of concern observed and written above.</p>	F 371			

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F 371	<p>Continued From page 69</p> <p>*The kitchen dinette areas had not been placed on a routine cleaning schedule.</p> <p>Review of the kitchen daily and monthly cleaning list for March and April 2015 revealed:</p> <p>*None of the following areas had been on the cleaning schedule:</p> <ul style="list-style-type: none"> <li>-The floor inside of the kitchen area.</li> <li>-The storage bins that contained clean dishes and bread crumbs.</li> <li>-The Kitchen dinette areas.</li> </ul> <p>Review of the March and April 2015 monthly cleaning schedule revealed the air conditioner vents were to have been cleaned every other Monday. There was no documentation on those cleaning sheets supporting they had been cleaned during those two months.</p> <p>Interview on 4/9/15 at 8:40 a.m. with the CDM revealed she could not confirm when the above areas of concern had been cleaned. She agreed if it was not documented on the cleaning schedules it was not done.</p>	F 371	<p><b>F 425 E Pharmaceutical Svc/Accurate Procedures, RPH</b></p> <p>Expired medications have been removed from medication carts, treatment carts and medication rooms. Medication refrigerators and freezers have been cleaned. New thermometers have been installed. Tramadol has been destroyed. <i>by staff RN's. dim</i></p> <p>Each medication cart has been audited for open dates on medications, outdates on medications and storage of medications properly in the medication cart</p>	5/20/15
F 425 SS=E	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and</p>	F 425	<p>Licensed Nurses and UAP's have been reeducated with regard to medication administration, medication outdates, medication destruction and medication storage <i>by DNS by May 29, 2015 dim</i></p> <p>Licensed Nurses and UAP's have been reeducated with regard to acceptable temperature levels and appropriate recording of temperatures for refrigerator and freezer.</p>	

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F 425	<p>Continued From page 70</p> <p>administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, interview, and policy review, the provider failed to ensure: *Expired medications and treatments were removed from four of four medication carts, one of one treatment cart, and two of two medication rooms. *Temperatures were monitored and recorded in three of three medication and/or food refrigerators. *Their policy for accountability of a scheduled medication was followed for one random resident. Findings include:</p> <p>1. Observation on 4/9/15 from 10:15 a.m. through 11:35 a.m. of four medication carts, one treatment cart, and two medication rooms revealed the following expired medications: *Nystatin powder expired July 2014. *Quetiapine tablets thirty expired 6/22/13. *Metoclopramide tablets twenty expired 2/20/14. *Tramadol tablets twenty-four expired August 2013. *Bottle of stock senna tablets expired October 2014. *Bottle of stock vitamin B1 expired July 2014.</p>	F 425	<p>The DNS or designee will audit temperature recordings on medication refrigerator <sup>three (3) times</sup> weekly for 4 weeks and monthly for 2 months. <i>dim</i></p> <p>The DNS or designee will audit one medication cart weekly for 4 weeks and monthly for 2 months, for properly marked open dates and expired stock medications. <i>dim</i></p> <p>The DNS or designee will audit medication storage and destruction <sup>(3) three times</sup> weekly for 4 weeks and monthly for 2 months. <i>dim</i></p> <p>Results of the audits will be reviewed at monthly QAPI meetings for further recommendations, presented by DNS or designee monthly to QAPI. <i>dim</i></p>	

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F 425	<p>Continued From page 71</p> <ul style="list-style-type: none"> <li>*Olanzapine tablets twenty-four expired August 2014.</li> <li>*Mupirocin ointment expired December 2014.</li> <li>*Quetiapinefumarate tablets four expired November 2014.</li> <li>*Multiple packets of lubricating jelly expired July 2014.</li> <li>*Two bottles of hand sanitizer expired November 2013 and October 2014.</li> <li>*Two bottles of sterile water expired October 2014.</li> <li>*Bottle of stock antidiarrheal liquid expired November 2014.</li> <li>*Bottle of stock antacid( liquid expired November 2014.</li> <li>*Lorazepam tablets twenty-four expired December 2014.</li> <li>*Glucagon injection expired April 2014.</li> <li>*Ondansetron tablets six expired 5/31/13.</li> <li>*Emergency kit Novulin insulin vial expired July 2014.</li> <li>*Trazadone tablets fifteen expired January 2015.</li> <li>*Donepezil tablets nineteen expired January 2015.</li> <li>*Hydrocodone tablets twenty-four expired March 2015.</li> <li>*Olanzapine tablets sixteen expired February 2015.</li> </ul> <p>Interview on 4/9/15 at 11:15 a.m. with the director of nursing (DON) regarding the expired medications revealed:</p> <ul style="list-style-type: none"> <li>*One of the nurses usually checked the medication carts, treatment cart, and medication rooms monthly for expired medications.</li> <li>*She was not sure why there were so many expired medications if that had been done.</li> </ul> <p>2. Observation on 4/9/15 at 11:45 a.m. of three</p>	F 425			

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F 425	<p>Continued From page 72</p> <p>refrigerators in one of two medication rooms (Rushmore)revealed: *One contained a bottle of beer. -There was a large amount of ice build-up in the freezer compartment. -The thermometer reading was 20 degrees Fahrenheit (F). *One contained five containers of applesauce and four containers of Ready Care supplement. -There was a large amount of ice build-up in the freezer compartment. -The thermometer reading was 58 degrees F. *One refrigerator contained multiple medications that included tuberculin solution, acetaminophen suppositories, and insulins. -There was a large amount of ice build-up in the freezer compartment. -There was not a thermometer in the refrigerator.</p> <p>Interview at that time with the DON regarding the refrigerators revealed: *No one had told her there was not a thermometer in one of the refrigerators. *The temperatures in the other two refrigerators should have been between 35 to 46 degrees F. *The nurses usually checked and recorded the refrigerator temperatures daily.</p> <p>Review of the April 2015 medication room refrigerator temperature monitoring revealed no documentation of refrigerator temperatures since 4/3/15.</p> <p>3. Observation on 4/9/15 at 11:50 a.m. in the medication room by the nurses' station revealed: *A bottle of Tramadol (controlled narcotic pain medication) sitting on the counter. *There was a piece of clear tape on the top of the bottle with "73" written on it.</p>	F 425		

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F 425	Continued From page 73  Interview at that time with the DON regarding the Tramadol revealed: *The bottle should not have been sitting like that on the counter. *The bottle should have been locked in the medication cart or should have been placed in the locked destruction box. *Tramadol should have had a controlled reconciliation sheet and should have been reconciled every shift until it had been destroyed.  Review of the provider's May 2012 Medication Administration General Guidelines policy revealed "The expiration date on the packaging/container is checked."	F 425	<b>F 428 D Drug Regime Review, report irregular/act on</b>  Residents 7 and 8 physicians have been notified of pharmacist recommendation for gradual dose reduction, orders have been received and implemented.  Residents residing in the facility have who have had a pharmacist recommendation for a gradual dose reduction have the potential to be affected in a similar manner.	5/29/15
F 428 SS=D	<b>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</b>  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.          This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure 2 of 14 sampled residents (7 and 8) with pharmacy gradual dose reduction (GDR) recommendations	F 428	<b>DNS or designee has reviewed the pharmacist March 2015 recommendations and appropriate follow up has been completed.</b> <i>DNS or designee will complete the follow up on pharmacist recommendations</i> Licensed Nursing Staff has been reeducated on following the pharmacist recommendations by <i>May 29, 2015.</i> <i>each month going forward.</i> The DNS or designee will audit pharmacist recommendations to ensure follow up monthly for 3 months. Results of the audits will be reviewed at monthly QAPI meetings for further recommendations, presented by the DNS monthly to QAPI.	<i>dim</i> <i>dim</i>

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F 428	<p>Continued From page 74 was followed-up on by the primary physician. Findings include:</p> <p>1. Review of resident 8's February 2015 consultant pharmacy report revealed: *The pharmacist identified a current order for Seroquel (treatment of mental illness) 25 milligrams (mg) every day and 75 mg at hs (hour of sleep). -The recommendation: "Please consider reducing the current medication dose to 75 mg hs or any other reduction of dose. *The physician response on 3/10/15 - Rejected: Please continue current orders and document clinical rationale below. Psych [psychiatric] meds adjusted through [name of psychiatrist] office."</p> <p>Review of resident 8's 4/1/15 psychiatric examination revealed: *There was nothing documented to show the psychiatrist had been made aware of the recommendation for a GDR. *The psychiatrist added "Seroquel 25 mg PRN [as needed] for agitation/anxiety or if awake more than 18 hours."</p> <p>Review of resident 8's 3/1/15 through 4/1/15/progress notes revealed there was no new behaviors noted to indicate the need for a dose increase.</p> <p>Interview on 4/8/15 at 10:00 a.m. with the director of nursing regarding resident 8 revealed she: *Was unsure why the psychiatrist had not addressed the GDR but instead added a PRN dose to be give for agitation/anxiety. *Agreed agitation and anxiety was not an appropriate indicator for Seroquel. *Was going to look further into the nurses notes</p>	F 428			

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F 428	<p>Continued From page 75</p> <p>to see if there was additional information to support the psychiatrist's plan.</p> <p>*Never provided any additional documented information before the end of the survey.</p> <p>Review of the provider's undated Using the Nursing Process approach to consider Gradual Dose Reduction (GDR)/Tapering for Off-Label Use of Antipsychotic Medications policy revealed:</p> <p>***For individuals prescribed an antipsychotic medication over a long period of time:</p> <p>-Check the medical record to make sure a mental health condition/history is noted that validates the use of the drug.</p> <p>-Check to see if GDR attempts have been made and the outcome of the trial.</p> <p>-Consult with the treating physician and pharmacist about the possibility of a gain attempting a GDR."</p> <p>*It had not addressed</p> <p>Surveyor: 32355</p> <p>2. Review of resident 7's medical record revealed:</p> <p>*An admission date of 7/30/14.</p> <p>*Diagnoses of left hip fracture (broken bone) with repair, dementia (forgetfulness), and depression (sadness).</p> <p>*Since 7/30/14 she had been taking Paxil 20 milligrams (mg) everyday for depression.</p> <p>Review of resident 7's 8/2/14 pharmacy medication review and recommendations to the attending physician revealed:</p> <p>*The pharmacist had recommended the physician review the current dose of her Paxil (antidepressant) and Zyprexa (mood altering medication) to ensure the resident was using the lowest possible dose.</p> <p>*The physician had discontinued the Zyprexa and</p>	F 428		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435060</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - BELLA VISTA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>302 ST CLOUD STREET RAPID CITY, SD 57701</b>		
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F 428	Continued From page 76 continued with the Paxil at the current dose. He documented her condition was stable. *On 1/14/15 the pharmacist again recommended the physician consider a GDR for her Paxil. *There had been no documentation to support the physician had received the 1/14/15 recommendation from the pharmacist and why a GDR had not been considered.  Review of resident 7's January 2015 through April 2015 medication administration record revealed she continued to take the Paxil 20 mg daily.  Interview on 4/8/15 at 9:20 a.m. with the director of nursing (DON) revealed: *She confirmed they had been having problems with documentation and follow-up with the pharmacy recommendations. *She could not provide any further documentation to support the physician had been notified of the GDR recommendations by the pharmacist on 1/14/15.	F 428			
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	F 441			

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F 441	<p>Continued From page 77</p> <p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</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</p> <p>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: 26180 Based on observation and interview, and policy review, the provider failed to ensure effective infection control practices were followed for: *One of one employee (S) with a potentially infectious disease for safe infection control measures.</p>	F 441	<p><b>F 441 D Infection Control, Prevent Spread, Linens</b></p> <p>Employee S was released from duty as soon as DNS was aware of illness.</p> <p>Residents residing in the facility have the potential to be affected in a similar manner.</p> <p>Executive Director, Director of Nursing and Interdisciplinary team have reviewed the GLC Infection Control Guideline by 4/30/2015 dim</p> <p>dim ALL * Staff has been reeducated related to working while suffering an illness by Director of Clinical Education 4/30/2015 dim ** The DNS or designee will audit staff illness weekly for 4 weeks and monthly for 2 months to ensure appropriate infection control procedures are followed. Results of the audits will be reviewed at monthly QAPI meetings for further recommendations. * All staff re-educated regarding hand washing by 5/29/2015 dim ** Infection control Nurse will monitor staff illness and follow company policy. *** All staff be educated according to company policy by 5/29/2015 by Director of Clinical Education for staff illness. dim</p>	5/29/15
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F 441	<p>Continued From page 78</p> <p>*One of two observations of following manufacturer's recommendations for disinfecting bath and shower facilities.</p> <p>*One of two observed sampled residents (2) during a dressing change.</p> <p>Findings include:</p> <p>1. Random observations and interview on 4/7/15 from 8:00 a.m. until 11:50 a.m. revealed certified nursing assistant (CNA) S:</p> <p>*Was assisting residents with getting up for breakfast and transporting them to the dining room.</p> <p>*Had symptoms of a cold including: congestion, watery eyes, shortness of breath, runny nose, and verbalized he was not feeling real well.</p> <p>*On several occasions wiped his eyes, touched residents on the shoulder, touched their hands and coughed directly into his hands without using any hand hygiene.</p> <p>*He stood at the food line to get trays for residents at breakfast, and coughed covering his mouth with his bare hands without completing any hand hygiene.</p> <p>*At 9:15 a.m. he had a mask on covering his mouth.</p> <p>-He appeared to have been short of breath with the mask on.</p> <p>*At 10:15 a.m. he came walking down the hall in the Advanced Alzheimer Care Unit carrying two plastic cups with party mix in them.</p> <p>-His finger tips were inside the cup.</p> <p>-He offered a cup to one of the residents who did not seem to understand what he was being offered.</p> <p>-He reached into the cup with his bare hands and picked up a piece of party mix and put it up to the resident's mouth encouraging him to eat it.</p> <p>-He then stopped as the resident had not</p>	F 441		

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F 441	<p>Continued From page 79</p> <p>accepted the party mix.</p> <p>-He offered another resident the party mix, before opening a utility-type door in the unit and getting rid of the party mix.</p> <p>*At 11:30 a.m. he had removed his mask and was assisting a resident go to the dining room.</p> <p>-He stood the resident up and was standing face-to-face with her as he tried to put a gait belt around her waist.</p> <p>Interview on 4/7/15 at 11:45 a.m. with the director of nursing revealed she was unaware he was exhibiting the described symptoms. She agreed he should have used hand hygiene if he was coughing and wiping his eyes.</p> <p>Review of the provider's 2001 Handwashing/Hand Hygiene policy revealed: *"All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections other personnel, residents and visitors." *The policy did not address what staff were to do if they had symptoms of an infectious illness.</p> <p>Surveyor: 34030 2. Observation and interview on 4/8/15 at 10:15 a.m. of CNA C cleaning the residents' shower on the 100 wing revealed: *She had worked at the facility for a few months and gave residents' showers and whirlpool tub baths. *After a resident's shower she sprayed quaternary (a disinfectant) cleaner on the shower and shower chair surfaces. *She waited two minutes then rinsed the surfaces off with water. (The appropriate time to wait for that disinfectant is ten minutes in order to kill all germs). *She "would do the same for the whirlpool tub</p>	F 441			

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F 441	<p>Continued From page 80 cleaning."</p> <p>Interview on 4/9/15 at 11:00 a.m. with the infection control nurse revealed she would have expected CNA C to have left the disinfectant on for ten minutes before rinsing it off to provide adequate germ control.</p> <p>Review of the provider's undated Whirlpool Cleaning Instructions revealed: *"Let disinfectant stay on the surface of the tub for 10 minutes." *No other policy or procedure provided mentioned the cleaning of resident showers.</p> <p>Surveyor: 22452 3a. Observation on 4/7/15 at 11:05 a.m. of resident 2's dressing change with licensed practical nurse (LPN) P revealed she: *Obtained the Tegederm dressing, Saf Clens (spray cleanser), and Santyl (debridement medication) ointment in a plastic medication cup from the medication room for his left buttock pressure ulcer dressing. *Placed all the above supplies on the roommate's arm chair with no protective barrier under the supplies before starting the dressing change.</p> <p>Interview with LPN P at that time revealed she should not have set the supplies for the dressing change on the roommate's chair with no protective barrier underneath them.</p> <p>Surveyor: 35237 b. Observation on 4/8/15 at 8:15 a.m. of resident 2's dressing change with RN E revealed she: *Arrived at the resident's room.</p>	F 441			

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F 441	Continued From page 81 *Set the wound care supplies directly on the roommate's bed with no protective barrier underneath them. *Proceeded with the dressing change as directed.  c. Interview on 4/8/15 at 10:00 a.m. with the DON revealed she would have expected infection control to be maintained during dressing changes.  Review of the provider's 2006 Clean Dressing Change procedure revealed: *The purpose was to protect the wound, prevent irritation, prevent infection, and the spread of infection and promote healing. *The procedure should have included to "create clean field with paper towels or towlette drape."	F 441	<b>F 490 E Effective Administration/resident Well Being</b>  The facility is unable to correct past administrative practices  Residents residing in facility have the potential to be affected in similar manner.	5/2/15
F 490 SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, interviews, and job description review, the provider failed to ensure the provider used its resources effectively to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Findings include:  1. Review of the provider's 8/30/11 director's job	F 490	* **  The facility is administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.  The Area Vice President (AVP) or designee will audit facility monthly for progress on plan of correction and that residents are achieving and maintaining their highest practicable well being. Results will be reviewed at monthly QAPI meetings for further recommendations, presented by the *** Executive Director, Intern to Monthly QAPI. * Directed policy review completed without changes in policy required 4/30/2015 ** Licensed Nurse and management will be educated on how to obtain Golden Living Center polices by 5/29/2015	dim

\*\*\* QAPI Meeting are held Monthly or more often as needed to ensure highest practicable well being is maintained. Subcommittees are in place through the PIP's Performance Improvement Plans in QAPI.

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F 490	<p>Continued From page 82 description revealed:                      *Leads the facility management staff and consultants in developing and working from business plan that focuses on all aspects of facility operations, including setting priorities and job assignments. Monitors each department's activities, communicates policies, evaluates performance, provides feedback, and assists, observes, coaches and disciplines as needed.                      *Maintain a working knowledge of and ensure compliance with all governmental regulations.                      *Comply with and support and enforce company policies involving all safety and infection control procedures to include the proper use of mechanical lifts, gait belts and personal protective back supports.                      *Promote and understanding of and compliance with all rules regarding resident's rights, promote positive relationships with residents, visitors and regulators.                      *Utilize the quality improvement process in all areas of facility operation."</p> <p>Review of the provider's 10/15/14 director of nursing services job description (DON) revealed:                      *Oversees the nursing staff for the provision of quality and appropriate resident / patient care that meets or exceeds company and regulatory standards.                      *Schedules and performs rounds [a scheduled review of resident care issues] to monitor and evaluate the quality and appropriateness of nursing care.                      *Oversees and monitors the Resident Assessment process for accuracy, attends care planning conferences periodically to determine compliance with care planning guidelines."</p> <p>Refer to F224, F226, F278, F280, F309, F314,</p>	F 490		

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F 490	Continued From page 83 F323, F325, F371, F441, and F520. Repeated deficiencies from previous recertification survey on 3/5/14 included: F280, F281, F323, F371, and F441.	F 490	<b>F 520 E QAA Committee-Members/Meet Quarterly/Plans</b>	<i>5/29/15</i>
F 520 SS=E	<p><b>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</b></p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on interview, record review, the provider</p>	F 520	<p>The facility is unable to correct past administrative processes</p> <p>Residents residing in facility have the potential to be affected in similar manner.</p> <p>Executive Director, Director of Nursing, Governing Board and Interdisciplinary team have reviewed the Quality Assurance and performance improvement policy</p> <p>The Quality Assurance Performance Improvement (QAPI) program will include review of resident care concerns and plans, identify trends in the quality indicator measures, identify trends and tracking of infection controls, identify needs and issues with electronic medical records, review admissions and discharges, discuss new and old policies and procedures, discuss monthly pharmacist reports, discuss incident and safety reports, discuss staff concerns and needs.</p> <p><i>xxx 520 page 82 dim</i></p>	

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F 520	<p>Continued From page 84</p> <p>failed to implement and follow through with a continuous quality assurance performance improvement (QAPI) program that ensured staff were knowledgeable of the process and that ongoing oversight of plans of corrections for past deficient practices for previous deficiencies were resolved.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Interview on 4/9/15 at 11:00 a.m. with the executive director (ED) revealed: <ul style="list-style-type: none"> <li>*The QAPI committee met every month.</li> <li>*The committee included the ED, director of nursing, medical director, all department heads, and other staff such as the pharmacist randomly attended.</li> <li>*Their focuses were concerns brought to their attention by family, residents, and staff.</li> <li>*Their morning stand-up meeting was a part of their QAPI process, as they tried to address some issues as they came up rather than waiting for the monthly meetings.</li> <li>-Some concerns were simple fixes, and others required a more systematic review.</li> <li>*They looked at all quality measures such as falls, weight loss, pressure ulcer (a sore that can be a result of not being repositioned), and psychotropic medications (used for treatment of mental illness or to decrease aggressive behaviors).</li> <li>*All staff were invited to the QAPI committee meetings, but they rarely came.</li> <li>-They did not have a set day they were scheduled for.</li> </ul> </li> </ol> <p>Interview with certified nursing assistant T revealed she was unaware of the quality assurance program.</p>	F 520	<p>Staff members have been reeducated on the QAPI process</p> <p>QAPI Committee meetings will be held at a minimum of quarterly consisting of the Executive Director, Director of Nursing, Medical Director and at least 3 other members of the facility staff.</p> <p>The Area Vice President (AVP) or designee will audit QAPI minutes for 6 months to ensure that facility is identifying deficient practices and correcting these areas of concerns.</p>	
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F 520	<p>Continued From page 85</p> <p>The following deficient practices were identified in these high risk, high volume, problem prone areas:</p> <ul style="list-style-type: none"> <li>*F221 Restraints.</li> <li>*F224/F226 Abuse and Neglect.</li> <li>*F309 Providing Care and Services to maintain the residents highest physical, mental and psychosocial well being.</li> <li>*F314 Pressure Ulcers.</li> <li>*F325 Weight Loss.</li> <li>*F327 Hydration.</li> <li>*F371 Sanitary Conditions.</li> <li>*F425 Pharmacy Services</li> <li>*F441 Infection Control.</li> </ul> <p>Review of the provider's 2014 QAPI guideline revealed:</p> <ul style="list-style-type: none"> <li>***The facility conducts Performance Improvement Projects (PIPs) to examine and improve care or services in areas identified as opportunities for improvement (OFIs).</li> <li>*A PIP is a concentrated effort on a particular opportunity for improvement and prioritized based on high risk, high volume, problem prone areas."</li> </ul>	F 520		

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NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - BELLA VISTA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>302 ST CLOUD STREET RAPID CITY, SD 57701</b>
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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) COMPLETION DATE
K 000	INITIAL COMMENTS  Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 4/08/15. Golden LivingCenter - Bella Vista was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000	STATEMENT OF COMPLIANCE: The following represents the plan of correction for the alleged deficiencies cited during the survey that was conducted on April 9, 2015. Please accept this plan of correction as the living center's Credible Allegation of Compliance with the completion date of May 29, 2015. The completion and execution of this plan of correction does not constitute an admission of guilt or wrong doing on the part of the living center. This plan of correction is completed in good faith and as the living center's commitment to quality outcomes for the residents. In addition, this plan of correction is completed as it is required by law.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain proper separation of one of four hazardous areas in one randomly observed area (kitchen pantry). Findings include:	K 029	K029 Self closing devices were installed on the kitchen pantry door on April 16, 2015.  All storage areas greater than 100 square feet were audited	5/29/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marqueta Prince TITLE: Executive Director (X6) DATE: 4/30/15

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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If continuation sheet Page 1 of 2  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435060</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/08/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - BELLA VISTA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>302 ST CLOUD STREET RAPID CITY, SD 57701</b>		
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K 029	Continued From page 1  1. Observation at 8:15 a.m. on 4/08/15 revealed the kitchen pantry storage room was over 100 square feet in area. The door to the kitchen was not equipped with a self-closing device. Interview with the maintenance supervisor at the time of the observation confirmed that finding. Doors to hazardous areas are required to be self-closing.  The deficiency affected requirements for providing separation of hazardous areas.	K 029	with closures installed where indicated.  All residents have the potential to be affected.  Maintenance Supervisor or designee will review all storage areas annually to ensure proper door closures are in use.  Completion of all door closure work and storage area closures will be reported by Maintenance Supervisor to the Quality Assurance Performance Improvement committee for review and recommendations.		

ORIGINAL

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER#  <b>435060</b>	MULTIPLE CONSTRUCTION A. BUILDING: <b>01 - MAIN BUILDING</b>  B. WING _____	DATE SURVEY COMPLETE:  <b>4/8/2015</b>
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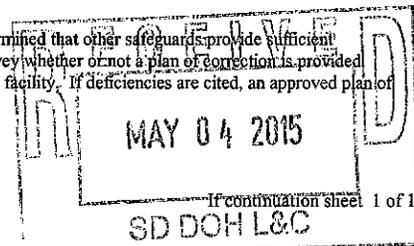
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - BELLA VISTA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>302 ST CLOUD STREET RAPID CITY, SD</b>
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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<b>K 144</b>	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain emergency lighting of at least 1-1/2 hour duration in one of one randomly observed area regarding the battery pack emergency light at the transfer switch that did not work. Findings include:</p> <ol style="list-style-type: none"> <li>1. Observation at 8:30 a.m. on 4/08/15 revealed the battery pack emergency light at the generator transfer switch did not work. Interview with the maintenance supervisor at the time of the observation confirmed that finding. Further interview revealed the battery pack emergency light was on the preventive maintenance schedule but had failed since the last check.</li> </ol> <p>The deficiency affected requirements for emergency lighting.</p>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10667</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/09/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - BELLA VISTA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>302 ST CLOUD ST RAPID CITY, SD 57701</b>
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S 000	Initial Comments  Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 4/07/15 through 4/09/15. Golden LivingCenter - Bella Vista was found not in compliance with the following requirements: S253 and S419.	S 000	STATEMENT OF COMPLIANCE: The following represents the plan of correction for the alleged deficiencies cited during the survey that was conducted on April 9, 2015. Please accept this plan of correction as the living center's Credible Allegation of Compliance with the completion date of May 29, 2015. The completion and execution of this plan of correction does not constitute an admission of guilt or wrong doing on the part of the living center. This plan of correction is completed in good faith and as the living center's commitment to quality outcomes for the residents. In addition, this plan of correction is completed as it is required by law.	
S 253	44:04:04:11.01 SECURED UNITS  Each facility with secured units must comply with the following provisions: (1) A physician's orders for confinement that includes medical symptoms that warrant seclusion or placement must be documented in the...resident's chart and must be reviewed periodically by the physician; (2) Therapeutic programming must be provided and must be documented in the overall plan of care; (3) Confinement may not be used as a punishment or for the convenience of the staff; (4) Confinement and its necessity must be based on a comprehensive assessment of the...resident's physical and cognitive and psychosocial needs, and the risks and benefits of this confinement must be communicated to the...resident's family; (5) Locked doors must conform to Sections 18.2.2.2.4 and 19.2.2.2.4 of NFPA 101 Life Safety Code, 2000 edition; and (6) Staff assigned to the secured unit must have specific training regarding the unique needs of...residents in that unit. At least one caregiver must be on duty on the secured nursing unit at all times.	S 253	S253 Secured Units  Residents 1 and 8 are receiving therapeutic activities based on Activity Assessment (Recreation Service assessment) and care plan update to resident assessments. Residents residing in the facility have the potential to be affected in a similar manner.  Residents residing in the facility will have their assessments reviewed and revised to reflect the resident's current status with the next scheduled MDS assessment	5/29/15  dim

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

*Margueta Prince*

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Executive Director  
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*Debra McLaughlin dim*

5/19/2015

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10667</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/09/2015</b>
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NAME OF PROVIDER OR SUPPLIER  
**GOLDEN LIVINGCENTER - BELLA VISTA**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**302 ST CLOUD ST  
RAPID CITY, SD 57701**

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S 253	<p>Continued From page 1</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 26180 Based on observation, interview, and policy review, the provider failed to ensure 2 of 14 sampled residents (1 and 8) received therapeutic programming in the secured unit. Findings include:</p> <p>1. Random observations on 4/7/15 from 8:00 a.m. until 6:45 p.m. of resident 1 revealed: *She reside in the locked unit with the whole secured building also known as the Advanced Alzheimer Care Unit (ACU). *She was in bed and appeared to sleep all morning. *She was brought out to the dining room for her noon meals and was brought back to her room and laid down immediately after the noon meal. *At 5:40 p.m. resident 1 was woke up and brought to the dining room where she ate her supper meal. *She had not participated in any therapeutic program during the day.</p> <p>Observation on 4/8/15 of resident 1 from 8:00 a.m. through 6:00 p.m. revealed she sat in front of her television throughout the day. The only exception was when she was brought to the dining room for the meals.</p> <p>Review of resident 1's 2/19/15 Minimum Data Set (MDS) assessment revealed her daily preferences included music, pets, books, her personal belongings, religion, and being with groups of people.</p> <p>Review of resident 1's 4/14/15 care plan revealed: **Focus:</p>	S 253	<p>Alzheimer Care Director has been re-educated on providing therapeutic activities for residents residing in the Alzheimer Unit <i>through relias hearing on 5/4/2015. (Alzheimers Therapeutic Activity Programming for persons with Dementia)</i></p> <p>Director of Nursing or designee will complete random <sup>four(4)</sup> audits weekly to correspond with the MDS schedule x 4 weeks then monthly x 2 months to ensure therapeutic activities are being provided to meet resident needs. Results will be reviewed at monthly QAPI meetings for further recommendations. <i>The DNS or designee will report the audits monthly to QAPI. dim</i></p>	

South Dakota Department of Health

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S 253	<p>Continued From page 2</p> <p>-Resident has diagnosis of Alzheimer's or related dementia. Due to cognitive loss, diminished decision making capabilities and safety and security issues, placement in the secure Alzheimer's Care unit (ACU) with programs designed for this population is needed as evidenced by: Moderate to severe cognitive loss.</p> <p>-I require some assistance in participating in activities of my choice related to Needing extra time to communicate or follow cues.</p> <p>*Interventions:</p> <p>-Allow resident to wheel throughout the ACU.</p> <p>-Provide environmental cues throughout the ACU to minimize effects of cognitive deficits, memory box, name and picture beside door.</p> <p>-Provide normalized programming based on patient assessment and interests: church choir, ___ [name of sorority] genealogy."</p> <p>*There were no specific interventions or a therapeutic program outlined for her.</p> <p>*Her daily preferences were not incorporated into her plan.</p> <p>2. Random observations on 4/7/15 from 8:00 a.m. until 6:45 p.m. of resident 8 revealed:</p> <p>*She reside in the locked unit with the whole secured building also known as the AACU.</p> <p>*She was in bed and appeared to sleep all morning.</p> <p>*She was brought out to the dining room for her noon meal and was brought back to her room and laid down immediately after the noon meal.</p> <p>*She remained in bed through the supper meal as she refused to get up.</p> <p>*She had not participated in any therapeutic programming during the day.</p> <p>Observation on 4/8/15 of resident 8 from 8:00 a.m. through 6:00 p.m. revealed she spent the</p>	S 253		
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S 253	<p>Continued From page 3</p> <p>day in her bed except when she came out to the dining room for meals.</p> <p>Review of resident 8's 2/19/15 MDS assessment revealed her daily preferences included staying up past 8:00 p.m. reading the news, music, music, attending activities with groups of people, religion, pet visits, and getting outside for fresh air when appropriate.</p> <p>Review of resident 8's 3/11/15 care plan revealed:                      ***Focus: Resident has diagnosis of Alzheimer's or related dementia. Due to cognitive loss, diminished decision making capabilities and safety and security issues, placement in the secure Alzheimer's Care unit (ACU) with programs designed for this population is needed as evidenced by: Moderately severe cognitive loss."                      ***Interventions:                      -Allow resident to walk throughout the ACU at will.                      -Provide normalized programming based on patient assessment and interests, books, food related socials.                      -Strongly encourage resident to attend meals in the dining room."                      *Focus: My level of activity participation changes due to: tiring easily, cognitive status."                      ***Interventions:                      -If I become less involved in group activities, please offer me 1:1 (one-to-one) or independent activities.                      -If I'm unable to attend religious services, please ask clergy to come to my room."                      *There were no specific interventions or a therapeutic program outlined for her.                      *Her daily preferences were not incorporated into her plan.</p>	S 253		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10667</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/09/2015</b>
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S 253	<p>Continued From page 4</p> <p>3. Random observations on 4/7/15 and 4/8/15 throughout the days revealed many unidentified residents:                      *Continuously wandered throughout the unit.                      *Clustered in corners of the unit where there was a loveseat that two residents could have sat on.                      *Sat in front of a large screen television with a picture that was discolored leaving actors with green colored faces.</p> <p>Observations from 4/7/15 through 4/9/15 revealed there was an activity calendar that was posted as you entered the building. There were no individual programs posted in resident rooms.</p> <p>4. Interview on 4/8/15 at 4:00 p.m. with the ACU director revealed:                      *They had one large calendar of activities that they encouraged residents to participate in.                      *They had recently developed a program for residents that had not participated in the large group activities.                      -This program was based on the resident's level of cognitive functioning.                      -They had not really started this program yet                      *They did not have a schedule of small group activities.                      *She agreed not all residents were appropriate for large group activities.                      *Residents 1 and 8 came to some activities but not a lot of the large group activities.                      *She confirmed their programming was not as thorough as it should have been.                      *She agreed programming could have impacted the behaviors the residents exhibited, as well as helped with reducing the amount of psychoactive medications the residents had received.</p> <p>Review of the provider's 2009 Recreation Services Guide: Program categories revealed:</p>	S 253		

South Dakota Department of Health

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S 253	Continued From page 5  **Objective: A wide variety of programs will be provided on a scheduled basis. *Purpose - Programs are designed to provide opportunities for each resident to meet their social, physical, cognitive and emotional needs, recreational interests, and developing leisure skills. *Process -Opportunity for participation in a variety of programming will be provided daily, seven days a week that addresses the needs and recreational interests of the resident population. -Programs will be scheduled at hours conducive to the participation of all residents including morning, afternoon, evenings and weekends."	S 253	S 419 Storage Rooms  The conference room and water storage area will be reverted to central storage. The total area of storage with this plan will provide for approximately 400 square feet.  Residents residing in the facility have the potential to be affected in a similar manner.  Completion of this conversion will be reported to QAPI by the Maintenance Supervisor.	5/29/15
S 419	44:04:15:04 Storage Rooms  There must be at least 10 square feet (0.929 square meters) of central storage provided for each bed. General storage must be concentrated in one area in the facility, but up to 50 percent of the general storage space may be provided on the premises. Each resident must be provided with an individual closet with an area of at least 5 square feet (0.465 square meters) which is directly connected to the resident room.  This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain the required amount of general storage. The building had seventy-eight licensed beds and was required to have 780 square feet of general storage (half of which-50%-could be in an outbuilding). Findings include:  1. Observation beginning at 8:00 a.m. on 4/08/15	S 419		

South Dakota Department of Health

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S 419	Continued From page 6  revealed the building had outbuildings for storage, but did not have a general storage area meeting 50% of the total requirement (390 square feet needed in the building). Two rooms marked as Storage were used for trash/soiled linen holding and clean linen storage in the center core area close to the conference room. There was no room identified as storage that was being used for general storage or met the area requirement. Review of the building floor plan revealed it had not been updated and did not show a general storage location. Interview with the maintenance supervisor at 11:30 a.m. on 4/08/15 revealed he was unaware the building's existing storage did not meet the requirements.	S 419		