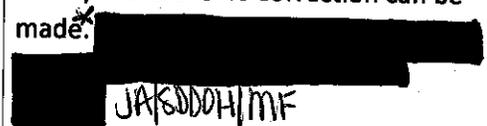


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435051</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/01/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - MEADOWBROOK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 ARROWHEAD DR RAPID CITY, SD 57702</b>
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F 000	<p><i>Addendums noted with an asterisk per 4/1/15 telephone to facility interim administrator. JAK000H/MF</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 32572 An extended recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/24/15 through 3/25/15 and from 3/31/15 through 4/1/15. Golden LivingCenter - Meadowbrook was found not in compliance with the following requirements: F157, F164, F165, F223, F224, F241, F246, F248, F252, F253, F280, F281, F314, F323, F431, F441, F490, F493, F494, F514, and F520.</p>	F 000	<p><b>STATEMENT OF COMPLIANCE:</b> The following represents the plan of correction for the alleged deficiencies cited during the survey that was conducted on April 1, 2015. Please accept this plan of correction as the living center's Credible Allegation of Compliance with the completion date of April 30, 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.</p>	
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in</p>	F 157	<p>F 157D Notify of changes (injury/decline/room, ect.)</p> <p>Resident #17 no longer resides in facility therefore no correction can be made.  JAK000H/MF</p>	4/30/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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.

APR 27 2015  
If continuation sheet Page 1 of 10  
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F 157	<p>Continued From page 1</p> <p>resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review and interview, the provider failed to ensure complete and accurate documentation was maintained for one of one sampled resident (17) who was discharged against medical advice (AMA). Findings include:</p> <p>1. Review of resident 17's medical record revealed: *She had been admitted on 9/25/14 for rehabilitation therapy after a left knee joint replacement. *She was discharged AMA on 9/28/14 at 4:06 p.m. *A release of responsibility for AMA discharge had been signed by her husband and the director of nursing service on 9/28/14. *Review of the interdisciplinary progress notes revealed no documentation resident physician had been made aware of the AMA discharge. *Review of the interdisciplinary progress notes regarding resident also revealed: -She had confusion to time and place. -She required assistance with transfers from wheelchair to other surfaces (bed, toilet, and reclining chair). -She was not able to ambulate independently. -She had a urinary catheter (tube in bladder to</p>	F 157	<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 Golden Living Policy 'Notification of Change in Resident Health Status'</p> <p>Licensed nursing staff have been re-educated on the Golden Living Policy 'Notification of Change in Resident Health Status'</p> <p>* five JALSDDH/ME Director of Nursing or designee will complete random audits weekly x 4 weeks then monthly x 2 months to ensure physician and responsible party notification has been completed when a resident experienced a condition change. Results will be reviewed at * monthly QAPI meetings for further recommendations. JALSDDH/ME</p>	



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F 164	<p>Continued From page 3</p> <p>section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on observation, interview, and resident's bill of rights handbook review, the provider failed to ensure privacy and confidentiality was maintained for: *Toileting in shared bathrooms for three of six interviewed residents (2, 9, and 29). *Resident specific information shared among staff members in hallways and residents' rooms in a loud enough voice to have been overheard by other residents in nearby rooms. Findings include:  1. Interview on 3/24/15 at 8:05 a.m. with resident 29 revealed she and her roommate shared a bathroom with two men. She stated there were multiple times those men had walked in on her when she had been using the toilet. She stated the door on the men's side did not lock. She also stated staff and family members had come into</p>	F 164	<p><b>QAPI meetings for further recommendations.</b></p>	

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F 164	<p>Continued From page 4</p> <p>the bathroom from the men's side when she had been using the toilet. She stated the door on her room side did lock. There were many times the men would lock that door and forget to unlock it. She would need to call for staff help to open the door, so she could use the toilet. She stated she had talked to administration several times about her frustration with sharing a bathroom with men. She was told there was nothing they could do about it.</p> <p>2. Interview on 3/24/15 at 2:20 p.m. with resident 9 revealed she was a roommate to resident 29. She voiced concerns about sharing a bathroom with two men. She stated she had also been walked in on when she had been using the toilet. Those interruptions had occurred by the men, staff, and family members. She stated it was frustrating not to have privacy when using the toilet. She also stated she had asked the administrator if she could be moved to another room. She stated she was told she could not be moved to another room.</p> <p>Surveyor: 32573</p> <p>3. Interview on 3/24/15 at 11:00 a.m. with resident 2 revealed:</p> <ul style="list-style-type: none"> <li>*There was no privacy in the bathroom.</li> <li>*The bathroom connected two rooms, so there were four residents using the bathroom.</li> <li>*Staff would just walk in and use the sink while a resident had been using the bathroom.</li> <li>*The door between the bathroom and her neighbors' room (7 and 8) did not latch.</li> </ul> <p>Observation at that time revealed room 7's bathroom door would not latch. Even if locked it could still be pushed or pulled open.</p>	F 164			

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F 164	Continued From page 5 4. Group interview on 3/24/15 from 3:00 p.m. to 4:40 p.m. revealed two of four residents agreed staff did not always knock, and came into the bathroom to use it while a resident was going to the bathroom.  Surveyor: 20031 5. Interview on 3/25/15 at 6:00 p.m. with the maintenance supervisor confirmed there were at least two bathroom doors that would not latch or lock. He stated he had just been made aware of the fact those doors were not working properly.  Surveyor 32573 6. Group interview on 3/24/15 from 3:00 p.m. to 4:40 p.m. revealed two of four residents agreed they had overheard staff making negative comments about residents. They stated those comments had been made in the hallway outside their rooms. Some of those same conversations had been held between staff members when they were assisting other residents.  7. Review of the Resident's Bill of Rights handbook provided to residents upon admission revealed: *"You have the right to privacy and confidentiality in a long-term care facility. This includes your accommodations, medical treatment, written and telephone communication, personal care, visits and meetings with family and resident groups." 483.10(f)(1) RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL  A resident has a right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been	F 164			
F 165 SS=G		F 165			

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F 165	Continued From page 6 furnished.  This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on interview, record review, and policy review, the provider failed to ensure residents felt free to voice grievances (complaints) without fear of punishment for three of five residents (unidentified per request) and one of two family members (unidentified per request) interviewed. Findings include:  1. Interview on 3/24/15 at 3:15 p.m. with a confidential resident revealed she was unwilling to answer the question if anyone in the facility had either abused or neglected her. She stated "I don't want to talk about that." Her roommate, whom the resident had said could be a part of the interview, stated "She doesn't want to tell you that if she complains about something they will leave her on the toilet for forty-five minutes." The resident then stated "Yes, that has happened."  Surveyor: 32573 2. Interview on 3/24/15 at 3:00 p.m. with a confidential resident revealed: *Staff had been rude to her. *Staff would tell each other "don't help (resident's name)" if she had a problem. *Staff would not give medications when asked for and would tell her it was not time, even though it was within the ordered timeframe.  Surveyor: 20031 3. Interview on 3/24/15 at 4:15 p.m. with a confidential resident revealed: *The resident care coordinator (RCC) had stated	F 165	F 165G Right to voice grievances without reprisal  Residents were not identified in the statement of deficiency therefore no correction for those instances could be investigated and validated.  Resident Care Coordinator (RCC) is no longer employed at GLC-Meadowbrook  Employee K has been reeducated and counseled with regard to resident's rights, abuse, neglect and grievance process.  Residents residing in the facility have the potential to be affected in a similar manner.  Executive Director, Director of Nursing and Interdisciplinary team have reviewed the grievance process  Staff members have been re-educated on the grievance process  Residents have been re-educated on the grievance process during resident council meetings*  *All JASDDOIMF *BY the social worker. JASDDOIMF *WITH room-to room interviews and JASDDOIMF	4/30/2015	

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F 165	<p>Continued From page 7</p> <p>to the resident "You are a leech off the state and are sucking the government dry."</p> <p>*Certified nurse assistant (CNA) K had stood at his door and announced she could not come into his room as he had an infection. Review of the resident's record revealed no diagnosis of any infection.</p> <p>*The residents would change their own moods and personalities to match the staff on duty. If any of the residents voiced a concern they were "immediately treated differently." The staff "would then act and care for them with a coldness or that they weren't important."</p> <p>*He was afraid of repercussion and harassment, and no longer went to the dining room for meals.</p> <p>*He only came out of his room to go outside to smoke and revealed he would "avoid staff if I can help it."</p> <p>Review of the above confidential resident's Brief Interview for Mental Status (BIMS) score revealed he was at fifteen and had a recent score of thirteen (thought processes intact).</p> <p>4. Interview on 3/31/15 at 8:15 p.m. with a confidential family member of a resident revealed:</p> <p>*He visited his family member every day.</p> <p>*He had spoken with social services (SS), nurses, and other staff several times regarding the care of his family member, and nothing had been done.</p> <p>*After he spoke with the staff his family member had been treated "differently." He then gave a summary of his term "differently." He stated he had noticed the following after consultation with staff:</p> <p>-"As an example _____ (resident name) would request pain medication at let's say 4:30. Staff</p>	F 165	<p>Resident council meetings will be held twice monthly for three months</p> <p><i>*five JAISDDOHIME</i></p> <p>Executive Director or designee will complete random resident interview audits of reported grievances weekly x 4 weeks then monthly x 2 months to ensure resident's grievances have come to resolution. Results will be reviewed at QAPI meetings for further recommendations.</p> <p><i>*monthly JAISDDOHIME</i></p>	

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F 165	<p>Continued From page 8</p> <p>would give him the meds. ____ (resident name) would then request the pain meds again at 8:30 and staff would say the first dose had been given at 5:30 and they couldn't give another dose until 9:30." The family member stated "it seemed to me they gave the pain meds and then wrote it down an hour later and used that time for when they gave it to him."</p> <p>-"____ (resident name) told me he didn't always get his breathing treatments that were ordered by the doctor." He stated when his family member asked for his breathing treatment he would be told by the resident care coordinator (RCC) "you're needy and always needing something." The RCC would "yell at him in the hall."</p> <p>*The family member stated he was afraid to say anything else to the staff at the nursing home as he was afraid of "further repercussions" to his family member when he was not there.</p> <p>Review of the above confidential resident's BIMS score revealed he tested at fifteen (thought processes intact). His family member revealed he was the resident's power of attorney and had tried and was still trying to get his family member relocated to another nursing home.</p> <p>Review of the provider's May 2001 Grievance Process policy revealed:</p> <p>*All individuals residing within the facility and their family members and/or responsible people would be provided with a means to communicate concerns, conflicts, complaints, grievance, or opportunities for improvement in care and services.</p> <p>**"Each individual is encouraged and assisted throughout their stay to exercise their rights as a citizen by freely voicing their grievances and recommended changes without fear of</p>	F 165			

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F 165	Continued From page 9 interference, coercion [threats], discrimination, or reprisal [revenge]." *The facility was responsible for protecting resident rights when an individual or their responsible person voiced grievances. *Encouraging an individual to express their feelings and concerns would maximize their quality of life, improve their care, and promote customer satisfaction. *All staff were responsible for ensuring customer satisfaction within the facility.	F 165	<b>F 223J Free from Abuse/Involuntary Seclusion</b>  <b>Abatement Plan</b>  All 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.	4/30/2015
F 223 SS=J	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION  The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.  The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.  This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on interview, job description review, and policy review, the provider failed to create an atmosphere free from abuse, intimidation, and demeaning (seeming of little importance or value) for the following: *Four of four individuals that attended the group interview and requested confidentiality (unidentified per request). *Four of five residents interviewed and requested confidentiality. *One of two families interviewed and requested confidentiality.	F 223	All oncoming 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"),  All 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.	

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F 223	Continued From page 10  <b>NOTICE:</b> Notice of immediate jeopardy (IJ) was given verbally on 3/24/15 at 6:27 p.m. to the interim administrator and the interim director of nursing (DON). The administrator was asked for an immediate plan of correction to ensure all residents would be free from abuse.  <b>PLAN:</b> On 3/24/15 at 8:00 p.m. the interim administrator and the administrator preceptor provided the surveyors with an immediate written plan of correction (POC) for that night. That POC dated 3/24/15 was accepted that same night at 8:03 p.m. by the surveyors and included:  1. "All residents will be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. Residents have the right to exercise his/her rights."  2. "All oncoming 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")."  3. "All staff will be reeducated in the Long Term Care Facilities Resident's Bill of Rights provided by the SD [South Dakota] Department of Social Services Adult Services and Aging: Ombudsman Program [resident advocate]."	F 223	<b>All residents have the potential to be affected.</b>  Staff currently working and oncoming staff will be immediately reeducated on the 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") and 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.  A Golden Living management staff member assigned throughout the evening and night shift will provide onsite coverage and monitoring of resident safety and well being throughout the night of March 24, 2015.	

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F 223	<p>Continued From page 11</p> <p>4. "Staff currently working and oncoming staff will be immediately reeducated on the 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 violation") and 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>5. "A Golden Living management staff member assigned throughout the evening and night shift will provide onsite coverage and monitoring of resident safety and well being throughout the night of March 24, 2015."</p> <p>6. "ED [executive director] and/or DNS [director of nursing services] and staff interviews will be completed weekly X (times) eight weeks to ensure residents are free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion and residents feel they have the right to exercise his/her resident rights."</p> <p>7. Interview on 3/25/15 at 11:40 a.m. with the transitional leader, registered nurse/nursing home administrator consultant confirmed the alleged certified nursing assistant was on administrative leave pending the police investigation.</p> <p>During the survey on 3/25/15 at 12:16 p.m. the surveyors confirmed removal of the immediate jeopardy situation. Findings include:</p>	F 223	<p>ED and/or DNS Resident and staff interviews will be completed 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 QAPI committee for further review and recommendations.</p> <p>*Five random audits and verbalized complaints will be completed by the ED and/or DNS. Results of these interviews/audits will be brought to the monthly QAPI committee for further review and recommendations.</p>		

*MONTHLY QAPI*

*JAKSDOH/MF*

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F 223	<p>Continued From page 12</p> <p>Surveyor: 32573</p> <p>1. Interview on 3/24/15 at 11:15 a.m. with a confidential resident revealed:</p> <ul style="list-style-type: none"> <li>*She had overheard staff in the hallway speak badly of residents multiple times.</li> <li>*A friend of hers (another resident) in the facility was "too afraid to say anything" because last time she had voiced a concern staff had left her on the toilet for forty-five minutes (that resident needed staff toileting assistance).</li> <li>*She was concerned about the treatment of her roommate who could not speak for herself. A review of the roommate's Brief Interview for Mental Status [BIMS] revealed her score was an eight indicating her thinking was moderately impaired.</li> <li>-One night she had heard her roommate tell a night staff member to stay away from her underwear.</li> <li>-She stated the male staff member replied "just lay there or I'll get in bed with you and you know what happens then."</li> <li>-She was not sure if the staff member had been trying to "kid" but she did not think it was appropriate.</li> </ul> <p>2. Interview on 3/24/15 from 3:00 p.m. to 4:40 p.m. with four of four residents who attended the group interview wanted to remain unidentified revealed:</p> <ul style="list-style-type: none"> <li>*Four of four residents agreed certain staff members were very "rude and mean" to residents.</li> <li>*Two of four residents expressed they had been spoken to harshly when they had tried to voice a preference or concern.</li> <li>*Two of four residents expressed a certain staff member told multiple residents the problem with them (regarding their diagnoses or illness) was</li> </ul>	F 223			

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F 223	<p>Continued From page 13</p> <p>"because they were Christian."</p> <p>*Four of four residents agreed they had heard staff members call residents negative names.</p> <p>3. Interview on 3/24/15 beginning at 3:00 p.m. with a confidential resident revealed:</p> <p>*She had been crying in the dining room, asked for one of her medications, and had been told she needed to "just grow up and deal with it."</p> <p>*When requesting assistance to go to the bathroom:</p> <p>-The aide was not listening to her.</p> <p>-The aide put her in front of the bathroom door and left.</p> <p>-The aide had returned with a nurse.</p> <p>-They yelled at her to "stop that" for trying to voice an opinion.</p> <p>*Staff instructed each other not to help her when she asked for assistance.</p> <p>*When she put her call light on for assistance for the bathroom staff had made comments such as "you just went, you go more than anyone I know, or are you done yet?"</p> <p>Surveyor: 23059</p> <p>4. Interview with a confidential resident revealed she had been left on the toilet for lengthy periods of time. She stated she had been told by staff "That's what you get when you complain." She stated she had not shared that concern with administration, because she was afraid things would get worse.</p> <p>Surveyor: 20031</p> <p>5. Interview on 3/24/15 at 4:15 p.m. with a resident revealed:</p> <p>*The resident care coordinator (RCC) had stated to the resident "you are a leech off the state and are sucking the government dry."</p>	F 223			

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F 223	<p>Continued From page 14</p> <p>*Certified nursing assistant (CNA) K had stood at his door and announced she could not come into his room as he had an infection. The resident did not have a diagnosis of an infection.</p> <p>*The residents would "change their own moods and personalities to match the staff on duty." If any of the residents voiced a concern they were "immediately treated differently." The staff would then "act and care for them with a coldness or that they weren't important."</p> <p>*He was afraid of repercussion and harassment and no longer went to the dining room for meals.</p> <p>*He only came out of his room to go outside to smoke and revealed he would "avoid staff if I can help it."</p> <p>Review of the above confidential resident's Brief Interview for Mental Status score revealed he was at fifteen and had a recent score of thirteen (intact thought processes).</p> <p>Surveyor 20031</p> <p>6. Interview on 3/31/15 at 8:15 p.m. with a confidential family member of a resident revealed:</p> <p>*He visited his family member every day.</p> <p>*He had spoken with social services (SS), nurses, and other staff several times regarding the care of his family member, and nothing had been done.</p> <p>*After he spoke with the staff his family member had been treated "differently." He then gave a summary of his term 'differently'. He stated he had noticed the following after consultation with staff:</p> <p>- "As an example ____ (resident name) would request pain medication at let's say 4:30. Staff would give him the meds. ____ (resident name) would then request the pain meds again at 8:30</p>	F 223			

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F 223	<p>Continued From page 15</p> <p>and staff would say the first dose had been given at 5:30 and they couldn't give another dose until 9:30." The family member stated "it seemed to me they gave the pain meds and then wrote it down an hour later and used that time for when they gave it to him."</p> <p>-"_____ (resident name) told me he didn't always get his breathing treatments that were ordered by the doctor." He stated when his family member asked for his breathing treatment he would be told by the resident care coordinator (RCC) "you're needy and always needing something." The RCC would "yell at him in the hall."</p> <p>*The family member stated he was afraid to say anything else to the staff at the nursing home as he was afraid of "further repercussions" to his family member when he was not there.</p> <p>Review of that confidential resident's BIMS score revealed he tested at fifteen (thought process intact). His family member revealed he was the resident's power of attorney and had tried and was still trying to get his family member relocated to another nursing home.</p> <p>Surveyor 32572</p> <p>7. Review of the provider's 8/30/11 Social Services Coordinator job description revealed: *The general purpose was to "Identify and provide for each resident's social, emotional, and psychological needs, and the continuing development of the resident's full potential during his/her stay at the facility and to assist in the planning for his/her discharge." *Some of the essential job duties were to "Develop a social history, social assessment and care plan which identifies pertinent problems and needs, realistic goals to be accomplished and the specific action to be taken in resolution of the</p>	F 223			

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F 223	<p>Continued From page 16</p> <p>problems and/or needs upon admission of each new resident...Organize family groups to promote communication, education and support between family members, facility staff and administration, and provide counseling as needed. Assist in the education of the community regarding aging, rights of residents, facility services and other related topics.</p> <p>*The code of conduct stated "Must adhere to the Company's Code of Conduct and Business Ethics policy including documentation and reporting responsibilities."</p> <p>Review of the provider's 9/25/14 CNA job description revealed:</p> <p>*The general purpose was to "Perform direct resident care duties under the supervision of licensed nursing personnel. Assist with promoting a compassionate physical and psychosocial (social) environment for the residents."</p> <p>*Some of the essential job duties were to: "Directly respond, within scope, to needs and concerns of residents and family members including call lights. Ensure residents' comfort while assisting them in achieving their highest practicable level of functioning."</p> <p>*The code of conduct stated "Must adhere to the Company's Code of Conduct and Business Ethics policy including documentation and reporting responsibilities."</p> <p>Review of the provider's 3/1/13 revised 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: "Each employee shall receive annual training on the requirements of the center/location's policies and procedures</p>	F 223		

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F 223	Continued From page 17 regarding alleged violations and the requirements of state and federal law. Staff, families and employees are required to report incidents of suspected abuse, neglect or misappropriation of resident property without fear of reprisal. Families, residents and volunteers shall be encouraged to report incidents of suspected abuse, neglect, or misappropriation of resident property without fear of reprisal."	F 223	<b>F 224 J Prohibit Mistreatment/Neglect/Misappropriatio Abatement Plan</b>	<b>4/30/2015</b>
F 224 SS=J	<b>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN</b>  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Surveyor: 32572 A. Based on interview, record review, job descriptions review, and policy review, the provider failed to create an atmosphere free from neglect (willful overlooking) for the following: *Four of four individuals that attended the group interview and requested confidentiality (unidentified per request). *Four of five residents interviewed and requested confidentiality. *One of two families interviewed and requested confidentiality.  <b>NOTICE:</b> Notice of immediate jeopardy (IJ) was given	F 224	<b>All 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.</b>  <b>All oncoming 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"),</b>  <b>All 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.</b>	

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F 224	<p>Continued From page 18</p> <p>verbally on 3/24/15 at 6:27 p.m. to the interim administrator and the interim director of nursing (DON). The administrator was asked for an immediate plan of correction to ensure all residents would be free from neglect.</p> <p>PLAN: On 3/24/15 at 8:00 p.m. the interim administrator and the administrator preceptor provided the surveyors with an immediate written plan of correction (POC) for that night. That POC dated 3/24/15 was accepted at 8:03 p.m. that same night by the surveyors and included:</p> <ol style="list-style-type: none"> <li>"All residents will be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. Residents have the right to exercise his/her rights."</li> <li>"All oncoming 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")."</li> <li>"All staff will be reeducated in the Long Term Care Facilities Resident's Bill of Rights provided by the SD [South Dakota] Department of Social Services Adult Services and Aging: Ombudsman Program [resident advocate]."</li> <li>"Staff currently working and oncoming staff will be immediately reeducated on the Abuse and Neglect policy and procedure appropriate steps to</li> </ol>	F 224	<p>All residents have the potential to be affected.</p> <p>Staff currently working and oncoming staff will be immediately reeducated on the 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") and 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>A Golden Living management staff member assigned throughout the evening and night shift will provide onsite coverage and monitoring of resident safety and well being throughout the night of March 24, 2015.</p> <p><i>* Five JASDDHMF</i> ED and/or DNS Resident and staff interviews will be completed weekly x 8</p>		

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F 224	Continued From page 19 prevent the occurrence of abuse, neglect, injuries of unknown origin [how it happened] and misappropriation of resident property and to ensure that all alleged [supposed] violations of Federal or State laws which involve mistreatment, neglect, abuse, injuries of unknown origin and misappropriation of resident property ("alleged violation") and 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."  5. "A Golden Living management staff member assigned throughout the evening and night shift will provide onsite coverage and monitoring of resident safety and well being throughout the night of March 24, 2015."  6. "ED [executive director] and/or DNS [director of nursing services] and staff interviews will be completed weekly X (times) eight weeks to ensure residents are free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion and residents feel they have the right to exercise his/her resident rights."  Interview on 3/25/15 at 11:40 a.m. with the transitional leader, registered nurse/nursing home administrator consultant confirmed the alleged certified nursing assistant was on administrative leave pending the police investigation.  During the survey on 3/25/15 at 12:16 p.m. the surveyors confirmed removal of the immediate jeopardy situation. Findings include:  Surveyor: 32573 1. Interview on 3/24/15 at 11:15 a.m. with a	F 224	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 QAPI committee for further review and recommendations.  <i>*monthly JA/SDDH/MF</i>	

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F 224	<p>Continued From page 20</p> <p>confidential resident revealed:</p> <ul style="list-style-type: none"> <li>*She was on PRN pain medications.</li> <li>*Staff had not always administered her pain medications on time when she had requested.</li> <li>*Staff were on their phones in the hallways and would ignore residents' requests.</li> <li>*She was concerned about the treatment of residents who could not speak for themselves.</li> </ul> <p>2. Interview on 3/24/15 from 3:00 p.m. to 4:40 p.m. with four of four residents who attended the group interview wanted to remain unidentified revealed:</p> <ul style="list-style-type: none"> <li>*All four residents stated staff would come in, turn off a call light, leave, and not come back.</li> <li>*All four residents agreed it took "a very long time" to get assistance for the bathroom. If they couldn't wait, staff would get "mad."</li> <li>*Two of four residents stated if an aide was helping one resident, another aide would come in and they would have personal conversations with each other and ignore the resident.</li> <li>*All four residents voiced concern about staff standing around talking and playing games on their phones and ignoring residents.</li> <li>*Two of four residents stated they had not received PRN (as needed) medications in a timely manner.</li> <li>-They had been told it was not time for them when they were within the ordered time.</li> <li>*All four residents agreed they had not been given baths or showers as requested.</li> <li>-Three of the four residents had gone two weeks without one.</li> <li>-One resident had gone ten days without one.</li> <li>*One resident told of an instance where a staff member had found a resident's "reacher" (device used to reach and grab objects) in the hallway and had left it there instead of returning it stating</li> </ul>	F 224		

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F 224	<p>Continued From page 21 "they'll figure it out eventually."</p> <p>3. Interview on 3/24/15 at 3:00 p.m. with a confidential resident revealed: *She was not given her PRN medications when she asked for them and had been told it was too early. *Staff had told each other not to help her when she asked for assistance.</p> <p>Review of the above resident's medical record revealed: *She had a current order for an anxiety medication that could be given every six hours as needed (PRN). *A 2/10/15 progress note at 4:01 p.m. in regards to her asking for PRN anxiety medication stated she was anxious, multiple attempts were made to explain her medications were ordered at specific times, and staff could only administer it as ordered. They would have to contact the doctor to get time changes approved. -Her 2/10/15 medication administration record (MAR) showed her PRN anxiety medication had been given at 8:24 a.m. -The medication could have been given at 4:01 p.m. as requested. *A 3/15/15 progress note stated she had requested an anxiety pill at 9:00 a.m. Nurse I told her it was too early and re-offered it at 12:18 p.m. -Her 3/14/15 MAR showed her last PRN anxiety medication had been given at 3:28 p.m. -The medication could have been given at 9:00 a.m. as requested.</p> <p>Interview on 4/1/15 at 1:00 p.m. with the director of nursing revealed the time a PRN medication was given was indicated on the MAR. Residents should have been getting their PRN medications</p>	F 224			

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F 224	Continued From page 22 as requested when it was within the ordered times.  4. Review of the provider's 8/30/11 reviewed Social Services Coordinator job description revealed: *The general purpose was to "Identify and provide for each resident's social, emotional, and psychological needs, and the continuing development of the resident's full potential during his/her stay at the facility and to assist in the planning for his/her discharge." *Some of the essential job duties were to "Develop a social history, social assessment and care plan which identifies pertinent problems and needs, realistic goals to be accomplished and the specific action to be taken in resolution of the problems and/or needs upon admission of each new resident...Organize family groups to promote communication, education and support between family members, facility staff and administration, and provide counseling as needed. Assist in the education of the community regarding aging, rights of residents, facility services and other related topics. *The code of conduct stated "Must adhere to the Company's Code of Conduct and Business Ethics policy including documentation and reporting responsibilities."  5. Review of the provider's 9/25/14 certified nursing assistant (CNA) job description revealed: *The general purpose was to: "Perform direct resident care duties under the supervision of licensed nursing personnel. Assist with promoting a compassionate physical and psychosocial (social) environment for the residents." *Some of the essential job duties were to: "Directly respond, within scope, to needs and	F 224			

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F 224	<p>Continued From page 23</p> <p>concerns of residents and family members including call lights. Ensure residents' comfort while assisting them in achieving their highest practicable level of functioning." *The code of conduct stated "Must adhere to the Company's Code of Conduct and Business Ethics policy including documentation and reporting responsibilities."</p> <p>6. Review of the provider's 3/1/13 revised 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: "Each employee shall receive annual training on the requirements of the center/location's policies and procedures regarding alleged violations and the requirements of state and federal law. Staff, families and employees are required to report incidents of suspected abuse, neglect or misappropriation of resident property without fear of reprisal. Families, residents and volunteers shall be encouraged to report incidents of suspected abuse, neglect, or misappropriation of resident property without fear of reprisal."</p> <p>Surveyor: 23059</p> <p>7. Review of the provider's January, February, and March 2015 grievance (complaint) tracking logs revealed grievances by residents and residents' families had been filed: *In January: -Baths not provided as scheduled two to three times a week. The resolution was to provide baths at least once a week until staffing improved. -Oral care was not provided. The resolution was to place oral care on the treatment administration</p>	F 224			

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F 224	Continued From page 24 record. -Long call light response time and call lights not within residents' reach. The resolution was to conduct audits and educate staff. A conversation had been held with staff regarding customer service. -Soiled briefs (disposable undergarments) left on residents too long and not checked and changed frequently. The resolution was to conduct audits and educate staff. -Hot food was cold and residents had been brought to the dining room too early. The resolution was to microwave the food and not take residents to the dining room too early. -Residents' fingernails had not been cleaned. The resolution was to make rounds on residents to ensure their nails had been cleaned. *In February: -Oxygen tanks had not always been filled. The resolution was staff education. -Staff have "inappropriate boundaries/conversations with residents." The resolution was to follow-up with residents. -Baths had not been provided as scheduled twice weekly. The resolution was to resume two baths per week when staffing improved. -Call lights were not placed properly. The resolution was staff education. -Medications were not provided in a timely manner. The resolution was staff education. -Staff had promised to provide a medication, and it was not given. The resolution was staff education and audits. A whiteboard (erasable board to write on) was provided to the resident, so he could write down the times of his medications. -Pain medications had not been provided for one week as scheduled. It was determined that was a pharmacy issue, and a plan would be put into	F 224			

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F 224	<p>Continued From page 25</p> <p>place to prevent it from happening again.</p> <ul style="list-style-type: none"> <li>-Medications were left next to residents' meal tray when incapable of self-administration. The resolution was staff education.</li> <li>-Infrequent toileting. The resolution was staff education.</li> <li>-Residents had not been receiving phone messages. The resolution was to place a note pad at the desk specifically for resident messages.</li> <li>-Residents being made to "feel bad when struggling to accept cares." The resolution was staff education on customer service.</li> <li>-Floors had not been cleaned thoroughly especially under furniture. The resolution was education for housekeeping staff.</li> <li>-Briefs were not changed and overly saturated. The resolution was staff education.</li> <li>-Staff were not friendly and had not been greeting residents and visitors. The resolution was staff education.</li> </ul> <p>*In March:</p> <ul style="list-style-type: none"> <li>-Staff "threatened to send resident to the West Unit [Behavioral/Psychiatric Unit at hospital]. The resolution was to interview other residents and no one stated they felt threatened. The resident in question had been discharged so it "was not a concern."</li> <li>-Slow call light response. Sometimes "up to 3 hours."</li> <li>-Not getting baths/showers as scheduled.</li> <li>-Floor staff using cell phones.</li> <li>-Staff having unprofessional discussions overheard by residents.</li> <li>-Snack pass had not been completed daily.</li> <li>-Medications and treatments not provided in a timely manner.</li> <li>--The above six grievances had no resolutions documented.</li> </ul>	F 224		

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F 224	Continued From page 26  Surveyor: 20031 B. Based on record review, the provider failed to ensure staff were aware and followed physician's orders for one of one resident's (25) treatment administration record (TAR) for correct oxygen administration. Findings include:  1. Review of resident 25's medical record revealed: *A 3/2/15 diagnosis of chronic airway obstruction disease (COPD) and painful respiration. *A 3/16/15 physician's order for O2 (oxygen) at 6 LPM (liters per minute) per nasal canula every shift for COPD. *Review of the 1/23/15 care plan showed the following: -Interventions: --Administer oxygen per nasal canula at 4 liters per physician order. Monitor oxygen flow rate and response. --The care plan had not been updated to show the 3/16/15 physician's order for O2 6 LPM. -Focus: --"3/31/15 Resident has hx [history] of self-adjusting O2 & [and] not following MD [medical doctor] prescribed O2 orders." That note had been hand written. *Review of the resident's progress notes from 3/25/15 through 3/26/15 revealed: -3/25/15: "O2 per NC [nasal canula] as ordered. Instructed resident to leave O2 concentrator and tank at settings as MD prescribed." -3/26/15: "Resident has been manually turning up O2 to 6L and would state he is having difficulty breathing. Resident was informed to keep levels at prescribed 4L." -3/26/15: "Resident was admitted to ICU [intensive care unit] with a diagnosis of respiratory	F 224			

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F 224	<p>Continued From page 27 failure."</p> <p>*Review of the nurses notes from 3/16/15 through 3/25/15 revealed several notations that indicated the resident would turn the concentrator up to 6L. Each time that happened, the nurse or CNAs would turn down the concentrator and remind the resident to keep it at 4L per physician's orders. The last nurses note on 3/25/15 stated the prior entries were incorrect, and the physician's order was for 6L.</p> <p>C. Based on observation, record review, and interview, the provider failed to follow post-fall guidelines for 1 of 12 sampled residents (23) with falls. Findings include:</p> <p>1. Observation and interview on 3/24/15 at 7:45 a.m. revealed the following in resident 23's room: *Resident 23 was in his wheelchair and stated he was waiting to go to breakfast. *The other resident was sleeping. *Hard plastic push button call lights were laid on both beds. *Grab bars were not noted in the residents' bathroom. *A night light was not on in the room, the drapes were closed, and the room was dusky and dim.</p> <p>Review of resident 23's 5/7/14 care plan revealed: *Focus area: "At risk for falls related: History of falls and needing assist with transfers-balance impairments." *Goal: "Revision on 12/15/2014," and "Target Date 03/13/2015." *Interventions: --"Footwear to prevent slipping." --"Grab Bar in the bathroom." *Immediate 3/19/15 plan of care for falls risk:</p>	F 224			

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F 224	<p>Continued From page 28</p> <p>-Problem: --At risk for falls related to: "Fell in the past 30 days" was checked.</p> <p>-Interventions: --"9. Institute fall prevention program" was not checked. --"Other: soft touch call light" was written.</p> <p>Review of the following Minimum Data Set (MDS) assessments revealed the following: *Re-admission 12/10/14 MDS: -"Yes" was noted for a fall in the last month. -"Yes" was noted for fracture in the last six months. -"Yes" was noted for falls since admission or reentry. -"One" was noted for number of falls with no injury. *Significant change 3/11/15 MDS: -"Yes" was noted for falls since admission or reentry. -"Two" was noted for number of falls with no injury.</p> <p>Review of the following Care Area Assessments (CAA) revealed: *12/10/14 - falls had been checked. *3/11/15 - falls had been checked. Those indicated areas should have been addressed with appropriate interventions.</p> <p>Physician order Summary Report dated 1/2/15 under diagnoses showed: **"OTH [Other] &amp; UNS [Unspecified] ACCIDENTAL FALL ON SAME LEVEL [E886.9]." Diagnosis Code E886.9 (Other and unspecified falls on same level from collision, pushing, or shoving, by or with other person: E886.9 described the circumstance causing an injury, not</p>	F 224			

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F 224	<p>Continued From page 29 the nature of the injury). *"Weight Bearing As Tolerated [WBAT]."</p> <p>Hospital discharge orders dated 3/19/15 revealed a physician's order for "WBAT-fall precaution."</p> <p>Review of resident 23's post-fall reports and post-fall analysis/plans from January through March 2015 revealed: *1/5/15 at 9:50 p.m. Post-Fall Report: -"Resident was found next to the bed; had white socks on his feet; used his wheelchair for adaptive equipment (equipment used to aid to move around)." -No actions/suggestions were listed to help prevent future falls. -No post fall analysis/plans could be located for the post-fall report. *2/5/15 at 9:45 p.m. Post Fall Analysis/Plan: -"Resident rolled or slid out of bed; no sheets were on the bed; had socks on his feet; was getting up to his wheelchair." -Contributing factors were "surface of bed was slippery with no sheets." -Interventions taken to prevent reoccurrence were to "make beds right after they are stripped." -No post fall report was found. *2/17/15 at 12:10 a.m. Post Fall Report and Analysis/Plan: -"Resident fell next to bed; had bare feet; used his wheelchair for adaptive equipment; slipped; history of falls; remind him to use call light." -"Change in footwear, and w/c [wheelchair] positioning" were listed for actions/suggestions to prevent future falls. *3/12/15 at 8:30 p.m. Post Fall Analysis/Plan: -"Roll/slid out of bed; had socks on his feet; resident was getting up out of bed and slid off bed to floor; history of falls; not wearing shoes."</p>	F 224			

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F 224	<p>Continued From page 30</p> <p>- "Remind resident to wear shoes and ask for assistance" was noted under interventions taken to prevent reoccurrence.</p> <p>- "Change in footwear" and "w/c positioning" was listed for actions/suggestions to prevent future falls.</p> <p>*3/13/15 at 1:02 a.m. Post Fall Analysis/Plan:</p> <p>- "Rolled/slid out of bed; history of falls; socks on his feet."</p> <p>- "Clear environmental obstacles" was listed under interventions.</p> <p>- "Remind resident to not lay close to the edge of the mattress" and "remind resident to call for assist" were noted under actions/suggestions to prevent future falls.</p> <p>- "Sent to ER [emergency room]. R/t [related to] pain; Dx [diagnosis] sesptic [septic: infection] to knee."</p> <p>- Hospital record review revealed resident had a history of "Joint pain and effusion [liquid or other fluid into an area]. A fluoroscopy [x-ray of internal tissue of the body] was performed and 85 [over three ounces] cc [cubic centimeters] of purulent [pus] fluid was removed from the knee.</p> <p>*3/23/15 at 1:10 a.m. Post Fall Report and Analysis/Plan:</p> <p>- "Lost strength in an attempt to self-transfer to go to the bathroom; history of falls; impaired safety awareness; socks on his feet."</p> <p>- "Not able to see clearly to transfer, room was dark; slipped on floor--has socks, no shoes" was listed under possible causes.</p> <p>- "Soft touch call light to assist with calling for help due to limited ROM [range of motion: flexibility] of hands, change in footwear, remind resident to call for help" was listed under interventions.</p> <p>Interview on 4/1/15 at 9:45 a.m. with the interim director of nursing, interim administrator, and</p>	F 224		

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F 224	<p>Continued From page 31</p> <p>west regional transitional leader/registered nurse revealed:</p> <ul style="list-style-type: none"> <li>*They could give no rational reason why a resident's bed had not been made at 9:50 p.m. at night.</li> <li>*Gripper socks, positioning of the wheel chair with the brakes on, or an over-the-toilet transitioning device had not been care planned or put in place for fall preventions.</li> <li>*The call light was burned out, and maintenance had not been notified.</li> <li>*A scoop mattress (concave) had not been put in place as they had considered a scoop mattress a restraint. They had not contacted the doctor to request a scoop mattress due to the resident's history of falls.</li> </ul> <p>Review of the provider's 1/22/15 Falls Management Guideline revealed:</p> <p>*Process:</p> <ul style="list-style-type: none"> <li>- "Newly admitted/readmitted residents are assessed for all risk by means of the Clinical Health Status tool.</li> <li>- At risk residents are identified through a "fall alert" communication system to care givers.</li> <li>- Following the completion of the MDS, if a resident triggers at risk for falls, the resident has further assessment utilizing the CAA guidelines. The plan of care is updated, if indicated, to further minimize the risk for falls.</li> <li>- Appropriate interventions are implemented.</li> <li>- Care plan is updated."</li> </ul> <p>*Monitoring/Compliance:</p> <ul style="list-style-type: none"> <li>- "Residents at risk for falls are care planned with individualized interventions.</li> <li>- Licensed nurse completes Change of Condition-Post Fall Analysis following a resident fall."</li> </ul>	F 224			

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F 241 F 241 SS=F	Continued From page 32 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Surveyor: 26632  Surveyor: 20031 A. Based on interview, record review, and policy review, the provider failed to give all residents baths, showers, or bed baths according to their personal preference or request. In addition the provider failed to follow their own bath sheet guidelines to give 67 of 69 residents at least one or more baths, showers, or bed baths per week, over a six month period from 10/1/14 through 3/25/15. Findings include:  1. Interview on 3/24/15 at 4:15 p.m. with a confidential resident revealed he would usually give himself a bed bath as he wanted to be clean everyday. He stated he had taken a shower every day when he was at home. He revealed he was not questioned about his bathing or grooming when he came to the facility in the previous year. He stated he had told the bath aides he wanted a shower every day. He stated "I told them when I got here "You get to take a bath or shower daily, I want to take a shower daily too!" He stated "nothin' has changed" since he said that on admission.  Review of the resident's record revealed there	F 241 F 241	F 241F Dignity and Respect of Individuality  Resident #14 is receiving daily baths *by reviewing of the bath records. JA/SDDOH/MF Residents residing in the facility have the potential to be affected in a similar manner.  Residents residing in the facility have been interviewed and bathing *All JA/SDDOH/MF preferences have been obtained. New admissions to the facility will be interviewed during the admission process to obtain bathing preferences.  Staff members have been re-educated on the bathing preference process.  Executive Director, Director of Nursing and Interdisciplinary team have reviewed contents of the Resident's Bill of Rights handbook *five JA/SDDOH/MF Social Services Director or designee will complete random resident interview audits of bathing preferences weekly x 4 weeks then monthly x 2 months to ensure resident's bathing preferences have been honored. Results will be *honored and physician ordered baths JA/SDDOH/MF	4/30/2015

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F 241	<p>Continued From page 35 region transitional leader revealed: *She agreed the above physician's orders had not been followed. *She was aware bathing was an issue.</p> <p>A policy for Physician's Orders had been requested from the west region transitional leader/RN on 3/31/15 at 5:30 p.m. None was received by the end of the survey.</p> <p>Surveyor: 20031 4. Review of the weekly bath sheets from 10/1/14 through 3/25/15 revealed the following: *A separate sheet was kept for the east hall and west hall bathing rooms. *Columns were titled "Bath day", "Bed Bath", and "W/P (whirlpool) Shwr (Shower). *The letters M, T, W, Th, F, Sa, Sun were used to identify the days of the week each resident was to have a bath, shower, or bed bath. *An x, check mark, or initials were used to identify the task had been completed.</p> <p>Review of the provider's three policies all dated 1/26/15 and titled Bath, Shower, Bath, Tub; Bath, Bed revealed: *Assessment Guidelines: resident's preference for time of day, frequency, and type of bath. *Care Plan Documentation Guidelines: list the amount of assistance the resident needed with bathing and any resident preferences..."</p> <p>B. Based on interview and observation, the provider failed to empty bedside urinals in the morning for two of six sampled male residents (unidentified per request). Findings include:</p> <p>1. Interview on 3/24/15 at 4:15 p.m. with a confidential resident revealed neither his nor his</p>	F 241	<p>*staff have been educated for proper care and emptying of urinals. JAKSDDOHI/MF</p> <p>*ED and/or DNS or designee will audit a resident urinal use weekly times 4 weeks, then monthly times 2 months. Results will be taken to be reviewed at the monthly QAPI meetings for further recommendations. JAKSDDOHI/MF</p>	

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F 241	<p>Continued From page 36</p> <p>roommate's urinals were emptied in the morning. He stated staff would enter the room and "maybe" help them to get dressed and get ready for the day such as "combing their hair." He stated they would leave and not empty their urinals that were on their bedside table or hung on the rails of the bed. He revealed the same staff or different staff would then return to make their beds or remove the bedding off the bed. Again they had not emptied the urinals. He stated it was "embarrassing to have those things sitting or hanging there."</p> <p>Observation on 3/25/15 at 8:30 a.m. revealed the above resident was in bed and his urinal hung on the rail on his bed. His roommate's bed had been stripped of bedding. His roommate's urinal sat on top of the bedside table. Both urinals were half full of urine.</p> <p>Surveyor: 23059 C. Based on observation, interview, and policy review, the provider failed to ensure dignity was maintained for one of three randomly observed residents (22) who had their glucose (blood sugar) testing and insulin administration done in the dining room during mealtime. Findings include:</p> <p>1a. Observation on 3/25/15 beginning at 11:30 a.m. revealed three residents in the dining room awaiting lunch had their fingers pricked to test their glucose level by registered nurse (RN) H. In addition, those three residents also received their insulin injections in the dining room by that same RN. Their shirts had been pulled up exposing their abdomen for insulin administration. At no time had the RN asked the residents if they were comfortable having those procedures done in the</p>	F 241	<p>* Education was provided to RN H in performing blood glucose monitoring and insulin injections. JA/SDDOH/MF</p> <p>* ED and/or DNS or designee will audit 5 per week of blood glucose monitoring and insulin injections weekly times 4 weeks, then monthly times 2 months. Results will be taken to be reviewed at the monthly QAPI meetings for further recommendations. JA/SDDOH/MF</p>	

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F 241	<p>Continued From page 37 dining room.</p> <p>Interview with RN H at the above time revealed that was her usual practice. She stated the residents did not mind having their glucose tested and insulin given in the dining room. She stated it would take too long to take each one to a private area, because they had so many residents who were diabetic.</p> <p>b. Interview on 3/31/15 at 4:45 p.m. with resident 22 revealed she did not like having her glucose testing and insulin done in the dining room. She stated that made her unhappy when that happened. She would have preferred that be done in a private setting but "they don't ask, they just do it."</p> <p>c. Interview with the other two residents revealed they did not mind having their glucose checked and insulin injected in the dining room. They stated they would rather do that than have to go back to their rooms to have it done.</p> <p>d. Interview on 4/1/15 at 12:20 p.m. with the interim director of nursing and the provider's west regional transitional leader revealed glucose testing and insulin administration should have been done in a private setting. It should not have been done in the dining room unless the resident had specifically requested to have it done there.</p> <p>Review of the provider's May 2012 Injectable Medication Administration policy revealed privacy was to have been provided when medications were injected.</p> <p>Surveyor: 32573 3. Group interview on 3/24/15 from 3:00 p.m. to</p>	F 241			

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F 241	Continued From page 38 4:40 p.m. revealed all residents in attendance had shared concerns about maintaining the dignity of all residents in the facility. Refer to: *F164, findings 3, 4, and 5. *F165, finding 2. *F223, findings 1, 2, 3, 4, and 5. *F224, findings A.1, 2, and 3, and B.1. *F246, findings A.1, 2, 3, and 4. *F248, finding 1.	F 241	F 246F Reasonable Accommodation of Needs/Preferences	4/30/2015
F 246 SS=F	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.  This REQUIREMENT is not met as evidenced by: Surveyor: 20031 A. Based on interview, record review, and policy review, the provider failed to give 69 of 69 residents baths, showers, or bed baths according to their personal preference or request. Findings include:  1. Interview on 3/24/15 at 4:15 p.m. with a confidential resident revealed he would usually give himself a bed bath as he wanted to be clean everyday. He stated he had taken a shower every day when he was at home. He revealed he was not questioned about his bathing or grooming when he came to the facility in the previous year. He stated he had told the bath aides he wanted a	F 246	Resident #14 is receiving daily baths*by reviewing of bath records. JASDDOHI MF Residents residing in the facility have the potential to be affected in a similar manner.  Residents residing in the facility have been interviewed and bathing preferences have been obtained.*All JASDDOHI MF New admissions to the facility will be interviewed during the admission process to obtain bathing preferences.  Staff members have been re-educated on the bathing preference process, Bath, Shower, Bath, Tub; Bath Bed, Assessment Guidelines and Care plan documentation Guidelines.  Executive Director, Director of Nursing and Interdisciplinary team have reviewed contents of the Resident's Bill of Rights handbook *five JASDDOHI MF Social Services Director or designee will complete random resident interview audits of bathing preferences weekly x *honored and physician ordered baths JASDDOHI MF	

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F 246	<p>Continued From page 39</p> <p>shower every day. He stated "I told them when I got here 'You get to take a bath or shower daily, I want to take a shower daily too!'" He stated "nothin' has changed" since he said that on admission.</p> <p>Review of the resident's record revealed no documentation in regards to a grooming and bathing preference. Review of the bathing report from 10/1/14 through 3/15/15 revealed he had received nineteen showers and two full bed baths in those twenty-five weeks. The resident's Brief Interview for Mental Status (BIMS) questionnaire revealed a recent score of thirteen and his admission BIMS was fifteen (thought processes intact [okay]).</p> <p>On 3/25/15 the following random staff interviews revealed:</p> <p>*The licensed social worker (LSW) stated there were no separate forms for resident's choice of grooming and bathing upon admission to the facility.</p> <p>*The interim director of nursing (DON) confirmed the interview with the LSW. She had thought the aides would ask the residents what their choices were for grooming and bathing.</p> <p>*The medical records staff person (N) stated the bath aides used a weekly bath sheet to know what day and how often a resident was to have a bath or shower.</p> <p>*Certified nursing assistant (CNA) K stated she confirmed the above interview with the medical records person N. She stated if a resident moved out or left their room then the bathing schedule or sheet with the names would be applied to the resident who moved into the former resident's room.</p>	F 246	<p>4 weeks then monthly x 2 months to ensure resident's bathing preferences have been honored. Results will be reviewed at QAPI meetings for further recommendations.</p> <p><i>*MONTHLY JANISBOH/ME</i></p>		

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F 246	<p>Continued From page 40</p> <p>2. Interview on 3/31/15 at 8:15 p.m. with a family member regarding a confidential resident revealed he thought he got a shower at least once a week. He stated when the resident was at home he had taken a shower at least every other day. Review of the resident's record revealed there had been was no documentation regarding a grooming and bathing preference. Review of the bathing report from 10/1/14 through 3/15/15 revealed he had received seventeen showers and had refused one bath in twenty-one weeks since his admission.</p> <p>Surveyor: 26632</p> <p>3. Review of resident 14's medical record revealed: *An 8/20/14 physician's order that daily baths were recommended. *A 10/31/14 physician's order for daily baths with no exceptions. *A 1/5/15 physician's note and order "Please re-note order of 10/31 [2014] as to baths and especially the betadine order - Pt. [resident 14] advises not being done - This order is to be continuous - DO NOT STOP. Please send me bath log in 30 days to review." *A 2/17/15 physician's note and order "ONCE AGAIN - above order and no date to note of 10/31 is NOT being done and the 30 day deal NOT DONE. If not followed and reported to me in 30 days I plan to file a complaint with Social Services - I am not kidding." *A 3/8/15 physician's note and order "Bath Daily." "Fax me bath record the last 30 days." "DON [director of nursing] please call me in AM as to this."</p> <p>Review of resident 14's weekly bathing report for the weeks of 10/29/14 through 3/18/15 revealed:</p>	F 246		

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F 246	<p>Continued From page 41</p> <p>*She had only received daily baths for two of those twenty-one weeks.</p> <p>*Two of those twenty-one weeks had no baths documented.</p> <p>Interview on 3/24/15 at 11:00 a.m. with the west region transitional leader revealed:</p> <p>*She agreed the above physician's orders had not been followed.</p> <p>*She was aware bathing was an issue.</p> <p>4. Review of the weekly bath sheets from 10/1/14 through 3/25/15 revealed the following:</p> <p>*A separate sheet was kept for the east hall and west hall bathing rooms.</p> <p>*Columns were titled "Bath day", "Bed Bath", and "W/P (whirlpool) Shwr (Shower).</p> <p>*The letters M, T, W, Th, F, Sa, Sun were used to identify the days of the week each resident was to have a bath, shower, or bed bath.</p> <p>*An x, check mark, or initials were used to identify the task had been completed.</p> <p>Review of the provider's three policies all dated 1/26/15 and titled Bath, Shower; Bath, Tub; Bath, Bed revealed:</p> <p>*Assessment Guidelines: resident's preference for time of day, frequency, and type of bath.</p> <p>*Care Plan Documentation Guidelines: list the amount of assistance the resident needed with bathing and any resident preferences..."</p> <p>Surveyor: 32573</p> <p>4. Group interview on 3/24/15 from 3:00 p.m. to 4:40 p.m. revealed:</p> <p>*Four of four residents agreed it was hard to get baths or showers on time.</p> <p>*One of four residents stated she was supposed to get a bath three times a week and it was hard</p>	F 246		

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F 246	<p>Continued From page 42 to get them on time. *Three of four residents had gone two weeks without a shower or bath. *One of four residents had gone ten days without a bath or shower.</p> <p>Review of resident council meeting notes from November 2014 through March 2015 revealed: *The November meeting notes stated residents felt they needed more bath aides. *The December through March meeting notes all stated bathing had not improved and residents were not getting showers or baths when they were supposed to.</p> <p>Surveyor: 26632 B. Based on observation, interview, and record review, the provider failed to assist all residents with room trays or those who required assistance with eating in a timely manner for four of four observed meal services. Findings include:</p> <p>1. Observations on 3/25/14 from 8:20 a.m. through 9:30 a.m. revealed: *The breakfast room trays were delivered to the east hall. *One certified nursing assistant (CNA) delivered those trays. *At 9:00 a.m. the breakfast trays were delivered to the west hall. *The same CNA from east hall delivered those trays.</p> <p>Review of a list of residents that received room trays received from the dietary manager revealed: *East hall: Seven residents received a room tray at breakfast. -One of those seven residents required total assistance to eat her meals.</p>	F 246	<p>* Education was provided to CNAs regarding room trays. JASDDOH/MF</p> <p>* ED and/or DNS or designee will audit 5 room trays per week at varying times. Results will be reviewed at the QAPI monthly meetings for further recommendations. JASDDOH/MF</p>		

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F 246	<p>Continued From page 43</p> <p>-One of those seven residents would come to the dining room at lunch only.</p> <p>*West hall: Ten residents received a room tray at breakfast.</p> <p>-Two of those ten residents required extensive assistance to eat their meals.</p> <p>-One of those ten residents would come to the dining room at lunch and sometimes for supper.</p> <p>2. During the observations of three of three meals services (lunch on 3/24/15, supper on 3/25/15, and lunch on 4/1/15) revealed:</p> <p>*Residents either entered the dining room or staff assisted them into the dining room.</p> <p>*The residents who were able would fill out their menu requests and then wait for a staff person to get them for their meal to be dished up.</p> <p>*During those meal services it was noted one staff person would be in the dining room for approximately fifteen to twenty minutes taking the residents' meal requests and delivering their food.</p> <p>*After fifteen to twenty minutes one to two more staff persons would come and assist.</p> <p>*The CNAs would not come into the dining room until thirty or more minutes had passed to assist residents who required eating assistance.</p> <p>*Those residents would be at their tables and waited without any interaction during that time.</p> <p>*The provider did not ensure residents were served according to policy.</p> <p>Interview on 4/2/15 at 4:15 p.m. with the interim administrator, interim director of nursing, and the west regional transitional leader revealed:</p> <p>*The CNAs would still be helping residents before they came to the dining room.</p> <p>*They agreed those residents that required assistance had to wait for their meals while the other residents were eating.</p>	F 246		

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F 246	Continued From page 44  3. Review of the provider's undated Dining Service Hours policy revealed: *The start time included any cart delivery time. *The dining service hours were 8:00 a.m. for breakfast, 12:00 noon for lunch, and 5:00 p.m. for supper.  Review of the provider's 2/12/15 Nursing Responsibilities at Meal Service policy revealed: *Staff from the nursing and dining services departments would work cooperatively to ensure each resident was served according to regulations. *A meal sequence was used in the dining room, so all residents at a table were served at the same time. *Staff should distribute food in a timely manner to residents.	F 246	<b>F 248F Activities Meet Interests/Needs of each Resident</b>  Residents were not identified in the statement of deficiency therefore no correction for those instances could be investigated and validated.  Residents residing in the facility have the potential to be affected in a similar manner.  Activity Director has been reeducated on Resident Council Minutes to include Documentation, Grievances (individual vs. group) and Follow up. Activity Calendar - conducting Diversified activity programs, Appropriate Activities, Attendance at activities, 1:1 and small group. Programming, Frequency, Capturing all residents that may need 1:1s, Participation Documentation, Group Activities, 1:1 Activities, Independent Activities  Executive Director, Activity Director and interdisciplinary team have reviewed the federal regulation and ensure the provision of activities are meaningful	4/30/2015
F 248 SS=F	<b>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</b>  The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on observation, activities calendar review, resident council meeting notes, and interview, the provider failed to have activities that met residents' preferences or promoted positive self-image for all 69 of 69 residents. Findings include:	F 248		

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F 248	Continued From page 45  1. Interview on 3/24/15 from 3:00 p.m. to 4:40 p.m. during the group interview revealed: *The activities calendar was not followed and many activities on it had not happened. *There were very few night and weekend activities. *Three of four residents in attendance felt some activities provided such as children movies, coloring books, and "homework" were not appropriate or enjoyable for them or their age group.  Observation on 4/1/15 at 11:00 a.m. revealed the activities director and several residents in the dining room throwing a ball back and forth. The activities director had been praising residents like she had been speaking to a child.  Review of the March 2015 activities calendar revealed two activities per day in the afternoon on Saturdays. There had been three activities on Sundays. There were no activities after 4:30 p.m. on weekdays.  Review of the November 2014 through March 2015 monthly resident council meeting notes revealed the section for activities suggestions and information had been left blank for three of five months. The two months that had notes were regarding a card table the residents had received.  Interview on 4/1/15 at 8:20 a.m. with the activities director revealed attendance for activities were low. She asked at resident council to try and get ideas to try other activities to increase attendance. To increase attendance in February she had started "homework" activities. The top five residents to turn in homework did a cake	F 248	and appropriate for the individual as well as the resident group.  Executive Director or designee will complete random resident interview audits of satisfaction of activities ^ weekly x 4 weeks then monthly x 2 months to ensure resident's satisfaction with activities. Results will be reviewed at QAPI meetings for further recommendations. * monthly JALSDDOHIME  * including: - following of activity calendar - age appropriate activities - identification of need to increase night and weekend activities JALSDDOHIME  * Resident 21 has been interviewed for activity preferences. JALSDDOHIME	

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F 248	Continued From page 46 decorating class. Evening activities were not scheduled because there had been such low attendance.  Surveyor: 20031  2. Interview on 3/31/15 at 8:15 p.m. with a family member of a resident (unidentified per request) revealed he had asked his family member if he attended any activities. The resident had revealed to the family member: *He did not do many of the activities at the facility. *They had nothing of interest to him. *He felt they were more like kid games and were not "age appropriate."  Review of the unidentified resident's Brief Interview for Mental Status score revealed he tested at the highest level at fifteen (intact [okay] thought processes).  Surveyor: 26632 3. Observation and interview on 4/2/15 at 12:15 p.m. with resident 21 revealed: *She was in the dining room and was waiting for her lunch to be served. *There was a sheet of paper in front of her on the table that had fill-in-the blank questions. *When asked what the paper was she replied "It's third grade homework they give us to do." *When asked if she was going to do the activity she stated "No, I've already been in third grade." *She stated she did not like the type of "Child-like homework" they gave her to complete. *She stated she was "offended" by the third grade homework sheet.	F 248			
F 252	483.15(h)(1)	F 252			

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F 252 SS=F	<p>Continued From page 47</p> <p><b>SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</b></p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32573</p> <p>Surveyor: 20031 A. Based on observation and interview, the provider failed to ensure the facility was free of preventable odors in one of two hallways (east). Findings include:</p> <p>1. Random observation from 3/24/15 through 3/25/15 and 3/31/15 through 4/1/15 each morning upon entrance into the facility between 7:00 a.m. to 7:30 a.m. revealed a very strong urine odor in the east hall that was noticeable by all surveyors. Interview with random staff on those mornings revealed the odor was "always bad" in the east hall. That hall had the residents who required more care.</p> <p>Surveyor: 32573 2. Interview on 3/24/15 from 3:00 p.m. to 4:40 p.m. during the group interview revealed four of four residents in attendance stated the building "always smells like urine."</p> <p>Surveyor:20031 3. Observation on 3/25/15 at 10:00 a.m. revealed a very strong harsh urine smell in the east hall. Interview at the time of the observation with the</p>	F 252			

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F 252	<p>Continued From page 48</p> <p>maintenance manager and housekeeping manager confirmed that finding. The housekeeping manager stated his staff tried to keep the odors under control. But there were some residents in the east hall that had incontinent (lacking control of bladder or bowel) issues.</p> <p>4. Interview on 3/31/15 at 8:15 p.m. with a family member of a confidential resident revealed he visited his family member every day. He stated he had complained of a very strong odor of urine in the east hall where his family member resided. He stated there had been some mornings when the urine smell was so offensive, he had to leave and come back later that morning. He stated mornings were the worst, but there had been some afternoons and evenings when the smell of urine was "overwhelming."</p> <p>B. Based on random observation, testing, and interview, the provider failed to maintain residents' dressers, over-the-bed tables, and night stands in 4 of 38 resident rooms (24, 27, 29, and 50) cleanable and in good quality condition. Findings include:</p> <p>1. Observation and testing on 3/24/15 from 9:30 a.m. to 11:10 a.m. and on 3/25/15 from 10:00 a.m. to 11:00 a.m. revealed residents' rooms 24, 27, 29, and 50 had night stands and/or dressers with the following: *Chipped and scratched wood. *Finish worn down to raw wood. *Drawers off-set of the rollers that were hard to operate with testing. The above items were uncleanable and in poor condition.</p>	F 252	<p><b>F 252 F</b> <b>Safe/Clean/Comfortable/Homelike Environment</b></p> <p>The source of the strong urine odor in the east hall was identified and areas identified were deep cleaned by April 15, 2015</p> <p>The night stands and/or dressers, over bed tables in resident rooms 24, 27, 29 and 50 will be replaced.</p> <p>Linen Par levels are at an appropriate level as of April 30, 2015</p> <p>Staff have been educated with regard to urine odor control, bed making, linen handling, furniture maintenance/infection control/homelike environment and the reporting of concerns to the appropriate supervisor</p> <p>Housekeeping supervisor or designee will audit 10 resident rooms (5 on each hall) for urine odor, bed making, linen handling, furniture maintenance/infection control and</p>	4/30/2015

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F 252	<p>Continued From page 49</p> <p>Additional observation at that same time revealed the over-the-bed tables in those same rooms had chipped wood, laminate missing, or there was no flexible plastic band to cover the edges of those tables. Those items made the over-the-bed tables uncleanable and in poor condition.</p> <p>Interview with the maintenance manager and housekeeping supervisor at the time of the above observations confirmed those findings. The maintenance manager revealed those items had been used for several years and had started to show wear and tear. The housekeeping supervisor revealed approximately ninety percent of the residents' rooms were furnished with that old "scruffy" furniture that belonged to the facility. He stated even though his staff would clean the furniture it still looked "bad."</p> <p>C. Based on random observation and interview, the provider failed to maintain a homelike atmosphere for 9 of 38 residents' rooms (30, 31, 38, 39, 45, and 46) that had bed spreads and sheets laying on the floor or had no bedding present. Findings include:</p> <p>1. Random observations on 3/24/15 from 9:30 a.m. to 11:10 a.m. revealed resident rooms 30, 31, 38, 45, and 46 had bed spreads and sheets laying on the floor. Some bed linens appeared to have been tossed onto the beds with no attempt to make the beds. Resident room 39-A had no bedding, and the resident was laying on top of the bare mattress.</p> <p>Interview with the housekeeping supervisor at the time of the above observations confirmed the untidiness and hastily made beds. He revealed the beds were not made up by housekeeping</p>	F 252			

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F 252	Continued From page 50 staff but were made up by the certified nursing assistants. He stated when he had started work at the facility in November 2014 he had noticed a severe shortage of bedding and linen. He stated he had already ordered new bedding and linen. He confirmed the facility might not have had enough clean bed linen at the time of the survey to remake resident 39-A's bed.	F 252	homelike environment, weekly for 4 weeks and monthly for 2 months. Results of the audits will be reviewed at <del>monthly</del> QAPI meetings for further recommendations. <i>monthly JAS/DC/MP</i>	
F 253 SS=F	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on observation, testing, and interview, the provider failed to maintain the following in clean, durable, cleanable, and/or in an organized condition for: *Two of two whirlpool rooms floors, walls, shelves, and equipment. *Two of two hopper (soiled utility) rooms windows, window sills, caulking around the sinks, and the basins of the sinks. *All trash receptacles and lids throughout the facility. *Two of two supply closets. *One of one mop cart. *Two of two housekeeping carts. *One of one clean sock and undergarments cart. *All floors under the residents' beds and furniture. *The handrails in two of two halls on both sides. *The guard rails in two of two halls on the north side.	F 253		

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F 253	Continued From page 51 *Three of three resident rooms (21, 24, and 29) had clogged mesh filters on the oxygen concentrators. *All outside window frames, casings, and sills had peeled paint, and the caulking had separated from the edges of the frames and casings. Findings include:  1. Random observations on 3/24/15 from 9:30 a.m. to 11:10 a.m. and on 3/25/15 from 10:00 a.m. to 11:00 a.m. revealed the following: *In the west and/or east whirlpool rooms: -The tile floor had visible dirt where residents would walk with their bare feet. Testing revealed the dirt could be swept together with a finger. -The wall tile behind the west room's door had open holes and chips from previous equipment. -The lifts had dirt and debris around the legs and bases of the lifts. -The wicker shelves in the west room were coated with dirt and debris. *In the west and/or east hopper rooms: -The white caulking around the edges of the metal hand washing sinks was brown and tan in color. It had started to pull away from the edges of the sinks and the walls. -The basins of the hand washing sinks had a layer and film a light tan in color that could be wiped off with finger pressure. -The window sills in the west room had a layer of dirt and dust that appeared to have blown in from the outside. *All trash receptacles including the lids had a rainbow of colors, both dried liquids and solids, of various sizes, on the outside and needed a deep cleaning. *The east and west supply closets were cluttered and disorganized. Resident-use equipment parts, gait belts, and unused numerous other items laid	F 253	<b>F 253 F Housekeeping &amp; Maintenance Services</b>  Two of two whirlpool room floors, walls, shelves and equipment will be cleaned by April 30, 2015  Wall tile in west whirlpool room will be repaired by April 30, 2015  The lifts legs and bases will be cleaned by April 30, 2015.  The wicker shelves in the west room will be cleaned by April 30, 2015.  The caulking around the metal hand washing sink will be replaced by April 30, 2015.  The window sills in the west room will be cleaned by April 30, 2015.  Trash receptacles and lids will be cleaned by April 30, 2015.  East and west supply closets will be cleaned and items removed from floor by April 30, 2015.	4/30/2015

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F 253	<p>Continued From page 52</p> <p>jumbled on the floor.</p> <p>*The two housekeeping carts and the mop cart were filthy with layers of grime and dirt.</p> <p>*The clean sock and undergarment cart had a layer of dust in the bottom that could be pushed around and gathered up with a hand.</p> <p>*The floors under residents' beds and furniture had remnants of food, food wrappers, pill cups, socks, shoes, and various other items.</p> <p>*The wooden handrails on both sides of the east and west halls had worn finish that exposed the bare wood of the handrail making it uncleanable and unsightly.</p> <p>*The guard rails on the north side of the east and west halls had gouges, scrapes, and a worn finish down to the bare wood making it uncleanable and unsightly.</p> <p>*The gray mesh oxygen concentrator filters in residents' rooms 21, 24, and 29 had a layer of lint that clogged the filter and made it appear a gray white in color.</p> <p>*All outside window frames, casings, and sills had peeled paint that exposed approximately 25-50 percent of the wood. The caulking had separated from the edges of the frames and casings and created gaps that were filled with dust, dirt, and debris.</p> <p>Interview with the maintenance supervisor (MS) and housekeeping supervisor at the time of the above observations confirmed those findings. The MS stated he was aware of some of the conditions in the facility such as the hand and guard rails and had requested help with the maintenance or contractor repairs for windows and other items. He stated he might not have been aware of all items such as holes in walls and caulking needed around sinks if no work orders had been given to him. The housekeeping</p>	F 253	<p>Housekeeping carts, mop carts, clean sock and under garment carts will be cleaned by April 30, 2015.</p> <p>The floors under the resident beds will be cleaned by April 30, 2015.</p> <p>The guard rails and hand rails in the east and west halls will be replaced in facility refresh project.</p> <p>The gray mesh oxygen concentrators <sup>*filters</sup> for resident 21, 24 and 29 will be <sup>JASDDH/ME</sup> cleaned by April 30, 2015.</p> <p>Paint chips, caulk and gaps on all outside window frames, casings and sills will be corrected with new window install in refresh project.</p> <p>Residents residing in the facility have the potential to be affected in a similar manner.</p> <p>Whirlpool rooms will be on a weekly <sup>*ROUTINE</sup> deep clean schedule by April 30, 2015. <sup>JASDDH/ME</sup></p> <p>Housekeeping carts, laundry carts, trash receptacles will be on a monthly cleaning schedule by April 30, 2015. <sup>*and monthly preventative maintenance program by the housekeeping supervisor. JASDDH/ME</sup></p>		

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F 253	Continued From page 53 supervisor revealed his staff was responsible for the cleanliness of the entire facility except for special resident care items, their carts, and the clean linen carts. He stated he had thought his staff were "on top of the job", but it appeared he needed to start audits. They both agreed the nurse aides and the nurses were responsible for the cleanliness and tidiness of the supply closets.	F 253	<b>Oxygen concentrator filters will be cleaned by April 30, 2015 and placed on a routine cleaning schedule.</b>	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, interview, record review, and policy review, the provider failed to ensure	F 280	Housekeeping supervisor or designee will audit 10 resident rooms and trash receptacles (5 on each hall) as well as housekeeping, garment, mop and laundry carts weekly for 4 weeks and monthly for 2 months to ensure cleanliness.  Maintenance supervisor or designee will audit 5 exterior windows and sill for caulk and seal and guard rails and hand rails for uncleanable surfaces weekly for 4 weeks and monthly for 2 months to ensure maintenance is maintained.  The DNS or designee will audit concentrator filter cleaning monthly for 3 months. <i>* Each supervisor will bring the JASDDH/MF Results of the audits will be reviewed at monthly QAPI meetings for further *HCH JASDDH/MF recommendations.</i>	

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F 280	<p>Continued From page 54</p> <p>residents' care plans reflected the current resident status for 5 of 29 sampled residents (5, 6, 8, 23, and 25). Findings include:</p> <p>1. Review of resident 6's medical record revealed a 1/16/14 care plan with the following focus areas:                      ***At risk for falls related to use of medications and history of falls and seizures." The goal stated "Risk of falls with injury will be minimal with current interventions." Some of the interventions listed were:                      -"Observe balance in Merriwalker [adult size seated walker]. Staff to push her in the Merriwalker as needed instead of pulling her if able."                      -"Resident will at times, walk very fast when having a seizure or immediately after seizure."                      -"Uses Merri Walker for self locomotion. Monitor use."                      -Hand written in was "Resident is using W/C [wheelchair] until MerriWalker can be repaired/replaced."                      ***Merri-walker used for assist with ambulation per MD [medical doctor] orders." The goal was to "Maintain current physical functioning level and prevent injury." Some of the interventions listed were:                      -"Restraint/positioning device assessment completed.                      -Staff to provide assist with getting in/out of Merry Walker as resident is unable to open/close the gate herself consistently.                      -Resident is using W/C until meriwalker can be repaired/replaced."                      ***Impaired neurological status [thought processes] related to seizure disorder and being on ___ [medications listed]." The goal was "Will be free of injury." Some of the interventions listed</p>	F 280	<p>F 280 D Right to participate planning care – revise care plan</p> <p>Resident 5, 6, 8, 23 and 25 care plans have been reviewed and revised.</p> <p>Residents residing in the facility have the potential to be affected in a similar manner.                      * All JAKDDOH/ME                      Residents residing in the facility will have their care plans reviewed and revised to reflect the resident's current status with the next scheduled MDS assessment</p> <p>Licensed nursing staff have been re-educated on the Centers for Medicare/Medicaid resident assessment instrument 3.0 manual pages 4-8 through 4-11.                      * FIVE JAKDDOH/ME                      Director of Nursing or designee will 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</p>	4/30/2015

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F 280	<p>Continued From page 55</p> <p>were: -"Assist in ADL's [activities of daily living (bathing, dressing, transferring)] and mobility [moving]." -"Monitor and report any seizure activity."</p> <p>Review of the provider's reviewed 6/4/10 Restraint/Positioning Device Assessment revealed: -"Reason for device was to be used to enable resident to ambulate around facility." -"Expected outcome was to increase the resident's mobility." -"Is resident able to remove device-No." -"This alternative is a restraint because resident is unable to get out of meri-walker without ass [assistance]."</p> <p>Review of the provider's reviewed 12/4/12 Merry Walker Safety Assessment regarding resident 6 revealed: -"Res [resident] continues to use merriwalker to ambulate about facility. -Staff continue to assist her out of merriwalker at meals and when in rm [room]."</p> <p>Review of the March 2015 nursing notes for resident 6 revealed three notes indicating seizure activity and mentioning the Merry walker: *On 3/3/15 at 3:23 p.m. "Reported at 1100 [11:00 a.m.] for seizure activity in dinning room, no injuries noted. 1400 [2:00 p.m.] called to dinning room, resident in mery walker with noted seizure, sitting on safety strap." *On 3/16/15 at 21:57 [9:57 p.m.] "She goes throughout facility in her merriwalker secondary to her seizures. She has had not observed seizure activity." *On 3/22/15 at 1505 [3:05 p.m.] "Resident has had several seizures this shift. She has been</p>	F 280		

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F 280	<p>Continued From page 56 placed in her merriwalker each time."</p> <p>Random observations from 3/24/15 through 3/25/15 revealed resident 6 in Merry walker ambulating throughout the hallways and in the dining room.</p> <p>Review of the provider's reviewed 1/5/15 Physical Restraints Review Procedures revealed: *"The care plan should reflect current restraint use. Care Plan should include documentation of type of restraint; frequency of release; risks of restraint use; and evidence of reduction/elimination." *"Review Nursing Notes for weekly documentation regarding the reason for the restraint use, that the restraint is being released as per physician's order and the Resident's response to the restraint use."</p> <p>Interview on 3/25/15 at 3:15 p.m. with the interim director of nursing revealed when resident 6 had seizure activity she "starts running the hallways uncontrolled and the Merry walker is used for safety during these episodes to keep her safe." That had not been noted on the restraint or Merry walker assessments. She confirmed those findings had conflicting information, and the appropriate information should have been included on the care plan and assessments.</p> <p>2. Review of resident 8's medical record revealed a 3/4/15 care plan with the following focus area: *"At risk for smoking related injuries related to presence of oxygen." *The goal was to "have no smoking related injuries while here and Will not be smoking with her O2 [oxygen] on." *The interventions were "Completed smoking</p>	F 280			

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F 280	<p>Continued From page 57</p> <p>safety assessment per Living Center policy" and "To observe for unsafe smoking behaviors or attempts to obtain smoking material from outside sources."</p> <p>Review of the 3/23/15 Re-admit Clinical Health Status revealed the question "Does the resident smoke, or desire to smoke?" Hand written in was "Res [resident] is O2 [oxygen] dependent and unsafe to smoke."</p> <p>Review of the electronic and paper medical records regarding resident 8 revealed: *Smoking assessments had not been completed. *The 11/11/14, 1/2/15, and 3/2/15 signed physician's order revealed there had not been an order enabling the resident to smoke.</p> <p>Interview on 3/25/15 at 3:15 p.m. with the interim director of nursing revealed resident 8 no longer smoked and the care plan should have reflected the change in smoking status.</p> <p>Surveyor: 28057 2. Review of resident 5's medical record revealed her care plan had not been updated to reflect her current care needs related to pressure ulcers located on her coccyx (bottom) and her left foot. Refer to F314, finding 2.</p> <p>Surveyor: 20031 4. Review of resident 25's medical record revealed staff had been unaware and had not followed physician's orders for the resident's treatment administration record (TAR) regarding oxygen administration. *Refer to F224, finding B.1.</p> <p>5. Review of resident 23's medical record</p>	F 280			

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F 280	Continued From page 58 revealed the provider failed to follow post-fall guidelines for resident 23's history of falls. *Refer to F224, finding C.1, 2, and 3.  Surveyor 28057 6. A care plan policy had been requested from the west region transitional leader/RN on 3/31/15 at 5:30 p.m. A copy of Centers for Medicare/Medicaid resident assessment instrument 3.0 manual pages 4-8 through 4-11 was received. She stated they had followed the manual and had no policy.	F 280	at QAPI meetings for further recommendations. * monthly JAKOCHIME	
F 281 SS=F	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on observation, record review, interview, and policy review, the provider failed to ensure physicians' orders were followed or clarified for 11 of 29 sampled residents (2, 7, 8, 14, 20, 22, 25, 28, 30, 32, and 33). Findings include:  1. Interview on 3/24/15 at 4:20 p.m. with resident 22 revealed she had a urinary tract infection (UTI) "and they [staff] refuse to do anything about it."  Review of a 3/1/15 facsimile (fax) sent to her physician revealed resident 22 had complained of burning with urination. She also had complained of lower abdominal pain, and her urine had an odor to it. The physician had ordered on 3/3/15 to obtain a urinalysis (u/a) and a culture and	F 281		

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F 281	<p>Continued From page 59</p> <p>sensitivity (C&amp;S) (test to see what antibiotic would work best).</p> <p>Review of resident 22's medical record revealed a u/a had been obtained on 3/4/15. That u/a showed abnormalities. Those results were faxed to the physician with a note stating "C&amp;S pending." No results of a C&amp;S were found in the medical record.</p> <p>Interview on 3/31/15 at 1:45 p.m. with registered nurse (RN) M revealed she had contacted the laboratory (lab) that had tested resident 22's urine. She stated they told her the C&amp;S had not been done, because it had not been requested on the lab order slip.</p> <p>Interview on 3/31/15 at 2:10 p.m. with the director of nursing and the west regional transitional leader confirmed no C&amp;S results could be found on resident 22's chart. They stated the results of the u/a indicated a C&amp;S should have been done.</p> <p>Review of the resident's medical record revealed there was no further follow-up on the u/a lab results. There was no documentation to indicate the physician had been notified the C&amp;S had not been completed as ordered.</p> <p>2a. Observation on 3/24/15 at 12:23 p.m. revealed licensed practical nurse (LPN) I brought medication in a cup to resident 28. He left those medications at the table and did not observe the resident swallow them.</p> <p>Review of resident 28's 12/11/14 physician's orders revealed there was no order for her to self-administer medications. Review of her 1/8/15 quarterly care conference notes revealed she</p>	F 281	<p><b>F 281 F Services Provided Meet Professional Standards</b></p> <p><b>Resident 2, 7, 8, 14, 20, 22, 25, 28, 30, 32 and 33 medical records have been reviewed with the following corrections:</b></p> <p><b>Resident 22 – physician contacted, orders received and implemented.</b></p> <p><b>Residents 28 and 33 – Residents were evaluated and found to not be able to self administer medications</b></p> <p><b>Resident 25 – physician order was clarified and is being followed</b></p> <p><b>Resident 14 – receiving daily baths</b></p> <p><b>Resident 20 – Past medication administration concerns are unable to be corrected. Physician was contacted related to urinalysis and orders have been implemented</b></p> <p><b>Residents 8, 30 and 32 past medication administration concerns are unable to be corrected</b></p>	4/30/2015	

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F 281	<p>Continued From page 60 was not approved to safely self-administer medications.</p> <p>b. Observation on 3/24/15 at 12:27 p.m. revealed LPN I brought medication in a cup to resident 33. He left those medications at the table and did not observe the resident swallow them.</p> <p>Review of resident 33's 3/5/15 physician's orders revealed there was no order for her to self-administer medications. Review of her 1/15/15 quarterly care conference notes revealed she was not approved to safely self-administer medications.</p> <p>c. Interview on 4/1/15 at 12:00 noon with LPN I revealed he only left medications with residents who were approved for self-administration. He stated he thought residents 28 and 33 had been approved to self-administer medications.</p> <p>Review of the provider's May 2012 Medication Administration policy revealed residents could only self-administer medications when ordered by their physician.</p> <p>Surveyor: 20031 3. Review of resident 25's medical record revealed staff were unaware and had not followed physician's orders for resident 25's treatment administration record (TAR) regarding oxygen administration. Refer to F224, finding B.1.</p> <p>Surveyor: 26632 4. Review of resident 14's medical record revealed daily baths had not been given as physician ordered. Refer to 241, finding A3.</p>	F 281	<p>Resident 2 - physician orders related to Percocet have been reviewed and clarified with physician and implemented</p> <p>Resident 7 past medication administration concerns are unable to be corrected. Tramadol is currently available</p> <p>Resident 12 past medication administration concerns are unable to be corrected. Lorazepam will be administered per physician's order</p> <p>The medication administration policy has been reviewed, revised and approved through the QAPI committee</p> <p>A pharmacist and Registered Nurse have reviewed current resident's medications and have completed revisions related to administration times.</p> <p>* All JAS/DOH/MF ↑ Licensed nurses and medication aides have been reeducated on requesting a physician order, receipt and clarification</p>		

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F 281	<p>Continued From page 61</p> <p>Surveyor: 28057</p> <p>5. Interview on 3/25/15 at 9:30 a.m. with resident 20's daughter revealed she had concerns related to the administration of her mother's medications. She stated they had not always been given on time and had been late at times. She believed at times her DuoNeb's had been given three times a day instead of four times a day as ordered by the physician.</p> <p>Review of resident 20's Medication Administration Audit Report from 3/18/15 through 3/25/15 revealed medications had been given outside of the allotted one hour before to one hour after the ordered time frame multiple times. That had occurred on the following dates and for the following medications:</p> <p>*On 3/21/15:</p> <ul style="list-style-type: none"> <li>-Metoprolol, benazepril, and amlodipine (all blood pressure medications), vitamin D3, aspirin, sertraline (for depression), DuoNeb solution (inhaler to improve breathing), and ReadyCare (a dietary supplement) had been given forty minutes after the allowed one hour from the scheduled 8:00 a.m.</li> </ul> <p>*On 3/21/15:</p> <ul style="list-style-type: none"> <li>-Singulair tablet (helps the ability to breathe), metoprolol, and acetaminophen (for pain) had been given twenty-four minutes after the allowed one hour from the scheduled 7:00 p.m.</li> <li>-DuoNeb solution due at 4:00 p.m. was given six minutes past the one hour limit.</li> <li>-DuoNeb solution due at 7:00 p.m. was given twenty-four minutes past the one hour limit.</li> </ul> <p>*On 3/22/15:</p> <ul style="list-style-type: none"> <li>-Metoprolol, benazepril, and amlodipine, vitamin D3, aspirin, sertraline, DuoNeb solution, and ReadyCare had been given one hour and twelve minutes after the allowed one hour from the</li> </ul>	F 281			

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F 281	Continued From page 62 scheduled 8:00 a.m. *On 3/23/15: -DuoNeb solution due at 4:00 p.m. was given three hours and forty-eight minutes after the allowed one hour limit. -That had caused her to miss a dose as a 4:00 p.m. and a 7:00 p.m. dose had been ordered and only the one dose had been given at 8:15 p.m. -ReadyCare, Singulair, acetaminophen, and metoprolol had been due at 7:00 p.m. and were given forty-eight minutes after the allowed one hour limit. *On 3/24/15: -ReadyCare, Singulair, metoprolol, and acetaminophen due at 7:00 p.m. were given one hour and forty minutes after the one hour limit. -DuoNeb solution due at 4:00 p.m. was given four hours and forty minutes after the allowed one hour limit. -That had caused her to miss a dose as a 4:00 p.m. and a 7:00 p.m. dose was ordered, and only the one dose was given at 9:40 p.m. *On 3/25/15: -DuoNeb, acetaminophen, metoprolol, Singulair, and ReadyCare due at 7:00 p.m. was given fifteen minutes after the allowed one hour limit. *On 3/26/15: -Sertraline, ReadyCare, benazepril, metoprolol, amlodipine, aspirin, and vitamin D3 were due at 8:00 a.m. and were given seven minutes past the allowed one hour limit. -DuoNeb solution due at 8:00 a.m. was given three minutes past the one hour limit. *On 3/25/15: -ReadyCare, DuoNeb solution, Singulair, acetaminophen, and metoprolol was due at 7:00 p.m. and was given fifteen minutes after the one hour limit. *On 3/26/15:	F 281			

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F 281	<p>Continued From page 63</p> <p>-DuoNeb solution was due at 4:00 p.m. and was given fifty-six minutes after the one hour limit. *On 3/29/15: -ReadyCare, metoprolol, acetaminophen, and Singulair were due at 7:00 p.m. and was given one hour and four minutes after the one hour limit. *On 3/30/15: -Singulair, acetaminophen, metoprolol, ReadyCare, and DuoNeb solution were due at 7:00 p.m. and were given fifty-seven minutes past the one hour limit.</p> <p>Review of resident 20's nursing progress notes through 3/31/15 revealed no documentation to support why the above medications had been given after the allowed one hour limit.</p> <p>Interview on 3/31/15 at 12:30 p.m. with the provider's west region transitional leader/RN confirmed: *The above doses had not been given in the expected one hour before or one hour after the ordered time frame. *There were some exceptions to the one hour rule if a medication had been ordered with a meal or before eating as examples.</p> <p>Interview on 4/1/15 at 9:00 a.m. with the provider's west region transitional leader/RN confirmed: *She had not been able to run any of the other requested residents' reports as the computer program had timed out. *She had contacted the provider's support staff for the electronic records, and she had still been unable to access any more reports. *She confirmed that many of the residents had the same issues with their medications not being</p>	F 281			

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F 281	<p>Continued From page 64 given in the required time frame. *It was a widespread problem.</p> <p>Review of the provider's May 2012 Medication Administration Policy revealed: *Medications were to be administered by following the five rights: -The right resident. -The right drug. -The right dose. -The right route. -The right time. *Medications were to have been administered according to the physician's orders. *Routine dose administration times were established by the provider and were to be followed. *Medications were to have been given within sixty minutes of the scheduled time. *The order exceptions were for before, with, or after meals. *The expiration date was to be checked on the packaging or container.</p> <p>7. Review of resident 20's 3/12/15 physician's orders revealed an order for a urinalysis for a suspected urinary tract infection. Review of her laboratory reports revealed the urinalysis had not been completed until 3/19/15.</p> <p>Interview on 4/1/15 at 5:10 p.m. with the director of nursing confirmed the urinalysis should have been done by 3/16/15 at the latest. She agreed it had not been completed in a timely manner.</p> <p>A policy for Physician's Orders had been requested from the west region transitional leader/RN on 3/31/15 at 5:30 p.m. None was received by the end of the survey.</p>	F 281			

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F 281	<p>Continued From page 65</p> <p>8. Review of the following resident 8, 30, and 32's March 2015 medications administration record (MAR) revealed:</p> <p>a. They had not received their Advair Diskus inhalers as ordered.</p> <p>*Resident 30's MAR had listed Advair Diskus 500/50 mcg one puff twice a day.</p> <p>-It was administered as ordered resulting in sixty-two doses being given for the month.</p> <p>-His Advair Diskus had been opened on 2/21/15 and expired on 2/23/15.</p> <p>-It was still in-use for the resident.</p> <p>-It should have run out of doses on that same date, yet it still contained eleven doses.</p> <p>*Resident 32's MAR had listed Advair Diskus 250/50 mcg one puff twice a day.</p> <p>-It was administered as ordered resulting in sixty-two doses being given for the month.</p> <p>-It was dated as opened on 3/5/15 and had forty-six doses left.</p> <p>-It should have had no more than eight doses left if it had been used since 3/5/15.</p> <p>*Resident 8's MAR had Advair Diskus 500/50 mcg one puff twice a day that had started on 3/23/15.</p> <p>-Her Advair Diskus had been opened on 3/4/15.</p> <p>-That diskus had nineteen doses left.</p> <p>-She had been in the hospital for no more than four days in March 2015.</p> <p>-It should have had fourteen or less doses left.</p> <p>*None of the above residents had any documented refusals of the above medications during March 2015 to explain for the extra doses left.</p> <p>b. The inhalers had not been dated when they had been opened as required by the manufacturer's directions.</p>	F 281		

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F 281	<p>Continued From page 66 Refer to F431, finding 2. a, b, c, and d.</p> <p>Review of the provider's May 2012 Medication Administration Policy revealed: *The label, container, and contents were to be checked against the MAR before it was administered to the resident. *Medications were to be administered by following the five rights: -The right resident. -The right drug. -The right dose. -The right route. -The right time. *The expiration date was to be checked on the packaging or container.</p> <p>Surveyor: 32573 9. Review of resident 2's complete medical record revealed: *A 10/13/14 physician's order for Percocet (pain medication) 10-325 as needed (PRN) every four hours. *A 10/13/14 order to discontinue the Percocet 5/325 when 10/325 was available (but to use the existing supply of 5/325 tablets until they were gone instead of 10/325). *A 2/16/15 physician's order for Percocet 5-325 PRN every four hours, use until supply arrives.</p> <p>Review of resident 2's March 2015 MAR revealed: *In the "Other" orders box the order to use Percocet 5/325 instead of 10/325 until they were gone had been written. *Throughout the month 10/325 and 5/325 had been given at different times. *On 3/17/15 the MAR had been marked as Percocet 5/325 had been given at 3:30 a.m.</p>	F 281			

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F 281	<p>Continued From page 67</p> <p>*On 3/17/15 the MAR had been marked as Percocet 10/325 given at 3:45 a.m.</p> <p>*Both doses had been given within fifteen minutes instead of one or the other every four hours.</p> <p>*There had been no nurses notes clarifying if that had been a documentation error or the medication had been given as marked.</p> <p>Interview on 3/25/15 at 3:30 p.m. with the director of nursing revealed she was unsure why it had been marked as given twice. She agreed the medication should not have been on there twice and that was "not okay."</p> <p>10. Review of resident 7's complete medical record revealed: *A current order for Tramadol HCL (medication for pain) once daily. *Her March 2015 MAR revealed: -Tramadol administration boxes had been marked as "see nurse notes" on 3/2/15 and 3/3/15. -Tramadol administration box had been left blank on 3/4/15. *The nursing progress notes revealed: -On 3/2/15 Tramadol had not been available due to script (prescription) out of date. -On 3/3/15 Tramadol medication card was not in the facility and the nurse could not get the medication. Pharmacy was made aware. -On 3/4/15 there had been no notes regarding why the Tramadol MAR space had been left blank.</p> <p>11. Review of resident 12's complete medical record revealed: *An order for lorazepam every four hours PRN for anxiety.</p>	F 281			

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F 281	Continued From page 68 *The December 2014 nursing notes revealed: -On 12/12/14 at 8:07 a.m. it had been noted the resident asked for an anxiety pill. One had not been given. -On 12/12/14 at 3:09 p.m. it had been noted the resident had tried to "bargain" for an anxiety pill. One had not been given. -On 12/31/14 it had been noted the resident had been attempting to "bargain with staff for extra/early" anxiety medication. Nurse I had attempted to explain it was not in the time frame to take one. The resident disagreed. *Her December 2014 MAR revealed: -On 12/12/14 lorazepam had been given once at 4:18 a.m. -On 12/31/14 lorazepam had not been given. *On both of those dates anxiety medications had been within the ordered time frames and could have been given to the resident as requested.  12. Review of a confidential resident's (unidentified per request) complete medical record revealed she had not received as needed (PRN) medications as requested. Refer to F224, finding 2.	F 281	and implementation of following physician orders.  The Director of Nursing has reviewed the policy and procedures related to requesting a physician order, receipt and clarification and implementation of following physician orders. <i>*five JALSDDOH/MF</i> Director of Nursing or designee will complete random audits weekly x 4 weeks then monthly x 2 months to ensure compliance with following physician orders, timely physician notification, appropriate medication administration and self administration of medication. Results will be reviewed at QAPI meetings for further recommendations. <i>*MONTHLY JALSDDOH/MF</i>		
F 314 SS=H	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314			

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F 314	Continued From page 69  This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review, interview, and pressure ulcer decision making tool, the provider failed to ensure: *One of one sampled resident (15) had not acquired six pressure ulcers (break in skin from continued pressure) after admission to the facility. *One of one sampled resident (15) had not acquired an osteomyelitis (infection in the bone) in a pressure ulcer. *One of one sampled resident (5) pressure ulcer had been identified in a timely manner to prevent further skin damage. Findings include:  1. Review of resident 15's medical record revealed: *She had been admitted on 4/8/14 with a fracture of her left femur (large bone in thigh). She had no pressure ulcers on admission. *She had additional diagnoses of dementia (altered thought process), anemia (low red cell blood count), osteoarthritis (arthritis in bones), atrial fibrillation (irregular heart rate), and hypertension (high blood pressure). *She did not have any preventative skin care measures put in place when she had been admitted. *During her stay she had acquired six pressure ulcers (medial coccyx [center of tailbone], right coccyx [right of the tailbone], left heel, left hip, right iliac crest [top of right hip bone], and left first toe). Those pressure ulcers included: -A stage two (shallow open area of skin) pressure ulcer to her medial coccyx on 4/15/14. It was closed as of 5/13/14 when she readmitted after a	F 314	F 314 H Treatment/Services to prevent/heal pressure sores  Resident 5 and 15 had a comprehensive skin assessment completed to identify any skin concerns. Physician and responsible parties have been notified of any skin concerns identified. Physician orders have been obtained and are being followed. Care plan has been reviewed has been reviewed and revised to reflect resident's current status.  Residents residing in the facility have the potential to be affected in a similar manner. <i>x at high risk for pressure ulcers</i> Residents residing in the facility have had a comprehensive skin assessment completed to identify any skin concerns. Physician and responsible parties have been notified of any skin concerns identified. Physician orders have been obtained and are being followed. GLC – Meadowbrook skin integrity guidelines are in place.	4/30/2015	

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F 314	<p>Continued From page 70</p> <p>hospitalization from 5/9/14 through 5/12/14.</p> <p>-A stage two admitted pressure ulcer to her right coccyx on 5/13/14. It was healed as of 5/26/14.</p> <p>-She was hospitalized from 6/13/14 through 6/16/14 and the pressure ulcer to her right coccyx was not present.</p> <p>-The right coccyx pressure ulcer was reacquired on 6/23/14 and was a stage two. There was no record of that pressure ulcer after 6/23/14 when it was open and a stage two.</p> <p>-A stage two pressure ulcer to her left heel on 5/5/14 that healed on 7/14/14.</p> <p>-An unstageable (Full skin thickness tissue loss covered by slough [yellow, tan, gray, green, or brown tissue] and/or eschar [scabbed appearance]) pressure ulcer to her left hip was still present on 3/23/15.</p> <p>-A stage one (Intact skin with redness that does not resolve) pressure ulcer to her right iliac crest. That pressure ulcer became unstageable on 1/26/15 and on 3/16/15 it was healed.</p> <p>-A stage two pressure ulcer to her left first toe on 11/3/14 was still present, and was unstageable on 3/23/14.</p> <p>Review of resident 15's clinical health status assessments for the following dates revealed:</p> <p>*4/8/14 She had no pressure ulcers present. She had a Braden (scale for predicting pressure ulcer risk) score of sixteen and was at risk for developing a pressure ulcer.</p> <p>*5/2/14 One sacral pressure ulcer that stated "Sore covered with Mepilex [dressing], CDI [clean, dry, and intact]," no stage noted. She had a Braden scale score of thirteen and was a moderate risk for a pressure ulcer.</p> <p>*6/16/14 One stage two pressure ulcer to her left coccyx with a Braden scale score of seventeen and was at risk for a pressure ulcer.</p>	F 314			

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F 314	<p>Continued From page 71</p> <p>*9/19/14 revealed:</p> <ul style="list-style-type: none"> <li>-An unstaged pressure ulcer to the left outer foot.</li> <li>-An unstaged pressure ulcer to her left heel.</li> <li>-An unstaged pressure ulcer to her right heel.</li> <li>-An unstaged pressure ulcer to the upper left of her coccyx with documentation "Tunneled, reddened around site, packing placed."</li> <li>-An unstaged pressure ulcer to the lower left of her coccyx with documentation "Area that is red, no blanching [color remains red when skin is pressed], closed."</li> <li>-An unstaged pressure ulcer to the left hip with documentation "Sore, red, no blanching w [with] black area in middle."</li> <li>-She had a diagnoses of osteomyelitis [bone infection].</li> <li>-Her Braden scale score was seven at a severe risk for pressure ulcers.</li> </ul> <p>*10/20/14 revealed:</p> <ul style="list-style-type: none"> <li>-A stage two pressure ulcer to her right hip.</li> <li>-A stage two pressure ulcer to her coccyx.</li> <li>-A unstageable pressure ulcer to her first left toe.</li> <li>-A unstageable pressure ulcer to her left hip.</li> <li>-Her Braden scale score was fourteen with a moderate risk for pressure ulcers.</li> </ul> <p>*2/9/15 Pressure ulcer to both her right and left hip with a Braden scale score thirteen for a moderate risk for pressure ulcers.</p> <p>Review of a 9/13/14 hospital history and physical revealed diagnoses included a sacral decubitus (pressure ulcer) stage three or above that was very suspicious for osteomyelitis.</p> <p>Review of the 9/19/14 hospital discharge summary revealed discharge diagnoses that included sepsis (severe infection) due to infected sacral decubitus, osteomyelitis in progress.</p>	F 314			

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F 314	<p>Continued From page 72</p> <p>Review of resident 15's wound evaluation flow sheets for her pressure ulcers revealed:</p> <ul style="list-style-type: none"> <li>*A waffle overlay (cover over regular mattress) was placed on her bed on 4/15/14.</li> <li>*Bilateral Prevalon boots (pressure reducing boots for feet and heels) had been placed on 5/5/14.</li> <li>*She was on a specific turning and repositioning program to be turned or repositioned every one to two hours starting on 4/15/14.</li> <li>*An Alpha active mattress (A pressure redistributing mattress overlay system for the prevention and management of pressure ulcers.) was initiated on 5/13/14 when she returned from a hospitalization.</li> <li>*Her turning and repositioning program was changed on 9/1/14 to thirty to sixty minutes on her left side and one to two hours on her right side.</li> <li>*A MA 65 mattress (Mattress with alternating air pressure)</li> </ul> <p>Review of resident 15's focus area for pressure ulcers initiated on 6/30/14 revealed interventions that included:</p> <ul style="list-style-type: none"> <li>*Bilateral Prevalon boots at all times.</li> <li>*She had a MA 65 lipped mattress for wound care purposes.</li> <li>*Turning and repositioning schedule per assessment.</li> <li>*Provide assistance with changes in position every two to three hours as resident will allow.</li> </ul> <p>Review of the provider's undated Pressure Ulcer Risk Identification/Prevention Diagram revealed:</p> <ul style="list-style-type: none"> <li>*Upon admission a skin assessment would have been completed.</li> <li>*If the resident was at risk for a pressure ulcer immediate interventions would have been implemented.</li> </ul>	F 314		

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F 314	<p>Continued From page 73</p> <p>*If the resident had a pressure ulcer present a pressure reduction mattress would have been initiated.</p> <p>*Develop an individualized care plan.</p> <p>Surveyor: 28057</p> <p>2. Review on 3/24/15 of resident 5's treatment administration records (TAR) revealed:</p> <p>*March 2015 TAR had:</p> <ul style="list-style-type: none"> <li>-A daily treatment for a pressure ulcer on her left medial (outside edge) foot.</li> <li>-No documentation for four of those twenty-four days that the treatment above had been completed.</li> <li>-No documentation to support why it had not been completed.</li> </ul> <p>*February 2015 TAR had:</p> <ul style="list-style-type: none"> <li>-A treatment to be done every Monday, Wednesday, and Friday for a pressure ulcer on her left medial foot from 2/1/15 through 2/23/15.</li> <li>-It had not been documented as completed on 2/4/15, Wednesday.</li> <li>-A change in the treatment to her left foot to be done every day starting on 2/24/15.</li> <li>-It had not been documented as completed on 2/26/15.</li> </ul> <p>*January 2015 TAR had:</p> <ul style="list-style-type: none"> <li>-A treatment to be done as needed for a pressure ulcer on her left medial foot that had started on 1/21/15 and ended on 1/23/15 to be cleansed with normal saline and cover with a hydrocolloid dressing (An absorbent dressing that provided a moist healing atmosphere to the wound).</li> <li>-Another treatment using a hydrocolloid dressing to be done every Monday, Wednesday, and Friday for a pressure ulcer on her left medial foot from 1/23/15 through 2/24/15.</li> <li>-No treatments had been documented in January as being completed to her foot until they had</li> </ul>	F 314			

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F 314	<p>Continued From page 74 been scheduled on Monday, Wednesday, and Friday starting on 1/23/15.</p> <p>Review of her nursing progress notes from 1/1/15 through 3/24/15 regarding resident 5 revealed: *On 1/13/15 licensed practical nurse (LPN) I documented the resident had a "wound" on her sacrum (bottom). *The rest of the resident's skin remained intact (without open areas) but fragile in appearance. *On 1/26/15 the daughter was called by registered nurse (RN) F to update her on the resident's skin. *The daughter had agreed the "wounds" had caused the resident less pain, and the treatments were effective. *There had been no documentation to indicate the resident's foot was red or had any other signs of skin breakdown until an order request was sent by facsimile to the physician on 1/19/15.</p> <p>Review of the resident's weekly skin assessments documented on her January 2015 TAR revealed: *She had a weekly assessment completed on 1/13/15 before the ulcer was documented. *The next one had been completed on 1/20/15 after the pressure ulcer had been documented on her left foot.</p> <p>Review of resident 5's physician's facsimile orders revealed she had a newly acquired pressure ulcer on her medial left foot. The pressure ulcer was described as unstageable. It had been covered with eschar and measured 1.5 by 1.0 by 0 and it had not stated inches or centimeters. The facsimile sent to the physician had requested orders to change the hydrocolloid dressings on Monday, Wednesday, Friday, and</p>	F 314			

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F 314	<p>Continued From page 75</p> <p>as needed. The request had been sent to the physician on 1/19/15, and those orders were received on 1/21/15.</p> <p>Review of her care plan last revised on 2/9/15 revealed:</p> <ul style="list-style-type: none"> <li>*She had a pressure ulcer listed as a focus.</li> <li>*It had not addressed that she had two pressure ulcers or where they were located.</li> <li>*Her goals were she would not have any further skin breakdown, and the pressure ulcers would heal without complications.</li> <li>*For interventions it had included a Prevalon boot to the left foot and to float her left heel in bed as she had allowed.</li> <li>*Weekly skin assessments were to have been completed by the licensed nurse.</li> <li>*Those interventions had been initiated on 8/16/13.</li> <li>*She had goals under her dietary assessment her skin would remain intact initiated on 8/8/14.</li> <li>-It was last dated as reviewed on 4/21/15.</li> <li>-It was not changed to reflect the presence of two pressure ulcers, one on her coccyx (bottom) and one on her left foot.</li> <li>*On 1/28/15 the dietary services manager had stated the resident was on a magic cup (nutrition supplement) twice a day for extra protein and calories.</li> <li>*She had not addressed the resident's dietary needs related to her pressure ulcers.</li> </ul> <p>Review of her weekly wound evaluation flow sheets documentation from 1/19/15 through 3/23/15 for her left medial foot revealed:</p> <p>*Current preventative interventions had included:</p> <ul style="list-style-type: none"> <li>-An Alpha Active mattress.</li> <li>-A wheelchair cushion.</li> <li>-A specific turn/reposition program.</li> </ul>	F 314			

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F 314	<p>Continued From page 76</p> <p>*It had not addressed the use of the Prevalon boot.</p> <p>Interview on 3/25/15 at 3:29 p.m. with the provider's west region transitional leader/RN confirmed:</p> <p>*Resident 5's weekly wound documentation had not been entered on 3/23/15 by RN F.</p> <p>*RN A had forgotten to enter the measurements.</p> <p>*She had re-measured and documented it today.</p> <p>Interview on 3/25/15 at 3:55 p.m. with RN L confirmed treatments were to be done as ordered or documented why it had not been done, example refused by the resident. She confirmed there had been no documentation done on a daily basis to support the Prevalon boot was used as ordered.</p> <p>Interview on 3/25/15 at 5:08 p.m. with the provider's west region transitional leader/RN confirmed:</p> <p>*The use of the Prevalon boot was a nursing initiated order.</p> <p>*It was poorly written on the nursing assistant "cheat sheets" that directed resident care.</p> <p>*It had stated "foam boots" on the cheat sheet.</p> <p>3. Review of the provider's revised November 2014 Skin Integrity Guideline revealed:</p> <p>*The purpose was to decrease pressure ulcer and/or wound formation.</p> <p>*Residents at risk were to be identified and interventions implemented to prevent breakdown.</p> <p>*Residents were to have been observed by the certified nursing assistant (CNA) daily for any reddened or open areas.</p> <p>*The CNA was to have reported any of those changes to the nurse.</p>	F 314		
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F 314	Continued From page 77 *Nutritional assessments were to have been completed to identify nutritional needs. *Documentation was to have been completed on a monthly basis by the dietary manager on any resident with a stage II or greater pressure ulcer until it had healed. *The care plan was to have implemented, evaluated, and revised care based on the resident needs.	F 314	The Director of Nursing has reviewed the Golden Living Center Skin integrity guideline.  Nursing staff have been reeducated on the Skin integrity guideline. <i>*five JASDDH/MF</i> Director of Nursing or designee will complete random audits weekly x 4		
F 323 SS=F	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Surveyor: 32573  Surveyor: 20031 A. Based on observation, testing, and interview, the provider failed to maintain: *Two of two hallways (west and east) used by all residents clear of all obstacles. *Two of two whirlpool rooms' hot water heater covers in good condition. Findings include:  1. Random observation from 3/24/15 through 3/25/15 and again from 3/31/15 through 4/1/15 throughout the day revealed the following were	F 323	weeks then monthly x 2 months to ensure compliance the skin integrity guideline. Results will be reviewed at <i>*monthly JASDDH/MF</i> QAPI meetings for further recommendations.		

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F 323	<p>Continued From page 78 stored in the west and east hallways: *Medication carts. *Wheel chairs. *Lifts. *Walkers. Residents would try and use the handrails, but they would have to stop or go around the stored equipment when navigating throughout the hallways.</p> <p>Surveyor: 32573 2. Group interview on 3/24/15 from 3:00 p.m. through 4:40 p.m. revealed: *Four of four residents in attendance agreed there were always lifts, wheel chairs, and medication carts in the hallways. *It was hard to get around. *They were told they would have to wait until the medication cart was moved when staff were done passing medications to get through the hallway. *There was often a line of residents behind the medication cart waiting to get through.</p> <p>Interview on 3/25/15 at 10:00 a.m. with the maintenance supervisor (MS) and housekeeping supervisor confirmed the above observations and group interview. The MS stated he had tried to have staff keep the hallways clear, but it would just go back the same way.</p> <p>3. Random observation from 3/24/15 through 3/25/15 revealed the hot water heater covers in the west and east whirlpool rooms were unhooked from the base and laid loose against the heater. Testing revealed those metal ends/edges of those covers were sharp to the touch and laid at a level that could provide a skin tear or hazard to residents' bare feet in wheelchairs. Interview on 3/25/15 at 10:00 a.m.</p>	F 323	<p><b>F 323 Free of Accident Hazards/Supervision/Device</b></p> <p>Medication carts, wheel chairs, lifts and walker not in use will be removed from the hallways by April 30, 2015.</p> <p>Hot water heater covers and sharp edges in the east and west whirlpool rooms were repaired for resident safety.</p> <p>Post Fall guideline for Resident 23 is reviewed with appropriate actions taken. <i>* Refer to tag F044 JAKSDDCHIME</i></p> <p>Residents residing in the facility have the potential to be affected in a similar manner.</p> <p>Executive Director, Environmental Supervisors and Interdisciplinary team have reviewed the policy and procedure related to identifying and limiting residents safety hazards</p> <p>Staff have been reeducated with regard to equipment in corridors and resident safety/hazards</p>	4/30/2015

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F 323	Continued From page 79 with the MS and housekeeping supervisor confirmed those observations. The MS stated he was aware of the condition of the old heaters and had tried to keep them connected to avoid a hazard.  Surveyor 20031 B. Based on observation, record review, and interview, the provider failed to follow post-fall guidelines for 1 of 12 sampled residents (23) with falls. Refer to F224, finding C.1.	F 323			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked,	F 431			

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F 431	<p>Continued From page 80</p> <p>permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on observation, interview, record review, and policy review, the provider failed to ensure: *Medications had been put in a secured area after they had been delivered to the facility by United Parcel Service (UPS). *Medications had been labeled, dated, and stored appropriately in three of three observed medication carts as follows: a. The west medication cart contained: -Two of two randomly sampled residents' Advair Diskus that had been expired or not given as ordered. -Three of three randomly sampled residents' (13, 29, and 31) insulin pens failed to have legible dates written when they had been opened. b. The east medication cart had one stock medication that had been expired. c. The south medication cart contained: -One of one resident 3's injectable Haldol that had expired. -Two of two residents' (8 and 28) Advair Diskus that had not been stored or given as ordered. *Medications awaiting destruction had been documented and accounted for until they had been destroyed.</p>	F 431	<p>Licensed Nurses have been reeducated with regard to post-fall guidelines</p> <p>The Maintenance Supervisor or <sup>*both</sup> designee will audit hallways for <sup>JASDDOH/MF</sup> equipment and hot water heater covers weekly for 1 month and monthly for 2 months.</p> <p>The DNS or designee will audit post fall <sup>*three</sup> documentation weekly for 1 month <sup>JASDDOH/MF</sup> monthly for 2 months.</p> <p>Results of the audits will be reviewed at <sup>monthly</sup> QAPI meetings for further <sup>JASDDOH/MF</sup> recommendations.</p>	

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F 431	<p>Continued From page 81</p> <p>*One randomly observed resident's (14) room had medications that had been authorized and accounted for use by the resident for self-administration.</p> <p>Findings include:</p> <p>1. Observation and interview on 4/1/15 at 10:25 a.m. with licensed practical nurse (LPN) I revealed a closed cardboard box on the floor in front of the medication room door. LPN I stated it was a UPS delivery of medications for residents. He stated the office manager had probably put the box there when UPS had delivered it that morning. He agreed they were not secured. There had been one staff person at the nurses desk, but her back was to the medication room door and the box. He opened the box and offered a copy of the packing slip upon request. The box contained the following medications:</p> <ul style="list-style-type: none"> <li>*Oxycodone thirty tablets, a controlled (narcotic) schedule II medication.</li> <li>*Vancomycin, fifty tablets, an antibiotic.</li> <li>*Metoprolol, fourteen tablets, for high blood pressure.</li> <li>*Amlodipine, fourteen tablets, for high blood pressure.</li> <li>*Cephalexin, six tablets, an antibiotic for infections.</li> <li>*Potassium chloride, twenty-eight tablets, for electrolyte balance (a high alert medication-can cause serious harm).</li> <li>*Lansoprazole, thirty tablets, used to treat ulcers and stomach upset.</li> <li>*Levothyroxine, fifteen tablets, for thyroid deficiency.</li> <li>*Metamucil, one-hundred-twenty tablets, a laxative.</li> <li>*Lidocaine patches, used for pain.</li> <li>*Quetiapine, ninety tablets, an antipsychotic.</li> </ul>	F 431	<p><b>F 431 Drug Records, Label/store Drugs &amp; Biologicals</b></p> <p>Medications delivered to the facility were placed in the medication room for proper storage.</p> <p>The outdated Advair inhalers have been removed from all medications carts (Resident 13, 29, 31, 8, 28, 30)</p> <p>Insulin pens without legible dates when opened for residents (resident 13, 29, and 31 ) have been removed from all medication carts</p> <p>The expired stock medication has been removed from all medication carts.</p> <p>The expired Haldol (Resident 3) has been removed from the south medication cart.</p> <p>All medications awaiting destruction have been documented and destroyed</p> <p>Resident 14 has completed the Medication Self Administration assessment is not able to self administer medications.</p>	4/30/2015

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F 431	<p>Continued From page 82</p> <p>*Prednisone, thirteen tablets, a corticosteroid used for a variety medical issues.</p> <p>*Cefuroxime, nineteen tablets, an antibiotic.</p> <p>Interview on 4/1/15 at 11:00 a.m. with the office manager confirmed she had put the box of medications in front of the medication room door. She had told an unlicensed assistive personnel (UAP) as the UAP had walked by that the box was there on the floor. That had been before 10:00 a.m. today.</p> <p>Interview on 4/1/15 at 11:02 a.m. with the director of nursing confirmed the medications should not have been left unsecured by the medication room door. They should have been locked in the medication room.</p> <p>2. a. Observation and interview on 4/1/15 at 10:15 a.m. with registered nurse (RN) H during review of the west medication cart revealed:</p> <p>*An Advair diskus 500/50 micrograms (mcg) for resident 30.</p> <p>-It had been dated as opened on 2/21/15.</p> <p>-It had eleven doses left in the diskus.</p> <p>*An Advair diskus 250/50 mcg for resident 32.</p> <p>-It had been dated as opened on 3/5/15.</p> <p>-It had forty-six doses left in the diskus.</p> <p>*RN H had not known how long an Advair Diskus could be used after it had been opened.</p> <p>-She had not realized it was to be discarded after thirty days from when it had been opened.</p> <p>*Two Novolog Flex insulin pens for resident 31.</p> <p>-One had been dated on 3/20/15, and the other was dated 3/30/15.</p> <p>*That same resident had a Levemir insulin Flex touch pen that had been opened.</p> <p>-The date had rubbed off of that pen and was not readable as to when it had been opened.</p>	F 431	<p>Residents residing in the facility have the potential to be affected in a similar manner.</p> <p>Director of Nursing and Pharmacist have reviewed the policy and procedure for appropriate drug storage, security of medications and accountability for residents self administration</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> <p><i>x all the UAPSDOHIME</i></p> <p>Audit has been completed of residents who may self administer medications. A self administration assessment will be completed and physician orders will be obtained and implemented. Care plans will be revised to reflect resident's current status.</p> <p>Licensed Nurse H and I, UAP J have been educated with regard to medication administration, medication outdate, and medication storage.</p>		

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F 431	<p>Continued From page 83</p> <p>*Resident 13 had a Lantus Solar Star insulin pen. -The dates had been unreadable that were written on the pen.</p> <p>*Resident 29 had a Novolog insulin Flex pen. -That had been opened with no dates entered.</p> <p>*RN H was not sure if the above dates were when the insulin pens had expired or when they had been opened.</p> <p>b. Observation and interview on 4/1/15 at 10:25 a.m. with licensed practical nurse I during review of the east medication cart revealed a stock supply bottle of vitamin C in use that had expired January 2015. He agreed it was expired and should not be in-use. He further stated it was the nurse's responsibility to ensure the medications were not expired before they were administered to the residents.</p> <p>c. Observation and interview on 4/1/15 at 10:30 a.m. with unlicensed assistive personnel (UAP) J during review of the south medication cart revealed: *Resident 3 had a ziplock bag of Haloperidol intramuscular injectable vials. -Two of those vials had expired in January 2015. *UAP J agreed the Haloperidol vials had been expired. *Resident 8 had an Advair Diskus 100/50mcg that had been opened on 3/4/15. -That diskus had nineteen doses left. -That same diskus had been stored in an Advair Diskus box with an unopened foil pouch that contained a 500/50 mcg Advair diskus. *Another Advair Diskus 100/50 mcg box labeled "Emergency kit" with resident 28's name written in permanent ink on the outside of the box. -Inside that box had been resident 8's labeled 500/50 mcg Advair Diskus.</p>	F 431	<p>Staff have been educated with regard to medication deliveries and proper storage at time of receipt <i>* All JASDDH/MF</i></p> <p>Licensed Nurses and UAP's have been reeducated with regard to medication administration, medication outdates, medication self administration, medication destruction and medication storage <i>*5 instances A JASDDH/MF</i></p> <p>The DNS or designee will audit Advair administration weekly for 4 weeks and monthly for 2 months.</p> <p>The DNS or designee will audit each medication cart weekly for 4 weeks and monthly for 2 months, for properly marked open dates, expired Advair, Insulin Pens and outdated stock medications.</p> <p>The DNS or designee will audit <i>*five JASDDH/MF</i> medication delivery storage weekly for 4 weeks and monthly for 2 months.</p> <p>The DNS or designee will audit <i>*five JASDDH/MF</i> medication storage and destruction</p>	

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F 431	<p>Continued From page 84</p> <p>*Inside of resident 8's 100/50 mcg Advair Diskus box was resident 28's 500/50 mcg labeled Advair Diskus.</p> <p>-Resident 28's name was written in permanent ink on that diskus.</p> <p>-It had been opened on 3/5/15, and forty-nine doses had been left.</p> <p>-That box had also contained resident 8's labeled Ventolin hand held inhaler.</p> <p>*UAP J agreed the Advair Diskus had not been stored in the correct boxes.</p> <p>*She had not known if other Advair Diskus had been opened for the above residents and discarded during March 2015.</p> <p>*That could have caused there to be doses left on the opened ones in the cart.</p> <p>Review of the following medication package inserts revealed:</p> <p>*The manufacturer's insert for an Advair Diskus stated upon opening the foil packet it was to be disposed of after one month or when the counter reached 0, whichever occurred first.</p> <p>*The Levemir insulin Flex touch pen package insert stated it was to be discarded after forty-eight days after it had been opened.</p> <p>*The Novolog Insulin Flex pen package insert was to be discarded in twenty-eight days after it had been opened.</p> <p>Surveyor: 26632</p> <p>3. Observation on 3/24/15 from 8:00 a.m. through 8:15 a.m. and on 4/1/15 from 10:30 a.m. through 11:00 a.m. revealed resident 14 had numerous medications in her room. She had:</p> <p>*One bottle of Nystatin powder (for yeast skin infections) powder on her dresser.</p> <p>*One half-filled box of Refresh Plus eye drops on her dresser.</p>	F 431			

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F 431	<p>Continued From page 85</p> <p>*One bottle of fluticonasone nasal spray in an open storage bedside stand.</p> <p>*One bottle of nasal decongestant spray with an expiration date of June 2014 in an open storage bedside stand.</p> <p>Review of resident 14's medical record revealed:</p> <p>*No order for the nasal decongestant spray.</p> <p>*No physician's order for the self-administration of those medications.</p> <p>*No assessment for the self-administration of those medications.</p> <p>Surveyor: 23059</p> <p>4. Observation on 4/1/15 at 1:40 p.m. revealed a large cardboard box of medications on the floor of the medication room. Interview at that time with registered nurse (RN) H revealed those medications were awaiting destruction. Interview at that time with the interim director of nurses revealed there was no record of what medications were stored in that box awaiting destruction. She stated paperwork would be completed once they were ready to be destroyed. She also confirmed any of those medications had the potential to be diverted (taken by staff or others for their own use). She confirmed she would not be able to know if that had happened if there was no record of what had been in that box. Observation of the medications in that box revealed the following:</p> <p>*One box of thirty 5% Lidocaine patches unopened (pain relief).</p> <p>*One clonidine 0.1 milligram (mg) patch (to control blood pressure).</p> <p>*Five single dose syringes of enoxaparin sodium 80 mg/0.8 milliliters (ml) (prevent blood clots).</p> <p>*One 50 ml bag of intravenous (IV) sodium chloride solution (fluid replacement).</p>	F 431			

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F 431	<p>Continued From page 86</p> <ul style="list-style-type: none"> <li>*One Lantus Solostar 100 unit/ml insulin flexpen (control diabetes).</li> <li>*Twenty-two pieces of Nicorette gum 4 mg (prevent cravings for nicotine).</li> <li>*One bag of 1.25 gram vancomycin IV solution (antibiotic).</li> <li>*One Advair diskus inhaler with fifty-three doses left (control asthma).</li> <li>*Two tablets of trazodone 100 mg (anti-depressant).</li> <li>*One tablet each of:               <ul style="list-style-type: none"> <li>-Clopidogrel 75 mg (prevent blood clots).</li> <li>-Buspirone 5 mg (anti-anxiety).</li> <li>-Duloxetine 60 mg (anti-depressant).</li> <li>-Bumetanide 1 mg (diuretic).</li> <li>-Gabapentin 100 mg (prevent seizures).</li> <li>-Metoprolol 25 mg (control blood pressure).</li> <li>-Amlodipine 5 mg (control blood pressure).</li> <li>-Lisinopril 10 mg (control blood pressure).</li> </ul> </li> <li>*Forty-one tablets of Amoxicillin 500 mg (antibiotic).</li> <li>*Thirty-eight tablets of venlafaxine 75 mg (anti-depressant).</li> <li>*Thirteen half-tablets of Quetiapine 25 mg (anti-psychotic).</li> <li>*Twenty-eight tablets of oxybutynin 10 mg (control bladder spasms).</li> <li>*An opened bottle of one-hundred tablets of meclizine 12.5 mg (control dizziness).</li> <li>*Four tablets of Norvir 100 mg (treat viral infections).</li> <li>*Multiple bottles of over-the-counter vitamins and stool softeners.</li> </ul> <p>Review of the provider's May 2012 Medication Destruction policy revealed unused, unwanted, and non-returnable medications would be "secured until destroyed." That policy did not address the need to be accountable for the name</p>	F 431			

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F 431	Continued From page 87	F 431	weekly for 4 weeks and monthly for 2	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	months.  Results of the audits will be reviewed at monthly QAPI meetings for further recommendations.	<i>DAISSD/HMF</i>

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F 441	Continued From page 88  This REQUIREMENT is not met as evidenced by: Surveyor: 28057  Surveyor: 26632 A. Based on observation, interview, and policy review, the provider failed to ensure: *Ten of eleven observed residents (8, 10, 11, 12, 14, 20, 24, 26, 27, and 28) who used oxygen had their oxygen cannulas stored in a sanitary manner when not in-use. *Two of two certified nursing assistants (CNA) (K and P) had disinfected one of two whirlpool tubs (East) and one of two showers (West) according to the policy. *Seventeen of seventeen residents' using oxygen concentrator had clean filters. *Three of three licensed nurses (H, R, and Q) had followed proper hand sanitizing procedures and had disinfected the glucose meter after each resident's use for eight of eight observed residents (2, 8, 13, 14, 29, 34, 35, and 36) with blood sugar checks. Findings include:  Survyor 28057 1a. Interview and observation on 3/25/15 at 9:30 a.m. with resident 20's daughter confirmed: *The resident had two oxygen cannulas. *One for her portable oxygen and one for the concentrator in her room. *She frequently found the resident's nasal canula that was not in-use at the time lying on the floor. *It would not be stored in a clean manner in the	F 441	<b>F 441 Infection Control, Prevent Spread, Linens</b>  The oxygen cannulas for residents 8, 10, 11, 12, 14, 20, 24, 26, 27 and 28 have been stored in a sanitary manner <i>* All JAKSDDOHMF</i> Oxygen concentrator filters have been cleaned  Residents residing in the facility have the potential to be affected in a similar manner  Executive Director, Director of Nursing and Interdisciplinary team have reviewed the Infection Prevention and Control Policy  CNA K and P has been reeducated with regard to whirlpool tub sanitation procedures  Licensed Nurses H and R have been reeducated with regard to hand washing and glucose meter sanitation after each use  Licensed Nurse Q is no longer employed at GLC Meadowbrook.	4/30/2015

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F 441	<p>Continued From page 89 bag available for storage.</p> <p>Surveyor 26632 b. Observation on 4/1/15 from 12:30 p.m. through 12:45 p.m. revealed residents 8, 10, 11, 12, 14, 24, 26, 27, and 28's nasal cannulas were all lying on the floor in their rooms. Those residents were at the noon meal.</p> <p>c. Interview on 4/1/15 at 4:15 p.m. with the west regional transitional leader/RN revealed they were aware nasal cannulas were not being put in the bags attached to the oxygen concentrators. She agreed those cannulas were being contaminated and could pose an infection risk to the residents.</p> <p>Surveyor: 32572 2. Observation and interview on 3/25/15 at 2:10 p.m. revealed CNA P had poured Classic Whirlpool Bathing Liquid Whirlpool Disinfectant Cleaner from a gallon container into a quart size spray bottle labeled Peroxide and Surface Glass Cleaner. She then demonstrated the shower cleaning technique by using that spray bottle. She let the disinfectant remain on the shower surface for five minutes when in fact the gallon label read to have the disinfectant remain on for ten minutes. She confirmed that was her usual practice.</p> <p>Observation and interview on 3/25/15 at 2:30 p.m. revealed CNA K had measured and poured two ounces of Classic Whirlpool Bathing Liquid Whirlpool Disinfectant Cleaner from the gallon container into the tub foot well. She then added additional water to "cover the jets." She stated covering the jets equaled six gallons. She stated that was her usual procedure.</p>	F 441			

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F 441	<p>Continued From page 90</p> <p>Observation in the bath areas on the east and west wings revealed a sign posted in the areas instructing staff members how to disinfect the tubs and showers appropriately. The posting stated to add two ounces/gallon of water. The posting also stated to "leave the solution [disinfectant] set for 10 minutes to disinfect."</p> <p>Interview on 3/25/15 at 3:10 p.m. with the interim director of nursing revealed the Tub Cleaning Procedure posting had been confusing as to how much of the concentrated disinfectant cleaning solution had to be added to the tub of water. She agreed the tub had not been disinfected properly. She also stated the spray container needed to reflect what was in the spray container.</p> <p>4. Random observations from 3/24/15 through 3/25/15 revealed seventeen residents' oxygen concentrator filters had approximately one-fourth inch gray debris on the filters. Interview with some of those random residents stated the filters were cleaned routinely by the certified nursing assistants (CNAs).</p> <p>Interview on 3/25/15 at 3:10 p.m. with the interim director of nursing confirmed the filters had been cleaned on a regular basis. But when examined they were visually dirty.</p> <p>Surveyor: 32573</p> <p>5. Observation on 3/24/15 at 5:40 p.m. in resident 2's room revealed: *Nurse Q entered the room to check her blood sugar. *She went into the bathroom and put on gloves. No handwashing had been performed. *She put the glucose meter down on the seat of</p>	F 441		

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F 441	<p>Continued From page 91</p> <p>the resident's wheeled walker.</p> <p>*She opened an alcohol wipe, wiped resident 2's finger and then set the alcohol wipe on the seat of the walker.</p> <p>*She tested the resident's blood sugar.</p> <p>*She then used that same wipe to clean resident 2's pricked finger.</p> <p>*She put the glucose meter in a small tray, removed her gloves, and left the room.</p> <p>*She had not been observed washing her hands after removing the gloves.</p> <p>*She had not been observed cleaning the glucose meter after use.</p> <p>Surveyor: 23059</p> <p>b. Observation on 3/25/15 beginning at 11:30 a.m. through 11:38 a.m. revealed RN H used a glucose meter to check the blood sugar level on five residents (8, 14, 29, 34, and 35). While checking those blood sugar levels RN H:</p> <p>*Did not wash her hands or use hand sanitizer before and after two of the above checks.</p> <p>*On one occasion used gloves that she had removed from her pocket.</p> <p>*Placed the glucose meter on residents' bedside tables or dining room tables with no barrier underneath.</p> <p>*Did not clean or disinfect the glucose meter between or after any resident.</p> <p>*Placed that uncovered glucose meter in a small basket full of alcohol swabs for storage.</p> <p>Interview with RN H after completion of those five testings revealed all of the above practices were her normal routine. She stated she had recalled education had been provided about disinfecting the glucose meter between residents. She stated she was unable to attend that educational meeting and had forgotten about the need to</p>	F 441			

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F 441	<p>Continued From page 92 disinfect the meter after each use.</p> <p>c. Observation on 3/25/15 beginning at 4:35 p.m. through 4:52 p.m. revealed LPN R used a glucose meter to check the blood sugar level on three residents (13, 35, and 36). While checking those blood sugar levels LPN R: *Did not wash her hands or use hand sanitizer before and after checks for two of the three above residents. *Placed the glucose meter on residents' bedside tables with no barrier underneath. *Wrapped the meter with a bleach wipe after each use. That wipe was not used to wipe down the meter. *Placed that wipe-covered glucose meter in a small basket full of alcohol swabs for storage.</p> <p>Interview with LPN R at that time revealed the above procedure was what they had been recently taught to do.</p> <p>d. Interview on 4/1/15 with the interim DON revealed it was her expectation the glucose meter should have been wiped with a bleach wipe after every use. She also confirmed hand hygiene should have been done before and after every glove use. She confirmed gloves were not a substitute for hand hygiene.</p> <p>Review of the provider's undated Caring for the Meter procedure revealed: *The glucose meter should have been cleaned and disinfected between each resident's use. *To disinfect the meter all external areas of the meter should have been wiped including both front and back surfaces until visibly wet. *The surface should have remained wet for one minute when using bleach wipes.</p>	F 441			

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F 441	Continued From page 93  Review of the provider's revised August 2014 Handwashing/Hand Hygiene policy revealed: *All personnel should have followed the hand washing/hand hygiene procedures to help prevent the spread of infection. *Hand hygiene products and supplies should have been readily accessible and convenient for staff use. *Alcohol based hand rub should have been used: -Before and after direct contact with residents. -After contact with a resident's skin. -After contact with blood. -After handling contaminated equipment. -After removing gloves. *The use of gloves did not replace handwashing/hand hygiene.  Surveyor: 20031 B. Based on observation and interview, the provider failed to maintain the following in a clean, cleanable manner, durable, and/or free of health hazards: *One of two isolation carts. *All sixty-nine residents' small plastic totes and containers in the bathrooms. *One of one mop sink/hand sink in the back room. Findings include:  1. Observation on 3/24/15 from 9:30 a.m. to 11:10 a.m. and again on 3/25/15 from 10:00 a.m. to 11:00 a.m. revealed the following: *The isolation cart in the west soiled utility room had a splatter of dark yellow dried drips and blotches. The splattered area was the size of a basketball, ranged in size from peas to dimes in appearance, and had run down the side of the cart.	F 441	*West isolation cart has been cleaned. JA/SDDOH/MF  *The plastic tote containers have all been cleaned. JA/SDDOH/MF  *The white cast iron sink is in the process of being replaced. JA/SDDOH/MF  *Housekeeping supervisor will complete 10 audits per week (5 on each half) times 4 weeks, then monthly times 2 months. The results will be reviewed at the monthly QAPI meetings for further recommendations. JA/SDDOH/MF	

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F 441	<p>Continued From page 94</p> <p>Interview with the maintenance manager and housekeeping supervisor at the time of the above observations confirmed that observation. The housekeeping supervisor stated his staff were not in charge of cleaning the isolation carts.</p> <p>Interview on that same day at 1:00 p.m. with CNA K revealed it was the housekeepers who would clean the isolation carts.</p> <p>2. The small plastic totes and containers used by the all sixty-nine residents and staff for storage of the residents' hygienic items (toothbrush, toothpaste, denture cleanser and brushes, combs, hair brushes, and creams/lotions) had layers of old crusted toothpaste, lotion, and other various unidentified substances on and in them.</p> <p>Interview with the maintenance manager and housekeeping supervisor at the time of the above observations confirmed those observations. The housekeeping supervisor stated his staff were not in charge of cleaning and disinfecting resident's personal use items.</p> <p>3. The large white cast iron sink in the back room was surrounded by old gray raw wood that had been stained by mop water splash and spill. The surveyor, maintenance manager, and housekeeping supervisor could not tell if the white sink and surrounding wooden area was stained a brownish tan, or was that dirty and appeared to be a brownish tan in color. That sink also had a paper towel and soap dispensers.</p> <p>Interview with the maintenance manager and housekeeping supervisor at the time of the observation confirmed that sink was also used as</p>	F 441			

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F 441	Continued From page 95	F 441	Staff has been educated with regard to oxygen cannula storage, whirlpool tub sanitizing procedure, oxygen concentrator filter cleaning, glucose meter sanitizing and proper hand washing		
F 490 SS=J	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: 23059  Surveyor: 32572 Based on record review, observation, interview, and job description review, the provider failed to ensure the facility was operated and administered in a manner that attained or maintained the highest practicable physical, mental, and psychosocial well-being for all sixty-nine residents residing in the facility. Findings include:  Surveyor 23059: 1. Review of the provider's letters of notification to the South Dakota Department of Health of administrative changes revealed: *Effective 8/15/14 a new executive director (ED) had been named. *Effective 3/6/15 an interim ED was named. That ED was also the permanent administrator at another nursing home within the community. *Effective 3/23/15 a new interim ED was named until a permanent ED could be hired. *Effective 2/27/15 a new interim director of	F 490	The DNS or designee will audit oxygen cannula storage weekly for 4 weeks and monthly for 2 months.  The DNS or designee will audit whirlpool tub sanitizing procedure weekly for 4 weeks and monthly for 2 months.  The DNS or designee will audit concentrator filter monthly for 3 months.  The DNS or designee will audit glucose meter sanitizing and proper hand washing weekly for 4 weeks and monthly for 2 months.  The DNS or designee will report the audits to the QAPI committee monthly. Results will be reviewed at QAPI meetings for further recommendations.		

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F 490	<p>Continued From page 96 nursing services had been named.</p> <p>Interview on on 4/1/15 at 1:25 p.m. with the West regional transitional leader confirmed there had been a lack of continuity in leadership positions within the facility. She confirmed that would have the potential to lead to a breakdown in communication for staff.</p> <p>Surveyor 32572: 2. Interview on 3/24/15 at 7:45 a.m. with the interim administrator revealed he had arrived at this current position at the facility on 3/18/15. He was new to the facility.</p> <p>Review of the provider's 3/26/14 job description for Executive Director Temporary (Administrator) revealed: *The general purpose was "To lead and direct the overall operations of the facility in accordance with customer needs, government regulations and Company policies, with focus on maintaining excellent care for the residents/patients while achieving the facility's business objectives." *Some of the Essential Job Duties were: -"Leads the facility management staff and consultants in developing and working from a business plan that focuses on all aspects of facility operations, including setting priorities and job assignments." -"Oversees regular rounds to monitor delivery of nursing care, operation of support departments, cleanliness and appearance of the facility; moral of the staff; and ensures resident needs are being addressed." -"Maintain a working knowledge of and ensure compliance with all governmental regulations." -"Promote and understanding of compliance with all rules regarding resident's rights; promote</p>	F 490			

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F 490	<p>Continued From page 97</p> <p>positive relationships with residents, visitors and regulators, to include presenting a professional appearance and attitude."</p> <p>Review of the provider's 10/15/14 job description for Director of Nursing Services Temporary (DON) revealed:</p> <p>*The general purpose was to: "Plan, coordinate and manage the nursing department. Responsible for the overall direction, coordination and evaluation of nursing care and services provided to residents. Maintains quality care that is consistent with company regulatory standards. Assumes responsibilities of daily operations in the absence of the Executive Director."</p> <p>*Some of the essential job duties were:</p> <p>-"Oversees the nursing staff for the provision of quality and appropriate resident/patient care that meets or exceeds company and regulatory standards."</p> <p>-"Hires nursing staff, oversee the provision of orientation/training by a qualified Director of Education and retains qualified staff to carry out nursing programs and services. Reviews employee performance and conducts periodic performance appraisals timely."</p> <p>-"Develops and implements the written staffing plan and nursing schedule that reflects the needs of the resident and patient population."</p> <p>-"Manages clinical aspects of state or federal government survey processes."</p> <p>The following deficiencies had been cited for the current licensure survey: F157, F164, F165, F223, F224, F241, F246, F248, F252, F253, F280, F281, F314, F323, F431, F441, F490, F494, F514, and F520.</p> <p>Review of the last licensure survey completed on</p>	F 490			

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F 490	Continued From page 98 2/12/14 revealed the following deficiencies had been cited and were being recited: F280, F281, and F441.	F 490	<b>F 490 Effective Administration/resident Well Being</b>	<i>4/30/2015</i>
F 493 SS=J	Review of a previous licensure survey completed on 1/16/13 revealed the following deficiencies were being recited: F157, F281, and F431. <b>483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN</b>  The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility  This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation and record review, the governing body failed to ensure the facility was administered in a manner that ensured the safe management and overall well-being for all sixty-nine residents in the facility. Findings include:  1. The following deficiencies had been cited for the current survey: F157, F164, F165, F223, F224, F241, F246, F248, F252, F253, F280, F281, F314, F323, F431, F441, F490, F494, F514, and F520.  2. Review of the last licensure survey completed	F 493	The facility is unable to correct past administrative changes  Residents residing in facility have the potential to be affected in similar manner.  The facility is administered in a manner that enables it to use its resources effective 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 QAPI <i>x monthly</i> meetings for further recommendations. <i>JANISDAH/MF</i>	

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F 493	Continued From page 99 on 2/12/14 revealed the following deficiencies had been recited: F280, F281, and F441.  3. Review of a previous licensure survey on 1/16/13 revealed the following deficiencies had been recited: F157, F281, and F431.  Surveyor: 28057 4. Interview on 4/1/15 at 5:10 p.m. with the field services clinical director confirmed: *The governing body had been involved during the transition period after the former administrator and director of nursing terminated their employment at the facility. *The governing body had been actively involved since 3/2/15. *There had been onsite clinical and operational visits weekly since that date. *Extra support had been provided to the facility by the governing body. *Areas of concern had been identified. *Those areas had been staffing, skin issues, falls, and documentation. *Other areas had been identified that she could not recall at that moment. *Inservices had been held for the frontline staff. *No documentation was offered for review of the above support given the facility.	F 493	<b>F 493 Governing Body - Facility Policies/appoint Admn</b>  The facility is unable to correct past administrative changes  Residents residing in facility have the potential to be affected in similar manner.  The facility has a governing body or designated persons functioning as a governing body that is legally responsible for establishing and implementing policies regarding the management and operation of the facility.  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.	4/30/2015	
F 494 SS=D	483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY  A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program	F 494	Results will be reviewed at QAPI <sup>*monthly</sup> meetings for further recommendations. <i>JA/SOLO</i>	4/30/2015	

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F 494	<p>Continued From page 100</p> <p>approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b).</p> <p>A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section.</p> <p>Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review, interview, and policy review, the provider failed to ensure one of one sampled nursing assistant (NA) E who had failed her certification test had not been allowed to work as a certified nursing assistant (CNA) independently past the four months allowed by regulation. Findings include:</p> <p>1. Review of NA E's personnel record revealed she had been hired on 11/11/14 as a NA. She had completed the certification test but had failed it. No date of that testing was found in her personnel record. She had been allowed to continue to work as a NA independently after failing her certification testing beyond the four month restriction.</p>	F 494		
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F 494	Continued From page 101 Review of a 3/22/15 request for an extension of CNA training and testing from the interim administrator revealed NA E had not been included in the list of employees granted the extension. The requirements for the extension stated the employees on the list could not work independently in the NA role while awaiting successful completion of the training and testing process.  Interview on 3/31/15 at 12:40 p.m. with the west regional transitional leader confirmed NA E: *Had not been included on the extension list of approval. *Had been working independently as a NA. *Had not passed her certification test. *Had been employed for over four months.  Review of the provider's 12/18/14 Professional License and Certification Tracking policy revealed: *The administrator or designee would enter the certification numbers and expiration dates in PeopleSoft (provider tracking computer program). *The administrator would ensure the individual assigned the tasks underwent the proper training. *The administrator would remain responsible for the process and would monitor the licensure and certification component of the individual's job duties to ensure completion.	F 494	F 494 Nurse Aide Work > 4 mo - Training/competency  Nurse Aide E is no longer employed at GLC Meadowbrook.  The nurse aides currently working in the facility have been granted extension of CNA training and testing and will be tested within the required time frame.  Residents residing in the facility have the potential to be affected in a similar manner.  The HR Generalist will monitor all nurse aide training and testing requirements monthly for 3 months. Results will be reviewed at QAPI meetings for further recommendations. <i>*1 MONTHLY QAPI/SDS/CHIME</i>	4/30/2015	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and	F 514			

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F 514	<p>Continued From page 102 systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on record review, guideline review, and interview, the provider failed to ensure complete and accurate documentation was maintained for: *One of one sampled resident (22) with complaints of urinary tract infection (UTI) symptoms. *One of one sampled resident (17) who was discharged against medical advice (AMA). *One of twenty-three sampled resident's (6) evaluation of communication status. *One of two sampled resident's (7) daily fluid restriction. Findings include:</p> <p>1. Interview on 3/24/15 at 4:20 p.m. with resident 22 revealed she had a UTI "and they [staff] refuse to do anything about it."</p> <p>Review of a 3/1/15 facsimile (fax) sent to her physician revealed resident 22 had complained of burning with urination. She also had complained of lower abdominal pain and her urine had an odor to it. The physician had ordered on 3/3/15 to obtain a urinalysis (u/a) and a culture and sensitivity (C&amp;S) (test to see what antibiotic would work best).</p>	F 514	<p>F 514 Res Records- Complete/accurate/accessible</p> <p>Resident 22 was assessed and determined to have increased urinary frequency and urine odor. Primary Care Physician ordered laboratory testing of the urine and antibiotic treatment for signs and symptoms of a urinary tract infection.</p> <p>Resident 17 left the facility Against Medical Advice (AMA) and no longer resides in the facility.</p> <p>* [REDACTED] JAL/SJDC/IME</p> <p>Resident 6 Cognitive Patterns Assessment had been corrected to reflect resident status</p> <p>Resident 7 Medication Administration Record (MAR) recording of fluid intake cannot be historically corrected. Fluid intake is now recorded on the MAR.</p> <p>Residents residing in the facility have the potential to be affected in a similar manner</p>	4/30/2015

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F 514	<p>Continued From page 103</p> <p>Review of resident 22's 2/26/15 through 3/31/15 nurses' progress notes revealed there was nothing noted regarding the resident's symptoms of a UTI. A 3/1/15 behavioral note indicated the resident stated "she had a bladder infection and no one is doing anything about it."</p> <p>Review of resident 22's medical record revealed a u/a had been obtained on 3/4/15. That u/a showed abnormalities. Those results were faxed to the physician with a note stating "C&amp;S pending." No results of a C&amp;S were found within the medical record.</p> <p>Interview on 3/31/15 at 1:45 p.m. with registered nurse (RN) M revealed she had contacted the laboratory (lab) that had tested resident 22's urine. She stated they told her the C&amp;S had not been done because it had not been requested on the lab order slip.</p> <p>Review of the resident's medical record revealed there was no further follow-up on the u/a lab results. There was no documentation to indicate the physician had been notified the C&amp;S had not been completed as ordered. No documentation could be found to indicate her symptoms had resolved or were ongoing.</p> <p>Interview on 3/31/15 at 4:55 p.m. with licensed practical nurse R revealed she was very familiar with resident 22. She stated she often complained of symptoms of a UTI but then would deny she had any complaints. She stated she was aware she had recently complained of those symptoms. She stated "I'm sure there was a fax from the doctor saying we didn't need to do anything about it."</p>	F 514		

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PRINTED: 04/14/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435051</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/01/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - MEADOWBROOK</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 ARROWHEAD DR RAPID CITY, SD 57702</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 514	<p>Continued From page 104</p> <p>Interview on 4/1/15 at 12:20 p.m. with the interim director of nursing (DON) revealed she expected documentation to address residents' concerns and resolution. She confirmed no documentation could be found in the progress notes regarding ongoing concerns or resolution to resident 22's complaints of UTI symptoms. She also confirmed no documentation could be found to verify the physician had indicated nothing further needed to be done.</p> <p>Review of the provider's undated Clinical Health Status - Change of Condition Guideline revealed the process for identification of a change in condition included: *Gathering objective data. *Documenting assessment findings, resident response, physician and family notification.</p> <p>Surveyor: 26632 2. Review of resident 17's medical record revealed: *She had been admitted on 9/25/14 for rehabilitation therapy after a left knee joint replacement. *She was discharged AMA on 9/28/14 at 4:06 p.m. *A release of responsibility for AMA discharge had been signed by her husband and the director of nursing service on 9/28/14. *Review of the interdisciplinary progress notes revealed no documentation resident <del>physician</del> physician <i>*17 JAKSDOCHIME</i> had been made aware of the AMA discharge. *Review of the interdisciplinary progress notes regarding resident <del>also revealed she:</del> <i>*17 JAKSDOCHIME</i> -Had confusion to time and place. -Required assistance with transfers from wheelchair to other surfaces (bed, toilet, and</p>	F 514		

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F 514	<p>Continued From page 105 reclining chair). -Was not able to ambulate independently. -Had a urinary catheter (tube in bladder to drain urine). -Had received narcotic pain medication. *No documentation of why resident 3 discharged AMA.</p> <p>Interview on 4/1/15 at 3:30 p.m. with the interim director of nursing (DON) revealed: *She had not been the DON when resident 3 had been admitted or discharged. *She agreed resident 17's physician should have been notified of her AMA discharge. *She agreed the documentation in the interdisciplinary notes did not reflect why resident 3 had discharged AMA.</p> <p>Review of the provider's 11/12/14 Notification of Change in Resident Health Status policy revealed: *The center would consult the resident's physician when there was a decision to discharge a resident. *The appropriate notification time was listed as immediate.</p> <p>Surveyor: 32572 3. Review of resident 6's medical record revealed: *A 3/19/15 Cognitive Patterns Assessment stated the assessment should not have been attempted, because the resident was "non verbal." The words "non verbal" had been hand written in. *The 12/22/14 Minimum Data Set (MDS) assessment revealed in the area B0600 Speech Clarity it had been coded as a 0 (speech was clear and understandable).</p>	F 514		

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F 514	Continued From page 106 Interview on 3/24/15 at 3:15 p.m. with resident 6 revealed she was able to answer yes and no questions appropriately.  Interview on 3/25/15 at 3:15 p.m. with the interim director of nursing confirmed resident 6 had been able to answer yes and no questions. The above assessments had not been accurate.  Surveyor: 32573 4. Review of resident 7's complete medical record revealed: *A 6/19/14 physician's order for fluid restriction to be monitored every shift (three times a day). *Her March 2015 medication administration record (MAR) revealed there were eight shifts that had not monitored her fluid intake (3/6, 3/13, and 3/20 day shifts; 3/22 and 3/23 evening shifts; 3/10, 3/11, and 3/22 night shifts). *The March 2015 nursing progress notes had not addressed the blanks in the MAR.  Interview on 4/1/15 at 1:00 p.m. with the interim director of nursing revealed she had implemented a policy for staff to look at the MARs before counting medications because she had noticed a lot of holes [blank areas] in the MARs when she had reviewed them.	F 514	✓ Nursing staff have been reeducated in regard to accurate, complete and concise documentation in the medical record *All JASDDOH/MF The Director of Nursing or designee will audit 5 medical records weekly x 4 weeks then monthly x 2 months to ensure resident's accurate documentation. Results will be reviewed at QAPI meetings for further recommendations. *Monthly JASDDOH/MF		
F 520 SS=J	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  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.	F 520			

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F 520	Continued From page 107  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.  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.  Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.  This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on record review, interview, and policy review, the provider failed to ensure an effective quality assurance and performance improvement (QAPI) program had been maintained to: *Review residents' 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 of residents. *Discuss new and old policies and procedures. *Discuss the monthly pharmacist reports. *Discuss incident and safety reports. *Discuss staff concerns and needs. Findings include:  1. Review of the provider's QAPI meeting minutes	F 520	F 520 QAA Committee-Members/Meet Quarterly/Plans  The facility is unable to correct past administrative processes  Residents residing in facility have the potential to be affected in similar manner.  Executive Director, Director of Nursing, Medical Director and Interdisciplinary team have reviewed the Quality Assurance and performance improvement policy <i>*reported JASDDH/MF</i> 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 <i>*reported JASDDH/MF</i> admissions and discharges, discuss new <i>*reported JASDDH/MF</i> and old policies and procedures, discuss monthly pharmacist reports, discuss <i>*reported JASDDH/MF</i> incident and safety reports, discuss staff concerns and needs.	4/30/2015	

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F 520	<p>Continued From page 108</p> <p>from December 2014 through the survey dates revealed the QAPI committee had identified areas based off reports run by members of the committee. There had been no notes explaining what QAPI activities had been done, their effectiveness, and if corrective action had been taken if they were not successful.</p> <p>Interview on 3/31/15 at 10:00 a.m. with the interim administrator revealed: *He was the responsible party for QAPI. *The QAPI committee met monthly and included himself, the interim director of nursing (DON), the medical director, and other department supervisors. *They followed the facility's policy for QAPI. *Issues were brought up the following month to see if they had improved from the previous meeting. *The monthly resident council meeting minutes were not reviewed for issues.</p> <p>Interview on 3/31/15 at 10:00 a.m. with the DON revealed she had started doing internal audits. Staff were informed about QAPI topics through morning staff meetings.</p> <p>Interview on 3/31/15 with certified nursing assistant (CNA) G revealed she had not been familiar with QAPI activities or the process.</p> <p>Interview on 4/1/15 with nurse F revealed she had not been familiar with anything for QAPI. She thought maybe staff could go to morning meetings to learn more about it.</p> <p>Review of the August 2014 QAPI Committee Guideline revealed five steps used to review</p>	F 520	<p><b>Staff members have been reeducated on the QAPI process</b></p> <p><b>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.</b> * <i>MONTHLY</i> <i>JAKSDDHMF</i> <b>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.</b></p>	

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F 520	<p>Continued From page 109 operations, identify opportunities for improvement, prioritize them, determination of root cause (determining factor[s]), and implementation of performance improvement projects. There had been no evidence all the above steps had been done.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, MO., 2005, p. 365, revealed: "...organizations must be responsible and accountable for evaluating and improving the quality of client care services being provided to all clients. This requires health professionals at all levels to critically evaluate their practices, to incorporate the latest scientific findings into client care, and to measure the success of meeting client outcomes on an ongoing basis."</p> <p>Refer to: F157, F164, F165, F223, F224, F241, F246, F248, F252, F253, F280, F281, F323, F431, F441, F490, F493, F494, and F514.</p>	F 520			

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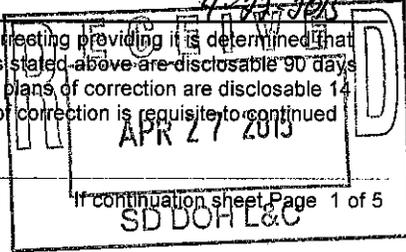
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K 000	<p><i>Addendums noted with an asterisk per 44115 telephone to facility administrator. CHRIS DOBSON</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/24/15. Golden LivingCenter - Meadowbrook was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of the deficiencies identified at K018, K025, and K029 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	<p>STATEMENT OF COMPLIANCE: The following represents the plan of correction for the alleged deficiencies cited during the survey that was conducted on April 1, 2015. Please accept this plan of correction as the living center's Credible Allegation of Compliance with the completion date of April 30, 2014. 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.</p> <p><b>K018</b> Resident room doors #1 and #25 were removed, outer edges sanded, re-hung and latch adjusted.</p> <p>All resident room doors were audited and necessary repairs or adjustments made to ensure the doors close and latch properly.</p>	
K 018 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p>	K 018		4/30/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Robert H. M... [Signature]</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4-27-2015</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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K 018

Continued From page 1

This STANDARD is not met as evidenced by:  
Surveyor: 18087  
Based on observation and interview, the provider failed to maintain corridor separation from use areas with doors capable of resisting the passage of smoke at 2 of 16 smoke compartment doors (resident rooms 1 and 25). Findings include:

1. Observation at 3:30 p.m. on 3/24/15 revealed the corridor door for resident room 1 in the east wing would not fully close and latch into the frame. Further observation of other resident room corridor doors in the east wing revealed the door for room 25 also would not close and latch into the frame. Interview with the maintenance supervisor at the time of the observation confirmed those findings. He indicated the wood doors were affected by the recent humidity and needed to be planed/adjusted in order to close and latch into the frames.

K 018

All resident have the potential to be affected.

Resident room doors will be checked monthly in the preventative maintenance schedule and reported to the Quality Assurance Performance Improvement committee for 2 months.

*\*The maintenance supervisor will report the auditing results to the QAPI. CH/SDDH/MF*

K 025  
SS=D

The deficiency affected two of numerous locations required to be equipped with a smoketight corridor door.

**NFPA 101 LIFE SAFETY CODE STANDARD**

Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems.

K 025

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K 025	Continued From page 2 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4  This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain the thirty minute fire resistive rating of smoke barrier walls. One of two smoke barrier walls (west wing from the lobby) had unsealed openings around several penetrations above the ceiling. Findings include:  1. Observation at 2:30 p.m. on 3/24/15 revealed the smoke barrier wall between the west wing and the lobby/central core area had unsealed openings around a 3 inch diameter sprinkler pipe penetration above the corridor lay-in ceiling: *Around a 3/4 inch flexible conduit on the west side of the wall. *At a 3 inch diameter hole in the gypsum board on the west side of the wall. *At a nurse call receptacle cover plate on the east side of the wall. Those unsealed penetration openings were all above the lay-in ceiling in the corridor.  Interview with the maintenance supervisor at the time of the observations confirmed those findings. He stated the contractor must not have finished sealing the wall after installing the new materials.  This deficiency could potentially affect all sixty-eight residents of the facility.	K 025	<b>K025</b> Smoke barrier penetrations for the west wing will be sealed with Flame Stopper 5000 retardant silicone on March 25, 2015.  All smoke barriers were checked by the Maintenance Supervisor for penetrations and penetrations sealed by March 26, 2015. All resident have the potential to be affected.  Smokes barriers will be examined by the Maintenance Supervisor, for penetrations following contractor work involving any smoke barrier walls.  Completion of all smoke barriers checks will be reported to the Quality Assurance Performance Improvement committee.  <i>*The Maintenance Supervisor will check the smoke barriers after contractor work. He will report the auditing results to QAPI. CHISSON/ME</i>	4/30/2015
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour	K 029		

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K 029	<p>Continued From page 3</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain proper separation of four of seven hazardous areas (kitchen pantry, hall closet in east wing, hall closet in west wing, and activities storage). Findings include:</p> <ol style="list-style-type: none"> <li>1. Observation beginning at 1:30 p.m. on 3/24/15 revealed the kitchen pantry storage room was over 100 square feet in area. Neither of the two doors were equipped with self-closing devices.</li> <li>2. Observation beginning at 1:45 p.m. on 3/24/15 revealed a hall closet adjacent to resident room 20 in the east wing was used for storage of large amounts of cardboard boxes with medical records. Further observation revealed a hall closet in the west wing adjacent to resident room 40 was used for storage of large amounts of cardboard boxes of medical records. The doors were not provided with self-closing devices.</li> <li>3. Observation at 2:00 p.m. on 3/24/15 revealed the activities office/storage room held a large</li> </ol>	K 029	<p>K029</p> <p>Self closing devices were installed on the kitchen pantry, fall closet in east wing, hall closet in west wing and activities storage by April 14, 2015</p> <p>All storage areas greater than 100 square feet were audit with closures installed where indicated by April 15, 2015.</p> <p>All resident have the potential to be affected.</p> <p>Maintenance Supervisor or designee will review all storage areas annually to ensure proper door closures are in use.</p> <p>Completion of all door closure work and storage area closures will be reported to the Quality Assurance Performance Improvement committee for review.</p> <p><i>*The maintenance supervisor will report the auditing results to the QAPI.</i> CHSDDOH/ME</p>	4/30/2015
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NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - MEADOWBROOK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 ARROWHEAD DR RAPID CITY, SD 57702</b>
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K 029	<p>Continued From page 4</p> <p>amount of combustibles. The corridor door was not provided with a self-closing device.</p> <p>4. Interview with the maintenance supervisor at the times of the observations confirmed those findings. Doors to hazardous areas are required to be self-closing.</p> <p>The deficiency affected requirements for providing separation of hazardous areas.</p>	K 029		
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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10668</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/01/2015</b>
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S 000	<p>Initial Comments</p> <p>Surveyor: 18087</p> <p>A extended licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, medical facilities, requirements for nursing facilities, was conducted from 3/24/15 through 3/25/15 and from 3/31/15 through 4/1/15. Golden LivingCenter - Meadowbrook was found not in compliance with the following requirements: S124, S210, and S236.</p>	S 000	<p><b>STATEMENT OF COMPLIANCE:</b> The following represents the plan of correction for the alleged deficiencies cited during the survey that was conducted on April 1, 2015. Please accept this plan of correction as the living center's Credible Allegation of Compliance with the completion date of April 30, 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.</p> <p><b>S 124 Cleaning Methods and Facilities</b></p> <p>Cleaning for residents with a diagnosis of Clostridium difficile (C.diff) will be completed using the HCSC cleaning policy.</p> <p>Residents residing in the facility have the potential to be affected in a similar manner.</p>	
S 124	<p>44:04:02:03 CLEANING METHODS AND FACILITIES</p> <p>The facility must have equipment, work areas, and complete written procedures for cleaning, sanitizing, disinfecting, or sterilizing all work areas, equipment, utensils, dressings, medical devices, and solutions used for residents'...care. Common use equipment shall be disinfected or sterilized after each use. ...Nursing facilities must have separate clean and soiled utility rooms.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 26632 Based on interview and policy review, the provider failed to ensure all housekeeping personnel were aware of the correct chemicals to use to decrease the possibility of spreading contagious diseases (causing infection). Findings include:</p> <p>1. Interview on 3/31/15 at 12:40 p.m. with the housekeeping manager revealed: *When a resident had a diagnosis of clostridium difficile (infection of the bowel) (C-Diff) the surfaces were first cleaned with a bleach solution "To open up the spores (hard to kill infection)."</p>	S 124		4/30/2015

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

TITLE

*Robert D. Medema*

*Administrative*

STATE FORM

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10668</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/01/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - MEADOWBROOK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 ARROWHEAD DR RAPID CITY, SD 57702</b>
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S 124	<p>Continued From page 1</p> <p>*After the bleach solution a quaternary disinfectant (used to kill infections) was used to disinfect the surfaces. *The above were instructions he had received from his supervisor.</p> <p>Review of the provider's revised August 2014 Cleaning and Disinfection of Resident-Care Items and Equipment policy revealed: *Quaternary disinfectants were used for non-critical items ("resident-care items include bed pans, blood pressure cuffs, crutches and computers"). *There was no information on how to clean for specific hard to kill infections.</p> <p>Review of the provider's undated Contracted Healthcare Services Group Housekeeping in-service for C-Diff revealed: *To use an "EPA (environmental protection agency) approved solution (e.g. [for example] Ultra Clorox Disinfectant 1:10 [one part Clorox to ten parts water] bleach solution." *There was no mention of using a quaternary disinfectant after using the bleach solution.</p>	S 124	<p>Housekeeping staff have been re-educated related to the C. Diff cleaning procedure</p> <p>Housekeeping supervisor will audit the C. Diff cleaning procedure 3 times weekly for 4 weeks and monthly for 2 months, if there is a resident with a C.diff diagnosis. Results will be reported to the QAPI committee for</p> <p><i>*monthly JAKSDOCHIME further review and recommendations. JAKSDOCHIME</i></p>	
S 210	<p>44:04:04:06 EMPLOYEE HEALTH PROGRAM</p> <p>The facility must have an employee health program for the protection of the...residents. All personnel must be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of</p>	S 210		<p><i>* JAKSDOCHIME</i></p>

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S 210	Continued From page 2  communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease which may endanger the health of...residents and fellow employees may not return to duty until they are determined by a physician or the physician's designee to no longer have the disease in a communicable stage.  This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 26632 Based on employee file review, interview, and policy review, the provider failed to ensure three of five sampled new employees (A, C, and D) were evaluated by a health professional for freedom from communicable diseases. Findings include:  1. Review of employees A, C, and D's personnel files revealed; *They had all been hired within the past four months. *Employees A and C had no record of a health evaluation. *Employee D had filled out a health evaluation, but a health professional had not reviewed and signed it.  Interview on 4/1/15 at 3:00 p.m. with the interim director of nursing confirmed the above findings.  Review of the provider's 12/18/14 Infection Control Policy revealed no information on a health evaluation for new employees.	S 210	<b>S 210 Employee Health Program</b>  Health evaluations have been completed for employees A, C and D.  Employee files have been audited for the inclusion of Health Evaluations. If indicated, Health Evaluations will be completed  Residents residing in the facility have the potential to be affected in a similar manner  HR Generalist has been educated on the Health Evaluation requirements for all employees  The HR Generalist will audit all new hire records monthly for 3 months. The results of the audit will be reported to the QAPI for [redacted] for further review and recommendations. <i>*monthly</i> JAKSDDH/MF	4/30/2015
S 236	44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS	S 236		

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RAPID CITY, SD 57702**

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S 236	<p>Continued From page 3</p> <p>Tuberculin screening requirements for healthcare workers or residents are as follows:</p> <p>(1) Each new healthcare worker or resident shall receive the two-step method of Mantoux skin test to establish a baseline within 14 days of employment or admission to a facility. Any two documented Mantoux skin tests completed within a 12 month period prior to the date of admission or employment shall be considered a two-step. Skin testing is not necessary if documentation is provided of a previous positive reaction of ten mm induration or greater. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32572 Based on record review, interview, and policy review, the provider failed to ensure tuberculin (TB) testing had been completed and results recorded within fourteen days for: *Three of five sampled employees (A, B, and D). *Seven of nine sampled residents (1, 2, 3, 4, 8, 9, and 12). Findings include:</p> <p>1. Review of resident 8's medical record revealed she had been admitted on 3/21/14. She had received the first step of a two-step TB Mantoux skin test on 3/22/14. The results of that testing had not been documented. There had been no documentation in either the electronic or paper medical record of any other TB Mantoux skin</p>	S 236	<p><b>S 236 Tuberculin Screening Requirements</b></p> <p>Resident 8, 4, 1, 3, 9, 12, and 2 have received the 2 step TB skin test with documentation in the medical record.</p> <p>Employees A, B and D have received the 2 step TB skin test with documentation in the employee health record.</p> <p>Resident records will be audited for appropriate TB testing and will have testing completed according to findings of the audit.</p> <p>All employee records will be audited for appropriate TB testing and testing completed according to findings of the audit.</p> <p>Residents and staff have the potential to be affected in a similar manner.</p> <p>HR Generalist will be reeducated with regard to the TB testing requirement for employees Licensed Nurses will be reeducated with regard to the TB testing requirement for residents</p>	4/30/2015

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S 236	<p>Continued From page 4 tests having been completed.</p> <p>Surveyor: 20031 2. Review of resident 4's medical record revealed he had been admitted on 10/3/14. There had been no documentation of the administration of the two-step TB test upon admission.</p> <p>Interview on 3/24/15 at 2:55 p.m. with registered nurse (RN) L confirmed a two-step TB test was required when a resident had been admitted. She also confirmed she was not able to find a TB test documented for resident 4.</p> <p>Surveyor: 28057 3. Review of resident 1's medical record revealed he had been admitted on 1/8/15. He had received the first step of a two-step TB Mantoux skin test on 5/3/14. There had been no documentation of any other TB Mantoux skin tests having been completed.</p> <p>Interview on 3/25/15 at 3:55 p.m. with RN L confirmed a two-step TB Mantoux skin test was required when a resident had been admitted.</p> <p>Interview on 3/25/15 at 5:10 p.m. with RN L confirmed she had not been able to find a second step Mantoux TB test documented for resident 1.</p> <p>Surveyor: 23059 4. Review of resident 3's medical record revealed he had been admitted on 9/25/14. Review of his immunization record revealed no documentation a two-step TB skin test had been done. Review of his September and October 2014 medication administration records (MAR) revealed documentation the above skin test had been completed. No results of that skin test had been documented.</p>	S 236	<p><b>HR Generalist will audit all new hires for one month and randomly select 5 new hires to audit each month for 2 months.</b></p> <p><b>The DNS or designee will audit all new admissions for one month and select 5 new admissions to audit each month for 2 months. The audits will be presented to QAPI for [redacted] *further recommendations.</b></p> <p><i>*monthly JA/SDDH/MF</i></p> <p><i>*further recommendations. JA/SDDH/MF</i></p>	
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S 236	<p>Continued From page 5</p> <p>5. Review of resident 9's medical record revealed she had been admitted on 7/30/14. No documentation was found on her immunization record or MAR to confirm TB skin testing had been done. There had been no documentation in either the electronic or paper medical record of any other TB skin tests having been completed.</p> <p>Interview on 3/25/15 at 3:40 p.m. with RN L confirmed no documentation could be found regarding the results of resident 3's TB skin tests. She also confirmed no documentation could be found to indicate resident 9 had TB skin testing completed within fourteen days of admission.</p> <p>Surveyor: 32573</p> <p>6. Review of resident 12's medical record revealed she had been admitted on 3/16/14. She had received the first step of a two-step TB Mantoux skin test on 3/27/15. There had been no documentation a two-step TB test had been done previously.</p> <p>7. Review of resident 2's medical record revealed she had been admitted on 9/10/14. There had been no documentation in either the electronic or paper medical record of any TB Mantoux skin tests having been completed.</p> <p>Surveyor: 26632</p> <p>7. Review of employees A, B, and D's personnel records revealed: *Employee A had been employed on 2/20/15. Her TB testing had started on 3/30/15. *Employee B had been employed on 12/3/14. There was no record of any TB testing. *Employee D had been employed on 2/4/15. Her TB testing had started on 3/26/15.</p>	S 236		

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S 236	Continued From page 6  8. Interview on 4/1/15 at 3:00 p.m. with the interim DON confirmed the above findings.  Surveyor 32572: Review of the provider's 12/01/14 Tuberculosis Infection Control Program policy revealed: *A policy statement of "The facility recognizes that tuberculosis (TB) transmission has been identified as a risk in healthcare settings. To try to prevent nosocomial [infection acquired within the building] transmission of TB, our facility has instituted a Tuberculosis Infection Control Program." *The "Assignment of responsibility for the oversight of TB infection control to the Infection Control Committee." *There were no time frames within the policy stating when the TB testing needed to occur or how the documentation should have been done.	S 236		