

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

**ORIGINAL**

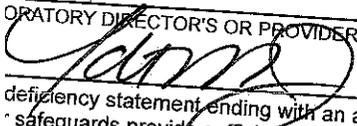
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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - PRAIRIE HILLS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 26632 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/10/15 through 2/12/15 and 2/17/15 through 2/19/15. Golden LivingCenter - Prairie Hills was found not in compliance with the following requirements: F176, F221, F241, F273, F278, F280, F281, F309, F314, F315, F323, F441, F464, F490, F514, and F520.</p>	F 000		
F 176 SS=E	<p><b>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</b></p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, interview, record review, and policy review, the provider failed to ensure four of four randomly observed residents (11, 15, 23, and 26) with medications at their bedside had been assessed and determined to be safe to self-administer medications according to the policy. Findings include:</p> <p>1. Observation on 2/10/15 at 8:30 a.m. revealed: *Resident 11 had unidentified medications (meds) in a med cup sitting on her breakfast room tray. There had also been an advair diskus (used for asthma or chronic obstructive pulmonary disorder [COPD]) inhaler and Fluticasone (used for allergies) nasal spray sitting on that breakfast</p>	F 176	<p>Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.</p>	3/21/15
			<p><b>F 176</b></p> <p>1. No immediate action could be taken for residents # 11, 23, 26 and 15. Residents residing in the facility who desire to self administer medications will have an evaluation completed to determine if they meet the safety criteria to self administer medications. * See page 2. KW/SDDOH/MF</p>	

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Executive Director</b>	(X6) DATE <b>03/05/2015</b>
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deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 am participation.

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F 176	<p>Continued From page 1 tray.</p> <p>-There had not been a nurse or a medication aide in that room.</p> <p>*Resident 23 had unidentified medications in a med cup sitting on her breakfast room tray. There also had been a Spiriva (used for COPD) inhaler sitting on that breakfast tray.</p> <p>-There had not been a nurse or a medication aide in that room.</p> <p>Review of the medical records revealed: *Resident 11 had been evaluated for medication self-administration on 1/26/15. -She had been determined "unable to safely self-administer medications." *Resident 23 had been evaluated for medication self-administration on 1/26/15. -She had been determined "unable to safely self-administer medications."</p> <p>Review of the Admission Clinical Health Status assessment revealed: *The 1/22/15 assessment for resident 23 revealed no answer documented if the resident requested to self-administer medications. *The 1/23/15 assessment for resident 11 revealed the resident had not requested to self-administer medications.</p> <p>Surveyor: 35237 Preceptor: 20031 2. Observation during initial tour on 2/10/15 at 8:15 a.m. revealed: *Resident 26 had unidentified medications in a cup with what appeared to be applesauce in it on her bedside table. *No nurse, medication aide, or any other employee was within sight of the resident's room.</p>	F 176	<p>2. The Director of Nursing Services (DNS) or designee will in-service all nurses and med aides on self administration of medication policy to include: a complete and accurate assessment and obtaining a physician order prior to self administration by March 21,2015.</p> <p>3. The DNS or designee will audit 10 instances of pill pass and correlating charts to ensure that proper pill pass procedure is taking place and if the resident is able to self administer that the appropriate assessment is complete weekly for 4 weeks and then monthly thereafter. Results of audits will be presented by DNS or designee for discussion at monthly QAPI meeting for further review and recommendations and/or continuation/discontinuation of audit.</p> <p>4. March 21, 2015</p> <p><i>*(continued from page 1, #1) Residents #11 and #16 were assessed and found to not be appropriate. Resident #23 was assessed and was found to be appropriate. Resident #15 could not be addressed due to being discharged from the facility. KW/SDD071/MF</i></p>		

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F 176	<p>Continued From page 2</p> <p>*The resident was awake and in bed at that time.</p> <p>Review of the resident's Medication Self-Administration Assessment dated 1/20/15 revealed she had been determined to be "unable to safely self-administer medications."</p> <p>3. Observation on 2/17/15 at 2:30 p.m. of resident 15 revealed she had a bottle of Refresh tears (eye drops) on her bedside table in her room. No nurse, medication aide, or any other employee was within sight of her room.</p> <p>Review of resident 15's Medication Self-Administration Assessment dated 12/13/14 revealed: *She had been determined to be "unable to safely self-administer medications." *She was "unable to correctly administer eye drops according to proper procedure."</p> <p>Interview on 2/18/15 at 8:15 a.m. with licensed practical nurse D revealed staff gave all residents their medications, and "no one's allowed to have meds (medications) in room."</p> <p>Surveyor: 32572</p> <p>4. Review of the provider's November 2011 revised Self Administration of Medications policy revealed "For those residents who self-administer, the interdisciplinary team verifies the resident's ability to self-administer medications by means of a skill assessment conducted on an ongoing basis or when there is a significant change in condition."</p> <p>Interview on 2/11/15 at 8:50 a.m. with the director of nursing confirmed he would have expected the medication self-administration assessment</p>	F 176			

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F 176	Continued From page 3 to have reflected the resident's ability to self-administer medications if medications had been left at the bedside.	F 176		
F 221 SS=D	<b>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</b>  The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.  This REQUIREMENT is not met as evidenced by: Surveyor: 20031  Surveyor: 26632 Based on observation, interview, record review, and policy review, the provider failed to ensure an assessment, physician's order, and care planning had been completed prior to the initial use of a wheelchair seatbelt for one of one sampled resident (22). Findings include:  1. Observation on 2/10/15 from 10:30 a.m. through 12:30 p.m. of resident 22 revealed: *She had a wheelchair seatbelt on. *She was seated in her wheelchair at the second floor nurses station. *She was taken into the second floor small dining room at 11:30 a.m. for the noon meal. *She required assistance with eating. *Her wheelchair seatbelt was not released while she was eating.  Surveyor: 20031 Observation on 2/11/15 at 5:20 p.m. revealed resident 22 sat in her wheelchair outside of the	F 221	<b>F 221</b>  1. Resident #22 has an assessment, consent, order, and care plan for seat belt. Resident is also having seat belt removed with activity and at meals. Residents residing in the facility who utilize a restraint will have an assessment, consent, order and care plan.  2. DNS or designee will in-service all staff on restraints, proper assessment of restraints, and care planning restraints by March 21, 2015.  3. The DNS or designee will audit all current restraints monthly for 3 months and new restraints upon initiation for appropriate assessment, order, and care plan. Results of audits will be presented by DNS or designee for discussion at the monthly QAPI for further review and recommendations and/or continuation/discontinuation of audits  4. March 21, 2015	3/21/15

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F 221	<p>Continued From page 4</p> <p>small dining room on the second floor. She had a secured seat belt around her waist. When questioned if she was aware she had a seat belt on she stated "No. I don't know what this thing is." She attempted and was unable to release the clasp at that time.</p> <p>Surveyor: 26632 Review of resident 22's medical record revealed: *She had diagnoses that included dementia (memory problems), anxiety, and depression. *Her 10/14/14 brief interview for memory ([BIMS] a memory test score) revealed a score of 3 (severely impaired memory). *Her 1/8/15 BIMS revealed a score of "99" (unable to complete the interview). *Staff interview for the 1/8/15 BIMS revealed she had short and long-term memory problems, and her daily decision making skills were moderately impaired. *An 11/12/14 nurse's note revealed resident 22's daughter was contacted regarding the use of the wheelchair seatbelt due to frequent falls. The daughter was in agreement with the plan. *An 11/12/14 care plan note "Self-releasing seatbelt when in WC (wheelchair). Resident able to remove" was noted under interventions for the risk of falls. *A physician's order was obtained on 1/21/15 for the use of the wheelchair seatbelt. *A restraint/positioning device assessment was completed on 1/29/15.</p> <p>Interview on 2/18/15 at 3:00 p.m. with registered nurse/resident care coordinator A agreed: *The physician's order and assessment had not been completed until after the wheelchair seatbelt had been applied for resident 22. *The comprehensive care plan for the use of the</p>	F 221			

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F 221	Continued From page 5 wheelchair seatbelt had not included a goal to reduce the restraint nor how often to release the seatbelt.  Review of the provider's reviewed 1/26/15 Restraint Devices, Physical policy revealed: *Assess the resident's need for restraint device use. *Obtain informed consent for restraint device use. *Obtain physician's order for restraint device. *Develop or review resident's care plan for type of restraint device, reason for use, alternate methods to be used and method of application. *List medical symptoms to be treated and methods to reduce or eliminate the restraint device.	F 221	<b>F 241</b>  1. Resident #11 has a care plan that addresses her catheter and bowel incontinence. Resident #11 does not currently have C-diff. Resident #11 also has a new Clinical Health Assessment completed. The CNA care sheets have been updated to include her mode of transfer. Resident #13 has a care plan that addresses his urinary incontinence. The CNA care sheets has been updated to reflect this information. Resident #9 has a care plan that contains an updated toileting plan and interventions for if resident is playing or eating his feces. Residents who triggered for low risk incontinence at the time of the survey will have their incontinence care plan revised.	3/21/15	
F 241 SS=G	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Surveyor: 26632  Surveyor: 32572 Based on observation, interview, record review, and admission packet review, the provider failed to ensure residents' self-esteem and dignity had been maintained with bowel (stool) and bladder incontinence (loss of control) for 3 of 12 sampled residents (9, 11, and 13). Findings include:  1. Interview on 2/10/15 at 8:30 a.m. revealed	F 241	2. DNS or designee will educate all staff on dignity of residents and specifically on resident incontinence by March 21, 2015.  3. DNS or designee will audit 10 care plans for accurateness in regards to resident's individual incontinence needs weekly for 4 weeks and then monthly thereafter. Resident Care Coordinator (RCC) or designee will update CNA care sheets at start up for any changes with resident incontinence or toileting programs. DNS and RCC or designee will present findings at monthly QAPI for review and recommendations and continuation/discontinuation of audits. <i>* See page 7. KN/SDDH/MF</i> 4. March 21, 2015		

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F 241	<p>Continued From page 6</p> <p>resident 11 had not been able to use the bathroom due to needing a mechanical lift for transfers. She stated the staff were physically unable to manage a lift into the bathroom. She also stated she used her incontinent pads as the bathroom. She had been directed to do so by the CNA (certified nursing assistant) staff. She also stated she did not routinely use the bedpan when in bed. She stated she had used a bathroom prior to her admission.</p> <p>Surveyor:22632 Observation on 2/10/15 at 4:45 p.m. revealed CNAs R, T, and U began to provide personal care for resident 11. Before the care started resident 11 stated she was feeling chilled and uncomfortable due to being wet. During the observation of personal care it was noted that a bath towel had been placed around resident 11's supra-pubic catheter (tube through opening in stomach into bladder to drain urine). That bath towel when removed by CNA U was noted to have been soaked with urine. Resident 11's abdominal skin was also noted to be red. After resident 11 had been placed in bed and personal care given she had been given a supper tray as getting her out of bed again would have caused her more discomfort.</p> <p>Surveyor:32572 Review of the 1/30/15 Minimum Data Set (MDS) assessment revealed the BIMS (testing of thought processes) score of 15. That score indicated she had intact thought processes or capable of thinking and making her own decisions.</p> <p>Review of the 2/4/15 bowel assessment revealed: *She had been incontinent of bowel with</p>	F 241	<p>*DNS or designee will audit 5 instances of toileting per week to ensure that nursing staff are following the residents care plan. This audit will be done weekly for 4 weeks and then monthly thereafter. DNS or designee will report results to monthly QAPI for review, recommendations, and continuation/discontinuation of audit. KW/SDDOH/MF</p>		

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F 241	<p>Continued From page 7</p> <p>abdominal cramping/discomfort/bloating and diarrhea." *She had been able to "recognize appropriate time/place to defecate [bowel movement]." *Staff were to "provide scheduled incontinent care and comfort."</p> <p>Review of the 2/4/15 bladder assessment revealed: *She had a supra-pubic (SP) catheter. *She had "persistent overflow incontinence [unable to totally empty the bladder], symptomatic [having symptoms] infections and/or renal [kidney] dysfunction [not properly functioning]." *She had been able to "make her needs known." *She was "not appropriate for toileting or retraining program at this time."</p> <p>Review of the 1/22/15 through 2/11/15 nursing progress notes revealed: *The resident had a SP catheter that leaked urine. -"Towels had been placed around the catheter to absorb the leakage." *The resident had been continent and incontinent of bowels. *The resident had a "C Diff [clostridium difficile] infection." That infection of the bowel causes diarrhea.</p> <p>Review of the 1/26/15 revised comprehensive care plan for resident 11's urinary incontinence revealed: *She used pad/briefs. *She used an indwelling SP catheter. *The care plan did not indicate her catheter leaked and what cares would have needed to be done for that leaking. There had been no care plan for bowel</p>	F 241			

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F 241	<p>Continued From page 8 incontinence or the C-Diff infection.</p> <p>Review of resident 11's 1/23/15 through 2/11/15 Bowel and Bladder Detail Report revealed: *The resident had been incontinent of urine twenty-eight times. -That had been due to the catheter leaking. -She had not been continent at any time. *The resident had been incontinent of bowel eighteen times.</p> <p>Review of the provider's 1/23/15 assessments for resident 11 revealed: *The Braden Scale for Predicting Pressure Sore Risk had been 15 which indicated high risk. -The moisture section had been coded as often moist. -"Skin is often, but not always moist. Linen must be changed at least once a shift." *The urinary incontinence section revealed she had been "frequently incontinent." *The appliance/programs section indicated: -No documentation of history of catheter use within the last forty-eight hours. That section had been left blank when she did in fact have a catheter. -The liner/briefs used line had been checked.</p> <p>Review of the provider's revised 2/4/15 CNA Report Sheet revealed resident 11 had been: *Transferred with assistance of two staff members. -There was no indication a mechanical lift was needed for transfers. *She had a SP catheter. *She was to use the bedpan for toileting needs. *She had been on C Diff precautions (special handling needed when providing care).</p>	F 241			

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F 241	<p>Continued From page 9</p> <p>2. Random observation on 2/10/15 from 8:30 a.m. through 11:00 a.m. revealed resident 13 sitting in a wheelchair in his room beside his bed. The front of his pants had been wet and remained wet during that time frame.</p> <p>Review of the 2/9/15 Readmission Clinical Health Status assessment revealed: *He had been occasionally incontinent. *Under the section appliances/programs the only item checked had been "liners/briefs used." -It did not indicate if he had been on a scheduled or bladder retraining program, or if he used the toilet or commode. *The Braden Scale for Predicting Pressure Sore Risk indicated he had been at high risk with a score of 18. -Under the section moisture it indicated he had been "occasionally moist." -"Skin is occasionally moist, requiring an extra linen change approximately once a day."</p> <p>Review of the 11/13/14 MDS assessment revealed a BIMS score of 14. That score indicated an intact thought process.</p> <p>Review of the 2/17/15 revised comprehensive care plan indicated he had been incontinent of bowel and bladder. *The goals listed indicated: -"I will improve my current level of frequently incontinent bladder by next quarter." -"I will improve my current level of bowel continence through next review." --Hand written under under that statement was "currently frequently incontinent." *The interventions were to: -"Monitor and report changes in ability to toilet or continence status to IDT [interdisciplinary team]."</p>	F 241		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 241	<p>Continued From page 10</p> <p>-"Use of briefs for incontinence protection." -"Provide pericare [personal care to the bottom] with each incontinent episode." There had been no documentation the resident was or had been on a scheduled or toileting retraining program.</p> <p>Review of the provider's 2/4/15 revised CNA Report Sheet revealed the following areas had not been addressed: *If he was incontinent of bowel and/or bladder. *How he was to have been transferred from one position to another.</p> <p>3. Review of resident 9's medical record revealed he had a history of eating feces (stool). That had been added to his behavior care plan on 11/13/14. In reviewing the care plan for incontinence of bowel and bladder revealed: *"Offer toileting often." *"Continue to reeducate on use of call light."</p> <p>Review of his most current 2/2/15 MDS assessment revealed a BIMS score of 9. That score indicated moderate thought process impairment.</p> <p>Review of the 8/15/14 bowel assessment revealed: *He had "prolonged straining during defecation [having a bowel movement]." *He had "conditions associated with chronic diarrhea or constipation." *The resident had been "able to feel the urge sensation for bowel movement."</p> <p>Review of the 8/15/14 bladder assessment revealed: *He had "leakage on way to the bathroom."</p>	F 241			

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 241	<p>Continued From page 11</p> <p>*He had "urgency-unable to suppress [stop]." *He had "daytime frequency and night time bedwetting." *The summary section stated "staff anticipate most needs."</p> <p>Review of the 1/14/15 through 2/11/15 nursing progress notes revealed entries stating: *The "needs [are] anticipated by staff" six times. *The "rsd [resident] was always incontinent of bowel and bladder" five times. *The "rsd needed extensive assistance with toileting" *On 2/11/15 at 1:04 p.m. the nursing progress note stated the "resident was found with his hands full of BM [bowel movement]."</p> <p>Review of fall records revealed he had fallen: *On 6/17/14 at 7:47 p.m. At that time he had been incontinent. His last toileting had occurred at 4:45 p.m. The recommendation had been to "toilet him immediately following meals." *On 11/15/14 at 4:03 p.m. At that time he had been incontinent. -The summary of activities during the three hours prior to the fall stated he had been resting in bed and had been up fifteen minutes. -The recommendations stated "Resident needs to lay down between lunch and dinner." *On 2/1/15 at 1:42 p.m. The report did not indicate if the resident had been continent or incontinent. -The recommendation was to apply a seat belt alarm.</p> <p>Review of the 8/25/14 revised care plan revealed: *The at risk for falls care plan indicated he had been on a toileting schedule. -That schedule was "upon rising, before and after</p>	F 241		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 241	<p>Continued From page 12 meals, HS [bedtime], NOC [night] rounds and PRN [as needed]." -That intervention had been initiated on 3/1/13 and revised on 8/25/14. *The potential for moods and behavior care plan revealed: -On 11/13/14 the resident had eaten feces (stool). -There had been no updating of the care plan after that incident.</p> <p>Interview on 2/12/15 at 10:40 a.m. with the director of nursing revealed: *He felt the following statements on the urinary incontinence care plan indicated how to care for the urinary and bowel incontinence. -"Keep resident clean and dry. Check on resident rounds..."</p> <p>Interview on 2/18/15 at 3:15 p.m. with the director of nursing revealed: *The CNA Report Sheets were considered "care sheets." -Those care sheets were for the nursing staff and indicated the care needed for the residents. *A toileting schedule had been completed when a resident had been taken to the bathroom upon rising, before and after meals, at bedtime, and on rounds during the night. -Rounds at night occurred at 12 midnight, 2:00 a.m., and 4:00 a.m. *A toileting plan was a restorative program, and the facility did not have anyone on a toileting plan. -That would have been a program to restore continence.</p> <p>Review of the provider's 1/19/15 revised Incontinence Management/Bladder Function Guideline revealed: *"The purpose was to:</p>	F 241			

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 241	<p>Continued From page 13</p> <ul style="list-style-type: none"> <li>-Enable the resident to control urination without a catheter whenever possible.</li> <li>-Prevent skin problems such as pressure areas and excoriation (raw irritated skin).</li> <li>-Improve the morale of the resident.</li> <li>-Restore the resident's dignity.</li> <li>-Manage urinary incontinence, restore or maintain as much normal bladder function as possible."</li> <li>***The general guidelines when working to retrain bladder function were to:</li> <li>-Develop a schedule of toileting times specific to the resident.</li> <li>-Observe and record the resident's voiding pattern, and revise the toileting schedule to meet the residents toileting needs."</li> <li>*In "Choosing a Program that fits the resident after evaluation was to determine:</li> <li>-Scheduled toileting/Habit training-if the resident has no pattern of urinary incontinence due to functional or transient incontinence then schedule the residents toileting at regular intervals to increase continent episodes per habit.</li> <li>-Prompted voiding-if the resident displayed a usual pattern of incontinence due to urge or mixed incontinence established toileting times prior to an accident. Prompted voiding is a behavioral technique.</li> <li>-Absorbent products/External collection devices-if the resident is cognitively impaired and is unsuccessful at toilet training or is unable to participate in retraining then the resident should be placed on an incontinence care program."</li> <li>***Monitoring/Compliance-observation of care provided matches the plan of care."</li> </ul> <p>Review of the Long-Term Care Facilities Resident's Bill of Rights booklet by the Department of Social Services, Adult Services and Aging: Ombudsman Program revealed the</p>	F 241			

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 241	Continued From page 14 following. The booklet stated "When you enter a long-term care facility, you must be treated as an individual with respect, dignity and consideration." This booklet is provided to each resident upon admission.	F 241	<b>F 273</b>		
F 273 SS=C	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT  A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)  This REQUIREMENT is not met as evidenced by: Surveyor: 20031  Surveyor: 26632 Based on record review, and interview, the provider failed to ensure 13 of 23 sampled residents (1, 5, 9, 10, 11, 12, 15, 17, 18, 22, 23, 25, and 26) had Minimum Data Sets assessments (MDS) completed according to the time frame set by The Centers for Medicare and Medicaid. Findings include:  1. Review of resident 1's annual MDS revealed it was due to have been completed on 1/9/15. It had been completed on 1/12/15.  2. Review of resident 5's significant change of condition MDS revealed it was due to have been completed on 10/15/14. It had been completed on	F 273	1. No immediate action could be taken for residents # 1,5, 10,12,17,18,22,25,26,15,9,11 and 23.  2. Clinical Assessment and Reimbursement Specialist (CARS) will educate RNAC (Resident Nursing Assessment Coordinator) and MDS coders regarding MDS timeliness by March 21, 2015.  3. Executive Director (ED) will audit MDS progress with clinical start up to ensure that the facility is not late on any assessments. ED or designee will present results of audits for discussion at monthly QAPI for further review and recommendations and/or continuation/discontinuation of audits.  4. March 21, 2015	3/21/15	

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 273	Continued From page 15 10/22/14.  3. Review of resident 10's admission MDS revealed it was due to have been completed on 10/20/14. It had been completed on 10/24/14.  4. Review of resident 12's admission MDS revealed it was due to have been completed on 2/10/15. It had been completed on 2/14/15.  5. Review of resident 17's admission MDS revealed it was due to have been completed on 9/16/14. It had been completed on 9/19/14.  6. Review of resident 18's admission MDS revealed it was due to have been completed on 1/25/15. It had been completed on 1/29/15.  7. Review of resident 22's significant change in condition MDSs revealed one was to have been completed on 9/22/14. It had been completed on 9/30/14. Another significant change in condition MDS revealed was to have been completed on 10/27/14. It had been completed on 10/30/14.  Surveyor: 20031 8. Review of resident 25's admission MDS revealed it was due to have been completed 10/15/14. It had been completed on 10/22/14.  9. Review of resident 26's admission MDS revealed it was due to have been completed on 1/29/15. It had been completed on 2/6/15.  Surveyor: 35237 Preceptor: 20031 10. Review of resident 15's admission MDS revealed it was due to have been completed on 12/24/14. It had been completed on 12/29/14.	F 273			

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 273	Continued From page 16 Surveyor: 32572  11. Review of resident 9's admission MDS revealed it was due to have been completed on 2/8/15. It had been completed on 2/14/15.  12. Review of resident 11's admission MDS revealed it was due to have been completed on 2/5/15. It had been completed on 2/12/15.  13. Review of resident 23's admission MDS revealed it was due to have been completed on 2/4/15. It had been completed on 2/10/15.  14. Interview on 2/18/15 at 1:35 p.m. with registered nurse (RN)/MDS coordinator B and RN/MDS nurse B revealed: *They were aware of the late MDSs. *They had other duties besides completing MDSs that included admission orders and work as an RN on the floor.  Interview on 2/18/15 at 2:40 p.m. with the administrator revealed: *She was aware of the late MDSs. *She had noticed it the beginning of the current year. *She had re-aligned some of the duties of the resident care coordinators to be able to help with the MDSs. *She would "spot check" the MDS section in the electronic medical record "periodically."  Review of the provider's copy of the Resident Assessment Instrument revealed: *An admission MDS should have been completed within fourteen days of the admission date. *An annual MDS should have been completed within fourteen days of the assessment reference	F 273		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 273	Continued From page 17 date (ARD). *A significant change of condition MDS should have been completed within fourteen days of the ARD.	F 273	<b>F 278</b>		
F 278 SS=B	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.  Clinical disagreement does not constitute a material and false statement.  This REQUIREMENT is not met as evidenced by:	F 278	1. Residents # 5, 22, 15, 23, and 1 have had their MDSs corrected and modifications completed. Resident 24 is coded in caretracker as occasionally incontinent for this time period and the MDS reflects that. Resident will have a new bowel and bladder assessment done and a revised care plan for incontinence.  2. CARS will educate RNAC and MDS coders on MDS accuracy by March 21, 2015.  3. DNS or designee will audit 3 MDSs for accuracy weekly for 4 weeks and then monthly thereafter. DNS or designee will present results of audits for discussion at monthly QAPI for further review and recommendations and/or continuation/discontinuation of audits.  4. March 21, 2015	3/21/15	

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

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F 278	<p>Continued From page 18 Surveyor: 26632 Based on interview and record review, the provider failed to ensure the Minimum Data Sets (MDS) assessments had been completed accurately for 6 of 23 sampled residents (1, 5, 15, 22, 23, and 24). Findings include:</p> <ol style="list-style-type: none"> <li>Review of resident 5's 7/25/14 quarterly MDS and 10/2/14 significant change in condition MDS revealed for section H0100 she had an ostomy (opening in the stomach that drained stool into a bag). Review of her 12/30/14 quarterly MDS revealed she did not have an ostomy. Review of her chart revealed she had continued to have an ostomy.</li> <li>Review of resident 22's 1/8/15 quarterly MDS revealed for section P0100 restraint out of bed she had no restraints. Review of her chart revealed a wheelchair seatbelt had been applied on 11/12/14.</li> </ol> <p>Surveyor: 35237 Preceptor: 20031</p> <ol style="list-style-type: none"> <li>Review of resident 15's 2/4/15 sixty day scheduled MDS revealed: *Section K0200 B noted a weight of 191 pounds (lb). *Section K0300 was marked "no" for weight loss of 5% or more in the last month or loss of 10% or more in the last six months.</li> </ol> <p>Review of the resident 15's medical record revealed: *Resident was admitted on 12/10/14: - Weight on 12/12/14 was 226.6 lb. - Weight on 12/26/14 was 213.6 lb. - Weight on 1/30/15 was 191.3 lb.</p>	F 278		

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 278	<p>Continued From page 19</p> <p>*A 15.5% weight loss had occurred since admission. A 10.4% weight loss had occurred in one month.</p> <p>*A 12/29/14 Nutrition Assessment completed by the register dietitian (RD) revealed: -"Wt [weight] is down from initial arrival wt, likely related to fluid status..." -"RD to recommend continuing current nutritional plan w/o [without] further interventions at this time."</p> <p>*A 2/11/15 Nutrition Assessment completed by the RD revealed: -"Note wt down from admit, this is planned as wt loss is RSD [resident] goal..." -"RD to recommend continuing current nutritional plan w/o further interventions at this time."</p> <p>Interview on 2/18/15 at 12:40 p.m. with the dietary manager confirmed she was aware of resident 15's weight loss. She stated the resident wanted to lose weight.</p> <p>Interview on 2/18/15 at 9:50 a.m. with the RD revealed the resident had been losing weight since admission. She "actively wants to lose weight."</p> <p>Surveyor: 32572 4. Review of resident 23's 1/29/15 admission MDS revealed M1200 f had been answered "no" for a surgical wound.</p> <p>Review of the 1/22/15 Admission Clinical Health Status revealed: *Skin condition had numerous areas identified as bruises, discoloration, and one surgical wound. *There had been no description of the surgical wound as for the length, width, or depth.</p>	F 278			

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

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F 278	<p>Continued From page 20</p> <p>Review of the February 2015 treatment administration record (TAR) revealed there had been a left lateral (side) breast wound that had been receiving wound care.</p> <p>Review of the weekly nursing progress notes for the following revealed: *1/26/15 "Left breast sore - covered." *2/2/15 "Post-surgical wounds left breast." *2/9/15 "Resident has small wound to left lateral breast."</p> <p>Review of the 2/11/15 comprehensive care plan revealed: *A care plan for pain management indicated there was a surgical wound. *There had been no care plan for the care and treatment of the surgical wound.</p> <p>5. Review of resident 24's 11/24/14 quarterly MDS revealed the resident had been coded as continent of bowel and bladder function.</p> <p>Review of the revised 6/18/14 care plan indicated she had been incontinent of bowel and bladder.</p> <p>Review of the revised 2/17/14 CNA Report Sheet revealed she had been incontinent of urine.</p> <p>Review of the 12/8/14 Bowel Assessment Form revealed the resident had been continent of bowel function. The statement "Resident is currently continent of bowel" was answered "yes." On the other side of the form the statement "Resident is currently incontinent of bowel" had been answered "yes."</p> <p>Review of the 10/13/14 Bladder Evaluation Form</p>	F 278		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 278	Continued From page 21 revealed the resident was continent of urine. It indicated she soiled her clothing or had used incontinent pads and had been wet. It indicated "Will initiate a toileting and/or retraining program see care plan." The last page of that form indicated "no" when asked if "able to participate in bladder program" and had been reviewed on 12/18/14. It did not indicate if she had been incontinent or continent of bladder function. It also indicated "Not appropriate for toileting or retraining program at this time."  Surveyor: 32573 6. Review of resident 1's 9/26/14 quarterly MDS assessment revealed J1800 had been marked as no falls had occurred since the prior assessment. The prior quarterly assessment had been done 7/2/14.  Review of resident 1's current care plan dated 1/20/14 revealed a fall had been recorded on 7/29/14 under the falls focus area.	F 278		
F 280 SS=F	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	F 280		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 280	<p>Continued From page 22</p> <p>disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, interview, record review, and policy review, the provider failed to review and revise care plans as changes occurred in 9 of 23 sampled residents (1, 8, 9, 11, 13, 15, 22, 23, and 25). Findings include:</p> <p>1. Review of resident 22's 2/15/13 initiated care plan for her fall risk revealed: *An intervention of a self-releasing seat belt when in the wheelchair, and she was able to remove by herself. It was dated 11/12/14. *The care plan had not followed the provider's 1/26/15 Restraint Devices, Physical policy for care plan documentation guidelines. Those guidelines included: *For the problem: Identify medical symptoms to be treated, identify the appropriate problem under which to list restraint use as an approach, or consider listing possible risks and complications. *For the goal: List measurable goals to be accomplished, the goal should lead to removal of restraints or use of less restrictive measures, and list target date. *For approaches: List responsible discipline for each approach, instructions unique to the resident, necessary monitoring and observation</p>	F 280	<p><b>F 280</b></p> <p>1. Resident #22 has a restraint care plan. Resident #25 has a new bowel and bladder assessment completed and her care plan has been updated. Resident #9 has had a smoking assessment completed and his care plan revised to reflect the smoking assessment and interventions for if he is eating/playing with his feces. Resident #11 has a care plan that reflects her leaking catheter, how often to care for the catheter, side rails and self administration of medications. Resident #13's incontinence has been addressed on his care plan and on the CNA care sheet. Resident #23's care plan reflect self administration of meds. No immediate action could be taken for resident #15 as she has been discharged. Resident #8's care plan has been revised to reflect her leg fracture and treatment. The CNA care sheet has also been updated to reflect this. <i>*See page 04. KANISDOOHIMF</i></p> <p>2. DNS or designee will educate all nursing staff on updating care plans by March 21, 2015.</p> <p>3. DNS or designee will audit 10 care plans per week for accuracy. DNS or designee will present results of audits for discussion at monthly QAPI for further review and recommendations and/or continuation/discontinuation of audits.</p> <p>4. March 21, 2015.</p>	3/21/15

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

PRINTED: 03/05/2015  
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F 280	<p>Continued From page 23</p> <p>of the condition that necessitated restraint use, observation for effectiveness of treatment, alternate methods used, plan to reduce and eliminate restraint use, restraint removal, exercise, positioning, checks of circulation, type of restraint to be used and method of application, observation for risks and complications.</p> <p>Interview on 2/18/15 at 3:00 p.m. with registered nurse (RN) resident care coordinator A agreed the comprehensive care plan for the use of the wheelchair seatbelt did not follow the policy.</p> <p>Surveyor: 20031</p> <p>2. Review of resident 25's 2/7/15 progress note revealed "Verbal order to D/C [discontinue] Foley [urinary catheter (tube inserted into bladder to drain urine)] was received from ____ (physician assistant). Foley balloon was deflated and catheter removed. Patient tolerated procedure well."</p> <p>A bladder re-evaluation had not been completed since that date. The last bowel and bladder reevaluation had been completed 10/6/14 and had a hand written note "+ Indwelling - Foley Catheter".</p> <p>Review of resident 25's 10/22/14 care plan revealed several hand written notes under focus, goals, and interventions. Under interventions was the description "Change Foley catheter per MD</p>	F 280	<p>* Resident #1's care plan has been updated to reflect her current ADL abilities, transfer assistance, and continence.      KWI/SDDH/mf</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 280	<p>Continued From page 24 (medical doctor) orders." Directly behind that typed intervention was a handwritten note "change monthly 1/12/15". No other handwritten notes could be located regarding a doctor's order to discontinue the Foley catheter.</p> <p>Interview on 2/18/14 at 11:00 a.m. with the executive director and director of nursing revealed their expectations would have been for another bladder basement and update to the care plan to have been completed after the Foley removal on 2/7/15. Surveyor: 32572 3. Review of resident 9's care plan revised on 2/1/15 revealed: *A focus area of at risk for smoking related injury. -An intervention had been to complete a smoking safety assessment. --Review of the medical record revealed no smoking assessment had been completed. Interview on 2/12/15 at 10:10 a.m. with the director of nursing confirmed no assessment had been completed. The resident did not currently smoke.</p> <p>*Resident 9 had a history of eating his own feces. -This had been documented on the behavior care plan. --No intervention had been implemented to prevent further behaviors. -The focus area for altered bowel elimination did not indicate any changes in interventions to prevent these behaviors.</p> <p>4. Observation on 2/10/15 at 8:30 a.m. and review of resident 11's 1/26/15 care plan revealed: *A focus area of urinary incontinence. -Resident had a suprapubic (tube through the</p>	F 280		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 280	<p>Continued From page 25 abdomen into the bladder) catheter. There was no indication the catheter leaked and how to care for the leakage, or how often to provide that care. *The resident had been admitted with an infection of Clostridium Difficile (C Diff [infection of the bowel]). -The care plan did not address the infection, and how care was to be performed. *The resident had half side rails on both sides of the top half of her bed. -The care plan did not indicate side rails were to be used. *The resident had been observed self-administering her medications on 2/10/15 at 8:30 a.m. -The care plan did not reflect self-administering of medications.</p> <p>Interview on 2/12/15 at 10:05 a.m. with the director of nursing confirmed the care plan did not address the suprapubic catheter leaking, side rails were used when in bed, and how to care for a resident with a C Diff infection.</p> <p>5. Review of resident 13's revised 12/13/14 care plan revealed the resident had been incontinent of bowel and bladder. *It did not indicate if he had been on a toileting plan. *The resident had been observed to be wet on 2/10/15 from 8:30 a.m. through 11:00 a.m. *Review of the CNA Report Sheet did not indicate he had been incontinent of bowel and bladder or on a toileting plan.</p> <p>6. Review of resident 23's care plan revealed: *The resident had been observed self-administering medications on 2/10/15 at 8:30</p>	F 280		

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

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F 280	<p>Continued From page 26</p> <p>a.m.</p> <p>-The care plan did not reflect self-administering of medications.</p> <p>Surveyor: 35237 Preceptor: 20031</p> <p>7. Review of resident 15's revised 2/16/15 care plan revealed:</p> <p>*A goal for the resident to lose one to two pounds per month until discharged. That goal was initiated on 12/22/14 and revised on 2/16/15. There had been no documentation the resident wanted to lose weight or that she had lost weight since she had been admitted.</p> <p>*An intervention of non-weight bearing to left lower extremity (leg) was initiated on 12/29/14 and had no further revisions. Review of resident 15's current treatment administration record dated 1/28/15 revealed the resident was weight bearing as tolerated to her left lower extremity.</p> <p>Observation on 2/17/15 at 3:45 p.m. revealed resident 15 was walking by herself with a walker in the hallway.</p> <p>Interview on 2/18/15 at 8:15 a.m. with licensed practical nurse (LPN) D confirmed the resident walked by herself.</p> <p>Interview on 2/18/15 at 9:50 a.m. with the registered dietitian/licensed nutritionist revealed resident 15 had been losing weight since admission. She "actively wants to lose weight."</p> <p>Interview on 2/18/15 at 12:40 p.m. with the dietary manager revealed the resident wanted to lose weight. She agreed the resident had lost weight since admission, and had lost more than one to</p>	F 280		

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

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F 280	Continued From page 27 two pounds per month.  Surveyor: 23059 8 Review of resident 8's revised 1/16/15 care plan revealed: *There was no mention of her left leg fracture that had occurred on 11/26/14. *There was no mention of wearing a leg brace except a 1/16/15 entry to monitor the skin under the left leg brace. That leg brace had been first ordered upon her return to the facility after her fall.  Review of resident 8's revised 2/17/15 CNA Report Sheet revealed she was to have worn her leg brace at all times. That had not been changed to reflect her 2/6/15 physician's orders to wear the leg brace only when up.  Refer to F314, finding 1.	F 280			
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.	F 281			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 281	<p>Continued From page 28</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 23059</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure professional standards were followed for:</p> <ul style="list-style-type: none"> <li>*Following physician's orders for 1 of 27 sampled residents (7).</li> <li>*Clarification of physician's orders for 2 of 27 sampled residents (4 and 7).</li> <li>*Ensuring the pharmacist's recommendations had been responded to by the physician for 2 of 27 sampled residents (3 and 9).</li> <li>*Abnormal blood pressure results not reported per physician's orders for 1 of 27 sampled residents (2).</li> <li>*Dating of medication to ensure it had not been outdated for two of two sampled residents (11 and 27) receiving an Advair diskus inhaler.</li> <li>*Following the dietitian's recommendations for 1 of 27 sampled residents (25).</li> <li>*Reassessing bladder function after the removal of a Foley catheter (tube inserted to empty urine from the bladder) for 1 of 1 sampled resident (25) who had a Foley catheter removed.</li> </ul> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of resident 7's February 2015 medication administration record (MAR) revealed an entry for Lidoderm patch 5% (percent) one-half patch to have been applied to each knee in the morning. Those patches were to have been removed in the evening. That medication was signed off as given 2/1/15 through 2/10/15.</li> </ol> <p>Also on that same MAR was an entry for Oxycodone hydrochloride 10 milligrams (mg) in the morning for pain and 5 mg in the afternoon for pain. Those medications were signed off as given</p>	F 281	<p><b>F 281</b></p> <ol style="list-style-type: none"> <li>1. Resident # 7's orders have been clarified and are accurate now. Resident #7's order recap has been reviewed by a nurse and noted. Resident #3's MD has responded to the pharmacy recommendation from January. Resident #9's MD has responded to the pharmacy recommendation from January. Resident #25 has a new bowel and bladder assessment. RD has assessed resident for protein needs and has made recommendations to nursing and dietary. Resident is receiving an HS snack. Resident #2's MD had been notified of blood pressures. Resident #4's code status has been clarified with family and order is accurate on MAR. Resident #6 is not currently on C-diff precautions.</li> <li>2. DNS or designee will educate all nurses regarding: clarifying and following physician orders, physician notification, dating medication, and assessing residents after foley removal by March 21, 2015. ED or designee will educate DNS on following up on pharmacy recommendations by March 21, 2015. ED or designee will educate RD on following orders for RD recommendations or documenting an assessment if not recommended by March 21, 2015.</li> <li>3. DNS or designee will audit 5 resident's charts for accuracy of orders, proper physician notification, and resident</li> </ol>	3/21/15

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 281	<p>Continued From page 29 2/1/15 through 2/10/15.</p> <p>Review of the resident's signed 2/3/15 physician's orders revealed: *The Lidoderm patch had been discontinued due to non-coverage by insurance. *Oxycodone 5 mg had been ordered to have been given twice a day every Monday, Tuesday, Wednesday, Thursday, and Friday. *There was no physician's order for Oxycodone 10 mg.</p> <p>Further review of those physician's orders revealed they had been dated 1/27/15 as having been sent by the director of nursing to the physician. Those orders were returned and signed by the physician on 2/3/15. There was no signature on the bottom line of the orders indicating those orders had been reviewed when returned. There was no documentation found on those orders to indicate they had been noted by anyone on the nursing staff.</p> <p>Interview on 2/11/15 at 5:15 p.m. with the second floor resident care coordinator revealed those orders should have been signed off by a nurse as having been reviewed when they were returned from the physician. She confirmed those physician's orders did not match the entries on the MAR. She confirmed no one had signed off indicating those orders had been reviewed.</p> <p>A policy related to clarification and transcription of physician's orders was requested. None had been provided by the end of the survey.</p> <p>2. Review of resident 3's 1/15/15 Clinical Pharmacist Medication Regimen Review Summary revealed a gradual dose reduction in</p>	F 281	<p>assessment after change in toileting needs weekly for 4 weeks and then monthly thereafter. ED or designee will audit all new admits for RD recommendation orders and follow up weekly for 4 weeks and then monthly thereafter. ED or designee will audit all monthly pharmacy recommendations for follow up monthly for 3 months. ED and DNS or designee will bring results to monthly QAPI for review, recommendations, and continuation or discontinuation of audits.</p> <p>4. March 21, 2015</p> <p><i>* Residents 11 and 27 were given new Advair Diskus and they were dated. KWS/DDOHI/MF</i></p> <p><i>* All med carts were checked for appropriate dating of medications. KWS/DDOHI/MF</i></p>	

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F 281	<p>Continued From page 30</p> <p>the use of his antipsychotics had been recommended to the physician. Those antipsychotics included:</p> <ul style="list-style-type: none"> <li>*Paroxetine (to treat depression and anxiety) 10 mg daily.</li> <li>*Trazodone (to treat depression and insomnia) 200 mg daily.</li> <li>*Buspirone (to treat anxiety) 15 mg twice daily.</li> <li>*Lorazepam (to treat anxiety) 0.5 mg three times daily.</li> </ul> <p>The above recommendation had been documented as sent to the physician by the director of nursing (DON) on 1/19/15. No response had been received from the physician regarding the pharmacist's recommendations.</p> <p>Interview on 2/11/15 at 4:45 p.m. with the DON revealed he was responsible for sending the notice of the pharmacist's recommendations to the physician. If the physician did not respond or reply, the pharmacist would make the same recommendation the next month. He stated neither he nor the floor nurses did any follow-up to ensure the physician had received the recommendations. He stated this process would recur monthly until the physician responded. He confirmed there had been no response from the physician regarding the pharmacist's 1/19/15 recommendations on resident 3.</p> <p>Surveyor: 32572</p> <p>3. Review of resident 9's medical record revealed:</p> <ul style="list-style-type: none"> <li>*The pharmacist had made a recommendation to the physician on 12/17/14 for a gradual dose reduction (GDR) of a medication. The pharmacist had documented on 1/16/15 "No answer to GDRs - reissue X [times] 2."</li> </ul>	F 281	<p>* DNS or designee will audit all med carts weekly for appropriate dating of medications. This audit will be done weekly for 4 weeks and then monthly thereafter. DNS or designee will report results to monthly AAPI for review, recommendations, and continuation/discontinuation of audit.</p> <p>KW/SD004/MF</p>	

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 281	<p>Continued From page 31</p> <p>Interview on 2/13/15 at 10:10 a.m. revealed the director of nursing faxed the pharmacist recommendations to the appropriate physician. If there had been no answer he would re-fax the recommendation. There would not be any verbal communication regarding the recommendations.</p> <p>Surveyor: 20031</p> <p>4. Review of resident 25's 2/7/15 progress note revealed "Verbal order to D/C [discontinue] Foley was received from _____ [physician assistant]. Foley balloon was deflated and catheter removed. Patient tolerated procedure well."</p> <p>A bladder re-evaluation had not been completed since that date. The last bowel and bladder re-evaluation had been completed 10/6/14 and had handwritten notes "+ Indwelling - Foley Catheter."</p> <p>Review of resident 25's 10/22/14 care plan revealed several handwritten notes under focus, goals, and interventions. Under interventions was the description "Change Foley catheter per MD [medical doctor] orders." Directly behind that typed intervention was a handwritten note: "change monthly 1/12/15." No other handwritten notes could be located regarding a physician's order to discontinue the Foley.</p> <p>Interview on 2/18/14 at 11:00 a.m. with the executive director (ED) and director of nursing (DON) revealed their expectations would have been for another bladder assessment and an update to the care plan to have been completed after the Foley removal on 2/7/15.</p> <p>5. Resident 25's 10/1/14 physician's discharge orders from the local hospital revealed a</p>	F 281		

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 281	<p>Continued From page 32</p> <p>handwritten note "Protein supplement per dietician." No documentation was located to ensure the physician's orders had been reviewed by nutritional services.</p> <p>Interview on 2/11/15 at 2:00 p.m. with resident 25 revealed she did not get a snack every night. Interview on 2/12/15 at 10:45 a.m. with the dietary manger (DM) confirmed resident 25 was not on a required supplemental snack at night. She stated "she should be due to her wounds and pressure ulcers [injury to skin] though." The DM stated resident 25 was offered a snack by nursing staff at night, but the dietary staff did not deliver a required supplemental night time snack to her.</p> <p>Review of resident 25's 10/13/14 care plan for nutritional services revealed: *Focus: "Resident at Nutritional risk due to: Ulcer to lower limb [leg], Hypothyroidism [decrease in thyroid output], Morbid Obesity [overweight], Depressive Disorder, skin ulcer and UTI [urinary tract infection]. *Interventions: Resident has a regular diet order." Review of the nutrition care team notes dated weekly from 11/5/14 through 1/21/15 revealed: *Eleven of twelve weeks had documentation of wounds. *All twelve weeks had been noted or wound monitoring to include a surgical wound on the right calf and a wound to the right of the coccyx (bottom tip of the spine). *No interventions had been checked for all twelve weeks. *No skin issues had been noted for all twelve weeks. The nutrition care team included but was not limited to the DM, the registered dietician/licensed nutritionist (RD/LN), ED, DON, the wound care</p>	F 281			

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 281	<p>Continued From page 33 registered nurse (RN), and care unit RNs.</p> <p>Review of resident 25's current 1/16/15 nutrition assessment revealed: *Estimated nutrient needs: calculations were noted under calories, calorie needs, protein, and fluid. No notes were given to evaluate the calculations to ensure the needs were met for wound care or pressure ulcers. *Nutrition diagnosis: "Increased Nutrient Needs" had been checked. -Signs and symptoms statement: "increased nutrient needs related to chronic non-healing ulcer to right calf." -Interventions: "Regular diet order; TID [three times a day] snack cart." -Goals: "wound healing." *Summary: "RD following in with RSD [resident 25] wound progress. ____ [resident 25] with long standing R [right] calf wounds with surgical interventions. wounds healing slowly."</p> <p>Interview on 2/18/15 at 10:00 a.m. with the RD/LN revealed: *He had not seen the physician's note for a protein supplement dated 10/1/14. *He was familiar with the resident's chart. *He could not confirm if a snack had been delivered to the resident three times per day or if they were high protein snacks. *He stated he had not considered an additional protein supplement for this resident.</p> <p>Continued review of resident 25's chart revealed there had been no RD/LN justifications for the resident's nutrient needs to ensure the physician's orders were followed or noted. Average meal intake for the past twelve weeks revealed an average of 73%. The intake had not</p>	F 281		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 281	<p>Continued From page 34</p> <p>been broken down between fruits, vegetables, breads and grains, and protein to ensure the protein intake met the protein needs for wound healing.</p> <p>Surveyor: 35237 Preceptor: 20031</p> <p>6. Review of resident 2's medical record revealed: *She had a diagnosis of hypertension (high blood pressure). *She had been on Metoprolol (medication for high blood pressure) since admission on 9/22/14. *A 1/26/15 physician's telephone order to check blood pressures daily for ten days. *Blood pressures (BP) during those ten days were noted to be elevated on several occasions. -1/27/15 at 3:45 p.m. BP 179/96. -1/28/15 at 2:04 p.m. BP 178/82. -1/29/15 at 5:19 p.m. BP 191/108. -1/30/15 at 1:27 p.m. BP 172/82. -1/31/15 at 2:09 p.m. BP 180/82. -2/1/15 at 2:35 p.m. BP 182/94. -2/2/15 at 5:42 p.m. BP 163/90. -2/3/15 at 2:43 p.m. BP 174/84. *There was no documentation of a recheck or follow-up assessment. *There was no documentation the physician had been notified of the elevated BPs.</p> <p>Review of the resident's February 2015 MAR revealed: *An order for BP daily for ten days in the afternoon. -Specified to monitor for duration of the diuresis (decreasing fluid in the body). -Ordered 1/27/15 through 2/5/15. *An order for Metoprolol (medication for high blood pressure) 12.5 mg two times a day.</p>	F 281			

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 281	<p>Continued From page 35</p> <p>-Started on 10/20/14.</p> <p>*An order for Lasix (medication to decrease fluid) 80 milligrams (mg) one time a day for ten days.</p> <p>-Ordered 1/26/15 through 2/5/15.</p> <p>*An order for Lasix 40 mg one time a day started on 2/7/15.</p> <p>Review of resident 2's 12/31/14 revised care plan revealed:</p> <p>*She had a current diagnosis of hypertension.</p> <p>*An intervention listed to "observe for abnormal vital signs and report to nurse/MD (physician)."</p> <p>-This intervention had a revised date of 10/7/14.</p> <p>Interview on 2/18/15 at 9:45 a.m. with licensed practical nurse (LPN) E revealed the physician should have been notified of the elevated BPs. That notification would have been documented in the resident's medical record.</p> <p>Interview on 2/18/15 at 3:15 p.m. with the director of nursing revealed he would have expected a re-check or follow-up assessment to have been completed when a resident had an elevated BP. He agreed the physician should have been notified. He confirmed there was no documentation to ensure a follow-up assessment or physician notification had been done for resident 2.</p> <p>Review of the provider's 11/12/14 Notification of Change in Resident Health Status policy revealed:</p> <p>*A guideline statement of "to ensure that proper notifications are made when a resident has a change in health status."</p> <p>**"Nursing judgment is an integral part of the skilled care provided in this LivingCenter; therefore, such judgement must be applied in a</p>	F 281		

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 281	<p>Continued From page 36</p> <p>case by case basis in keeping with acceptable nursing practice."</p> <p>Review of Patricia A. Potter and Anne Griffin Perry et al, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, p. 466, revealed: **"In addition to the actual vital sign values, record in the nurses' notes any accompanying or precipitating symptoms such as chest pain and dizziness with abnormal BP..." **"Document any interventions initiated as a result of vital sign measurement such as administration of oxygen therapy, hydration, or an antihypertensive medication." **"If a vital sign value is above or below the anticipated outcomes, write a variance note to explain the nature of the variance and the nursing course of action."</p> <p>Surveyor: 28057</p> <p>7. Observation on 2/18/15 at 3:30 p.m. revealed in the first floor east medication cart had been an Advair Diskus 500/50 for resident 27. It had not been dated when it had been opened. It had been filled on 1/13/15 on the label and had fifty-two doses remaining. Interview on that same day and time with RN K confirmed it should have been dated when it had been opened as it was good for only thirty days after opened. She confirmed she had not known when it had been opened and that fifty-two doses remained.</p> <p>8. Observation on 2/18/15 at 3:40 p.m. revealed the first floor west medication cart had an Advair Diskus 250/50 with twenty-two doses left for resident 11. It had not been dated when it had been opened. It had been filled on 1/23/15 according to the label. Interview on that same day and time with RN L confirmed it should have been</p>	F 281			

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 281	<p>Continued From page 37</p> <p>dated when it had been opened as it was good for only thirty days after opened. She confirmed she had not known when it had been opened and twenty-two doses remained.</p> <p>Review of the provider's May 2012 Storage of Medications policy revealed: *A nurse was to have placed a date opened sticker on a medication when it had been opened for use. *The expiration date would be thirty days after it had been opened. *The only deviation from the thirty days would have been if regulations or guidelines indicated otherwise.</p> <p>Review of the manufacturer's directions for the use of the Advair Diskus revealed the diskus was to have been disposed of after thirty days or when it had read zero, whichever occurred first.</p> <p>Surveyor: 32573</p> <p>9. Review of resident 4's physician's orders revealed she had returned from the hospital on 2/3/15 with a do not resuscitate (DNR) order.</p> <p>Review of her February 2015 medical administration record (MAR) revealed under the advance directive space it had been written as "do not resuscitate (discontinued as of 2/3/15), full code (discontinued as of 2/3/15)." It was not clear on her MAR if she was to be resuscitated or not.</p> <p>10. Review of resident 6's treatment administration record revealed: *An order to test stools for C-diff (a bacterial infection) if diarrhea returned dated 1/27/15. *The "hours" column specifying when to give a</p>	F 281		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 281	Continued From page 38 treatment had been left blank. *Each date box had an "X" in it, so it could not be filled in.	F 281	<b>F 309</b> * [REDACTED]	3/2/15
F 309 SS=K	<b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, interview, record review, and policy review, the provider failed to ensure an effective incontinence (lack of control of bowel and bladder) prevention and individualized toileting programs were initiated and/or maintained for 11 of 23 sampled residents (1, 2, 5, 8, 9, 10, 11, 13, 17, 23, and 24) Creating a situation of immediate jeopardy that had the potential for causing harm to all residents with incontinence.  NOTICE: Notice of immediate jeopardy was given verbally to the administrator and the director of nursing services (DNS) on 2/11/15 at 4:45 p.m. The administrator was asked for an immediate plan of correction to ensure all residents who were incontinent were monitored and provided toileting and personal care.	F 309	* Refer to abatement plan on pages 40-45 of form CMS-2567. In abatement plan the 5 residents that were identified were residents #1, #5, #9, #11, and #13. KW/SDDOH/MF  * Refer to the abatement plan for residents 1, 5, 9, 11 and 13. KW/SDDOH/MF  * Residents 10, 17 and 24 have new bowel and bladder assessments and updated care plans in regards to toileting. KW/SDDOH/MF	

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

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F 309	<p>Continued From page 39</p> <p>PLAN: On 2/11/15 at 5:45 p.m. the administrator provided the surveyors with the written plan of correction (POC). The written POC dated 2/11/15 was accepted by the surveyors at 5:45 p.m. That immediate POC included: *Education: Nursing staff would be re-educated on meeting the individual needs of the residents in regards to incontinence management, including pericare (personal care), frequent toileting, turning, and repositioning. Staff currently working would be educated immediately by the DNS and oncoming staff would be educated prior to starting their shift by the registered nurse (RN) in charge. *Supervision: RN in charge of current shift and ongoing night shift would receive education in regards to frequent rounding (frequent checking on residents), incontinence care, and toileting being provided by DNS for current shift and RN in charge for oncoming night shift. RN will supervise and ensure residents incontinence needs were being met throughout the shift. Certified nursing assistants (CNA) will use check list throughout current shift and oncoming night shift to document incontinence care provided. Check list will contain care performed with time and initials of staff. *Designee: DNS will be the designee for this plan of correction.</p> <p>On 2/12/15 at 2:00 p.m. the administrator provided the surveyors with the written abatement (correction) plan. This was accepted by the surveyors on 2/12/15 at 2:00 p.m. That abatement plan included: *All residents will maintain or reach their highest practicable well-being. *What correction action will be accomplished for</p>	F 309	<p>* Resident #3 has a new clinical health assessment done and an updated care plan in regards to toileting. KW/SDDAH/MF</p> <p>* Refer to tag F315 for Resident #2. KW/SDDAH/MF</p> <p>* Resident #3 had a bowel and bladder assessment completed. KW/SDDAH/MF</p>	

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

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F 309	<p>Continued From page 40</p> <p>those residents found to be affected by the deficient practice?</p> <p>-All nursing staff will be re-educated on meeting the individual needs of the residents in regards to incontinence management including pericare, frequent toileting, turning, and repositioning before the start of their next shift.</p> <p>*A bladder tracking tool completed to identify any trends or patterns the resident may have in relation to incontinence. A bladder evaluation will be completed to identify potentially reversible (transient) causes of urinary incontinence. The bladder evaluation will include:</p> <p>--Conditions, environmental factors, and hydration status.</p> <p>--Identification of a contributing diagnosis/medical condition.</p> <p>--Identification of medications that may be contributing to bladder dysfunction problem.</p> <p>--Continuing evaluation that includes past medical history/laboratory results, etc.</p> <p>--Depiction (written picture) of the incontinence symptoms the resident has present with-stress, urge, mixed, overflow, or functional incontinence.</p> <p>--Upon completion of this evaluation as well as the tracking tool a toileting/bladder program can be determined.</p> <p>--A note to summarize the findings will be written.</p> <p>--The care plan will be updated to include the findings of the bladder evaluation and interventions to manage incontinence.</p> <p>--This evaluation and care plan review will be done on 2/12/15 for all residents identified.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>*Residents who triggered (were identified) for low risk incontinence on the most recent Minimum</p>	F 309			

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - PRAIRIE HILLS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702</b>		
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F 309	<p>Continued From page 41</p> <p>Data Set (MDS) assessment will have a bladder tracking tool completed to identify any trends or patterns the resident may have in relation to incontinence.</p> <p>*A bladder evaluation will be completed to identify potentially reversible (transient) causes of urinary incontinence. The bladder evaluation will include:</p> <ul style="list-style-type: none"> <li>-Conditions, environmental factors, and hydration status.</li> <li>-Identification of a contributing diagnosis/medical condition.</li> <li>-Identification of medications that may be contributing to bladder dysfunction.</li> <li>-Continuing evaluation that includes past medical history/lab results, etc.</li> <li>-Depiction of the incontinence symptoms the resident has present with-stress, urge, mixed, overflow, or functional incontinence.</li> <li>--Upon completion of this evaluation as well as the tracking tool a toileting/bladder program can be determined.</li> <li>--A note to summarize the findings will be written.</li> <li>--The care plan will be updated to include the findings of the bladder evaluation and interventions to manage incontinence.</li> <li>--This evaluation and care plan review will be completed by 2/20/15.</li> <li>-All residents with catheters will be evaluated for appropriateness and care plan updated by 2/20/15.</li> </ul> <p>What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur includes:</p> <p>*All nursing staff on the current shift were immediately educated on meeting the individual needs of the residents in regards to incontinence management including pericare, frequent toileting, turning, and repositioning by the DNS.</p>	F 309			

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 309	<p>Continued From page 42</p> <p>Oncoming night shift was educated on this by the RN in charge.</p> <p>*RN in charge of current shift and oncoming night shift received education in regards to frequent rounding, incontinence care, and toileting being provided by DNS for current shift and RN in charge for oncoming night shift.</p> <p>-RN in charge supervised and ensured residents incontinent needs were being met throughout the shift.</p> <p>-CNAs used check list throughout current shift and oncoming night shift to document incontinence care provided. Check list contained care performed, time, and initials of staff.</p> <p>*All nursing staff would be re-educated on the Golden Living Incontinence Management/Bladder Function Guideline, pericare, frequent toileting, turning, and repositioning to meet the individual needs of each resident, activities of daily living (ADL) assistance, and dignity for residents with incontinence, and use of absorbent material for leaking catheters prior to the start of their next shift.</p> <p>-The nursing administration team will be educated on including comprehensive documentation and rationale to bladder and bowel assessments and appropriate use of catheters for residents before the start of their next shift.</p> <p>*New admissions, re-admissions, and significant changes of condition that experience incontinence will have a bladder tracking tool completed to identify any trends or patterns that the resident may have in relation to incontinence.</p> <p>-A bladder evaluation will be completed to identify potentially reversible (transient) causes of urinary incontinence. The bladder evaluation will include:</p> <p>-Conditions, environmental factors, and hydration status.</p> <p>-Identification of a contributing diagnosis/medical</p>	F 309		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 309	<p>Continued From page 43 condition.</p> <ul style="list-style-type: none"> <li>-Identification of medications that may be contributing to bladder dysfunction.</li> <li>-Continuing evaluation that includes past medical history/lab results, etc.</li> <li>-Depiction of the incontinence symptoms the resident has present with-stress, urge, mixed, overflow, or functional incontinence.</li> <li>--Upon completion of this evaluation as well as the tracking tool a toileting/bladder program can be determined.</li> <li>--A note to summarize the findings will be written.</li> <li>-The care plan will be updated to include the findings of the bladder evaluation and interventions to manage incontinence.</li> <li>-CNAs sheets will be reviewed at nursing start-up and changes to residents incontinence program will be added.</li> <li>-Current residents who experience incontinence will have their individual incontinence management/bladder function program evaluated with each quarterly MDS assessment to ensure continued appropriateness of the current program.</li> </ul> <p>How will the corrective actions be monitored to ensure the deficient practice will not recur? *The DNS or designee will complete an audit weekly for four weeks and monthly for two weeks for newly admitted residents and residents who have had a quarterly MDS completed to ensure a bladder evaluation and appropriate incontinence management interventions are in place.</p> <ul style="list-style-type: none"> <li>-Audit results will be reviewed during the monthly quality assurance performance improvement (QAPI:) meeting for further recommendations.</li> <li>*The DNS or designee will complete a weekly visual audit of five CNAs performing toileting and pericare to ensure that CNAs are following</li> </ul>	F 309		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - PRAIRIE HILLS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702</b>		
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F 309	<p>Continued From page 44</p> <p>resident's individual care plans.</p> <p>-This audit will be completed weekly for four weeks and then monthly for two months. Audit results will be reviewed during the monthly QAPI meeting for further recommendations.</p> <p>*Both audits will be started immediately.</p> <p>During the survey on 2/12/15 at 2:00 p.m. the surveyors confirmed removal of the immediate jeopardy situation.</p> <p>Findings include:</p> <p>Surveyor: 32573</p> <p>1. Review of resident 1's complete medical record revealed:</p> <p>*She had a current brief interview of mental status (BIMS) (test of thinking processes) score of 13, indicating her thought processes were intact.</p> <p>*She had diagnoses of muscle weakness, depressive disorder, anxiety, type II diabetes, macular degeneration (vision problems), osteoporosis (joint and bone problems), and several others.</p> <p>*She had four falls in the past six months (7/29/14, 11/25/14, 12/29/14, and 1/17/15).</p> <p>*All falls had occurred when trying to take herself to or from the bathroom.</p> <p>*She was not on a toileting program.</p> <p>Review of her 1/20/14 care plan revealed:</p> <p>*A focus area of "at risk for falls" with an initiation date of 3/30/11.</p> <p>-Under the interventions it stated "resident ambulates independently." The date initiated was 3/12/12 and revised on 1/20/14.</p> <p>*She had been found sitting on her bottom in the bathroom on 7/29/14. The fall intervention was to "encourage to use call light for help and ensure</p>	F 309		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - PRAIRIE HILLS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702</b>		
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F 309	<p>Continued From page 45</p> <p>resident is wearing glasses when awake." *An 11/28/14 intervention from the 11/25/14 fall had been to change her activities of daily living (ADL) ability from mostly independent to "assist of 1 for toileting."</p> <p>Review of her current care plan dated 2/10/15 revealed: *A focus area of "at risk for falls" with an initiation date of 3/30/11. An intervention of "resident ambulates with SBA (stand by assist) and gait belt" initiated 3/12/12 and was revised 1/8/15. *A focus area of "alteration in elimination of bladder related to frequent bowel incontinence, occasional bladder incontinence, and assistance required with toileting" had an initiation date of 6/17/11. There was a goal dated 3/12/13 and revised on 2/10/15 of "I will improve my current level of bladder continence which is occasionally incontinent." Interventions were as follows: -Extensive assist of one staff with toileting, initiated 1/9/15. There had been no indication that status should have changed from "assist of 1" to extensive assistance. That should have been initiated on 11/28/14 as stated on the previous care plan. -Received a diuretic medication which may cause increase urination, initiated 3/12/13 and revised 1/9/15. -Report changes in ability to toilet or continence status to interdisciplinary team, initiated 3/12/13 and revised 1/9/15. *A focus area of "extensive assist with bathing, transfers, dressing, bed mobility, and toilet use" initiated 4/1/10. -An intervention of "uses walker with assist of staff 1-2 with gait belt" initiated 3/11/13 and revised 1/8/15.</p>	F 309			

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - PRAIRIE HILLS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702</b>	
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F 309	<p>Continued From page 46</p> <p>The two above care plans had conflicting information and dates between focus areas and interventions. The current care plan had conflicting information about the resident's ADL abilities, transfer assistance needed, and bowel and bladder continence frequency when compared to the following nursing progress notes and fall reports.</p> <p>Review of resident 1's November 2014 nursing progress notes revealed:            *11/19/14, 10:57 p.m. She had a headache rated 8 out of 10 for pain and was given Tylenol.            *11/21/14, 10:37 a.m. "Resident having slurred speech and difficulty finding words. Order received to send resident to emergency room (ER)," left with daughter for ER at 10:56 a.m.            *11/21/14, 9:38 p.m. Returned from the ER, and "encouraged to call for help this pm, since some dizziness persists. Is usually independent with ADL's and transfers."            *11/22/14, 8:05 p.m. She had headache pain rated 7 out of 10 and was given Tylenol.            *11/23/14, 9:59 a.m. "Resident is weak. Using call light appropriately. Complaining of headache. Loose stools reported and complaints of upset stomach."            *11/24/14, 1:32 a.m. She had gone to the nurses station in her wheelchair because her headache had returned.            *11/25/14, 3:43 a.m. after a fall, it was noted she had a "history of a dizziness episode, unsteadiness, and a headache. It was currently recommended that she use her wheelchair."</p> <p>Review of resident 1's 11/25/14 at 3:45 a.m. fall report revealed:            *Fall occurred when she was walking back from the bathroom.</p>	F 309		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - PRAIRIE HILLS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>916 MOUNTAIN VIEW ROAD 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 309	<p>Continued From page 47</p> <p>*She had tripped over her wheelchair. *That had resulted in broken ribs. *Fall interventions were "resident reminded to always call for help every time she needs to get out of bed/using toilet."</p> <p>Review of her November 2014 bowel and bladder detail report revealed she had been incontinent of bowel three times and incontinent of bladder once in the two days before the fall on 11/25/14. She had not been incontinent of bowel any other times in November.</p> <p>Review of resident 1's December nursing progress notes revealed: *12/18/14, 12:16 p.m. Resident "requires assist of one with ADL's and transfers, is reminded to use a call light for staff assist due to weakness, toilets with staff assist, wears pull ups." *12/24/14, 7:46 a.m. Resident refused MiraLax powder (for constipation), because she "was up all night." *12/27/14, 7:27 a.m. Resident stated she "had been having loose stools lately." *12/29/14, 7:05 a.m. When she had been found after her fall she had been "incontinent to stool." *12/31/14, 9:26 a.m. Resident "reminded to ask for assistance as needed."</p> <p>Review of her 12/29/14 at 5:30 a.m. fall report revealed: *She had tried to transfer herself to the bathroom and tripped on her nightgown. *She hit her head with a reddened area noted. *Fall report interventions were to encourage her to use her call light and ask for assistance.</p> <p>Review of resident 1's January nursing progress notes revealed:</p>	F 309		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 309	<p>Continued From page 48</p> <p>*1/8/15 11:35 p.m. "Resident continues on tamiflu. Displays mild cold symptoms-nasal congestion and "stuffy head".</p> <p>*1/9/15 10:37 a.m. "Unsteady but able to stabilize during transitions and walking."</p> <p>*1/16/15 2:33 p.m. The Tamiflu course had been completed.</p> <p>*There were no notes between 1/9/15 and 1/16/15 regarding her condition.</p> <p>*1/17/15 1:46 p.m. the fall follow-up note stated she was "reminded to use call light to ask for assistance as needed."</p> <p>Review of her 1/20/14 care plan and 1/17/15 at 6:00 a.m. fall report revealed: -The fall had occurred when she tried to take herself to the bathroom.</p> <p>*She had been found on her room floor incontinent of bowel with loose stool. There had been stool smeared on the floor.</p> <p>*The fall intervention had been to "remind resident to wait for assistance-even if urgent."</p> <p>Review of her 12/27/14 Clinical Health Status assessment revealed: *Under urinary incontinence she had been marked as usually continent. *For programs, briefs had been checked as used.</p> <p>Review of resident 1's 1/2/15 bowel and bladder assessment forms revealed she had been checked off for the following: *Was continent and incontinent of bowel. *Recognized the appropriate time and place to toilet. Treatment/management program placement decisions: provide incontinent care and comfort PRN. *Was continent and incontinent of bladder partially due to "urgency and unable to suppress."</p>	F 309		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - PRAIRIE HILLS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>916 MOUNTAIN VIEW ROAD 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 309	<p>Continued From page 49</p> <p>-Had strong, uncontrolled urgency prior to incontinence, urine loss on the way to the bathroom, and mixed incontinence. *Had decreased vision due to macular degeneration (eye condition). -Decreased vision might have been an environmental option for what may cause incontinence. *Contributing diagnoses and/or medical conditions were falls, diabetes, constipation, and history of urinary tract infections. **"Not appropriate for a toileting program" because "resident with one episode of bowel incontinence and two episodes of bladder incontinence during week lookback. Wears pullups for security. Able to make needs known, uses call light appropriately. Requires limited to extensive assist with ADLs."</p> <p>Review of the provider's 1/13/15 Incontinence Management/Bladder Function Guideline revealed the purpose was to: *Enable the resident to control urination without a catheter whenever possible. *Prevent skin problems such as pressure areas and excoriation (a superficial break in the skin such as a scratch). *Improve the morale of the resident. *Restore the resident's dignity. *Manage urinary incontinence, restore or maintain as much normal bladder function as possible.</p> <p>General guidelines to retain bladder function included "develop a schedule of toileting times specific to the resident. Observe and record the resident's voiding pattern and revise the toileting schedule to meet the residents toileting needs. Keep floor clear of obstacles."</p>	F 309		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 50</p> <p>The "choosing a program that fits the resident after evaluation" section of the guideline included:            **Scheduled toileting/habit training- If the resident has no pattern of urinary incontinence due to functional or transient incontinence then schedule the residents toileting at regular intervals to increase continent episodes per habit such as upon arising, before and after meals and before going to bed. Schedule toileting is a timed voiding."            **Prompted voiding- If the resident displays a usual pattern of incontinence due to urge or mixed incontinence establish toileting times prior to an accident. Prompted voiding is a behavioral technique."            **Absorbent products/external collection devices- If the resident is cognitively impaired and is unsuccessful at toilet training or is unable to participate in retraining then the resident should be placed on incontinence care program."</p> <p>Monitoring/compliance to the guideline included the following:            **Incontinent residents are assessed per guideline."            **Evaluation of casual factors determines program initiated."            **Care plan reflects individualized program."            **Observation of care provided matches the plan of care."</p> <p>Surveyor: 26632            2. Review of resident 5's medical record revealed:            *She had acquired a stage two pressure ulcer (open area on skin) to her lower left buttock (side of bottom) on 12/1/14.            *The pressure ulcer had increased in size and</p>	F 309		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - PRAIRIE HILLS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702</b>		
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F 309	<p>Continued From page 51</p> <p>was a stage three (deeper open area on skin) on 12/9/14.</p> <p>*A physician's order was requested for the use of a urinary catheter (tube to drain urine from bladder) due to her being incontinent of urine.</p> <p>*The pressure ulcer was healed on 1/12/15.</p> <p>*A facsimile request to her physician was sent on 1/12/15 to continue the use of the urinary catheter due to a diagnosis of unspecified retention of urine.</p> <p>Review of resident 5's 12/2/14 immediate plan of care for pressure ulcer risk revealed an intervention of "Resident at risk for urinary incontinence." There were no other interventions present for pressure ulcer risk.</p> <p>Review of resident 5's 3/30/10 initial care plan for incontinence revealed:</p> <p>*A focus of incontinent of urine. Urine was crossed out and bowel added on 1/16/15. Had colostomy for bowels.</p> <p>*Goals included: "Skin around colostomy intact and free from breakdown/redness."</p> <p>*Interventions included:</p> <p>- "Wears briefs to help manage incontinent episodes and maintain dignity."</p> <p>- "Check and change brief upon rising, before and after meals, bedtime, NOC (night) rounds, and as needed initiated on 1/21/14."</p> <p>- "Indwelling catheter, catheter care per MD (physician) orders initiated on 1/16/15."</p> <p>3. Review of resident 10's medical record revealed</p> <p>*She had been admitted on 10/7/14 with a diagnosis of closed fracture of her pelvis.</p> <p>*Her 10/14/14 admission MDS revealed she was frequently incontinent of urine and bowel.</p>	F 309			

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 309	<p>Continued From page 52</p> <p>*A 10/9/14 bladder evaluation assessment revealed:</p> <ul style="list-style-type: none"> <li>-She was currently continent of bladder was checked yes.</li> <li>-If the above had been checked yes the form was considered to have been completed. The form was only to have been completed if a no had been checked for bladder incontinence.</li> <li>-She was currently incontinent of bladder was checked yes</li> <li>-For potentially reversible causes of urinary incontinence impaired mobility/ambulation was checked.</li> <li>-For contributing diagnosis/medical conditions impaired mobility status post pelvic fracture was checked.</li> <li>-For medication that might contribute to bladder dysfunction narcotic and sedatives were checked.</li> <li>-For further evaluation physical examination performed and history and physical was checked yes.</li> <li>-Incontinence symptom profile, functional urinary incontinence due to mobility and medication use was checked.</li> </ul> <p>*A 2/2/15 quarterly update to the bladder evaluation assessment revealed:</p> <ul style="list-style-type: none"> <li>-She required assistance of one staff for her ADLs.</li> <li>-She made her needs known to staff.</li> <li>-Four out of seven bowel movements were incontinent for the prior two weeks.</li> <li>-Forty-three out of fifty-one urination's were incontinent over the prior two weeks.</li> <li>-Wore a brief for security.</li> <li>-Was not appropriate for toileting or retraining program at this time.</li> </ul> <p>Review of resident 10's 10/24/14 care plan for alteration in elimination of bowel and bladder due</p>	F 309			

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 309	<p>Continued From page 53</p> <p>to immobility related to pelvic fracture revealed: *Goals that she would improve her current level of bowel and bladder continence by 10% by the next review with a target date of 1/2/15. *Interventions included use of briefs for incontinence protection.</p> <p>4. Review of resident 17's record revealed: *She had been admitted 9/3/14 due to a fracture of her left lower leg. *She had been admitted with an indwelling urinary catheter. *The catheter had been discontinued on 9/24/14. *Review of 9/23/14 bladder evaluation revealed: -She was continent of bladder had been checked yes. -No further bladder evaluation's had been completed after her urinary catheter had been discontinued on 9/24/14.</p> <p>Review of resident 17's following MDSs revealed: *Admission 9/10/14 MDS she used a urinary catheter. *Re-admission 12/3/14 MDS she was frequently incontinent of urine. *Quarterly 12/10/14 MDS she was frequently incontinent of urine.</p> <p>Review of resident 17's 9/19/14 alteration in elimination of bowel and bladder, indwelling urinary catheter, constipation, and assistance required with toileting and bowel incontinence care plan revealed: *She would improve her current level of bowel incontinence, currently always incontinent. *She would have no complications from the use of the indwelling urinary catheter such as pain, infection, or obstruction. *The interventions for her urinary catheter had</p>	F 309			

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 309	<p>Continued From page 54 been crossed out with a date of 2/12/15. Her urinary catheter had been discontinued on 9/24/15.</p> <p>*Use of briefs for incontinence protection. *Monitor and report changes in ability to use toilet or continence status to the interdisciplinary team. *Provide extensive assistance for toileting, uses bedpan at times.</p> <p>Surveyor: 32572 5. Review of resident 9's medical record revealed: *The 8/15/14 Annual Clinical Health Status assessment contained the following regarding incontinence: *The Braden Scale for Predicting Pressure Sore Risk indicated he had been "often moist." The urinary continence sections indicated he was frequently incontinent. *The 1/12/15 through 2/11/15 Bowel and Bladder Detail Report indicated seventy-two of seventy-three times he had been incontinent of urine. *The 2/4/15 CNA Report Sheet indicated he had been incontinent of bowel and bladder. He currently was on an incontinence toileting schedule. *The comprehensive care plan did not indicate he had been on a incontinence toileting schedule.</p> <p>6. Review of resident 11's medical record revealed: *The 1/30/15 Minimum Data Set (MDS) assessment revealed a BIMS score of 15 indicating her thought processes were intact. *The 1/23/15 Admission Clinical Health Status assessment indicated she did not have a catheter (tube into the bladder), she was frequently incontinent, she had a history of Clostridium</p>	F 309			

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 309	<p>Continued From page 55</p> <p>Difficile (C Diff)(infection of the bowel). There had been a supra-pubic catheter present upon admission.</p> <p>*Review of the 2/4/15 Bowel and Bladder Evaluation forms revealed:</p> <ul style="list-style-type: none"> <li>-She had been incontinent of bowels.</li> <li>-She had been "able to recognize appropriate time/place to defecate [stool]."</li> <li>-She had "urinary retention (unable to empty bladder completely) with persistent overflow incontinence, symptomatic infections and/or renal [kidney] dysfunction [abnormal function]."</li> <li>--There had been no documentation of the catheter leaking urine onto her skin.</li> </ul> <p>Surveyor:22632 Observation on 2/10/15 at 4:45 p.m. revealed CNAs R, T, and U began to provide personal care for resident 11. Before the care started resident 11 stated she was feeling chilled and uncomfortable due to being wet. During the observation of personal care it was noted that a bath towel had been placed around resident 11's supra-pubic catheter (tube through opening in abdomen into bladder to drain urine). That bath towel when removed by CNA U was noted to have been soaked with urine. Resident 11's abdomen was also noted to be red.</p> <p>Surveyor: 32572 Review of the 2/4/15 CNA Report Sheet indicated resident 11 had a history of C Diff infection, she needed assist of two for transferring, she had a catheter, it did not indicate she was incontinent of bowels. The form indicated she used the bedpan for toileting needs. The comprehensive care plan did not include the catheter leaking and the care needed to protect the skin from wetness.</p>	F 309		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 309	Continued From page 56  7. Review of resident 13's medical record revealed: *The 11/13/14 MDS assessment revealed a BIMS score of 14 indicating her thought processes were intact. *Review of the 2/9/15 Re-admission from a hospital stay Clinical Health Status assessment revealed he was able to pivot transfer (how to move) with limited assistance. *He was occasionally incontinent. *He was not on a scheduled toileting plan or bladder retraining program. The Braden scale for predicting pressure sore risk had been coded as occasionally moist.  Observation on 2/10/15 from 8:30 a.m. through 11:00 a.m. revealed resident 13 had been sitting in his wheelchair in his room. His pants were wet and remained wet during that time.  Review of the following reports and care plan revealed: *The 2/4/15 CNA Report Sheet revealed no documentation on how he was to have been transferred or if he had been incontinent of bowel and bladder. *The Bowel and Bladder Detail Report for 1/12/15 through 2/11/15 revealed urinary incontinence had been documented sixty-nine out of eighty-nine times. *The 2/17/15 revised comprehensive care plan revealed he had been incontinent of bowel and bladder with no incontinent scheduled toileting or toileting plan, and he required the assistance of one staff person with transfers.  8. Review of resident 23's medical record revealed:	F 309		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - PRAIRIE HILLS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702</b>		
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F 309	<p>Continued From page 57</p> <p>*The 1/29/15 MDS assessment revealed a BIMS score of 14 indicating her thought processes were intact.</p> <p>*The 1/22/15 Admission Clinical Health Status assessment indicated she had been continent of bladder.</p> <p>*The 2/4/15 Bowel and Bladder Evaluation Forms indicated she had been continent of urine but had functional urinary incontinence.</p> <p>*The 2/17/15 CNA Report Sheet revealed she was to use a walker or wheelchair for mobility (getting around), she had required assistance of one staff person to stand by assistance for transfers. It stated she toileted herself independently.</p> <p>*The 2/11/15 comprehensive care plan revealed the resident had the potential to be incontinent due to functional incontinence.</p> <p>*The comprehensive care plan included a risk for pressure ulcer care plan that had an intervention to "provide thorough skin care after incontinent episodes and apply barrier cream to any redness and/or excoriation (soreness)." The physical functioning care plan indicated she needed limited assistance from staff with toileting and transfers.</p> <p>9. Review of resident 24's medical record revealed:</p> <p>*The 11/24/14 MDS assessment revealed a BIMS score of 15 indicating her thought processes were intact.</p> <p>*Review of the 12/18/18 [14] Quarterly Interdisciplinary Resident Review indicated a bowel and bladder assessment had been completed and the summary section stated "Resident is a potential candidate for nursing, restorative/rehabilitation, or bladder training program." The Braden Scale section for</p>	F 309			

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - PRAIRIE HILLS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702</b>	
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F 309	<p>Continued From page 58</p> <p>predicting pressure sore risk indicated she had been "occasionally moist."</p> <p>*Review of the 12/18/14 Bladder Evaluation Form indicated she was continent and both her "clothes or incontinence pad were wet." That assessment determined she had overflow and functional urinary incontinence, and she was not a candidate for toileting or retraining program. That assessment did not indicate how many times she had been continent or incontinent over the last two weeks.</p> <p>*Review of the 12/8/14 Bowel Assessment Form indicated she had been continent and incontinent of bowel. It indicated she "recognizes appropriate time/place to defecate and is able to feel urge sensation for bowel movement." It indicated she was unable to participate in a program due to "new admit, has been incont [incontinent] and continent of bowel, will continue to monitor for B&amp;B [bowel and bladder]."</p> <p>*Review of the 2/17/15 CNA Report Sheet indicated she required the assistance of one staff member for transfers, she had been incontinent of urine, she used the toilet, and she received incontinent care with a toileting schedule.</p> <p>*Review of the 12/2/14 revised comprehensive care plan indicated bowel and bladder incontinence, it did not indicate she had been on a toileting schedule.</p> <p>Interview on 2/18/15 at 3:15 p.m. with the director of nursing revealed the toileting schedule for the resident was to be toileted upon rising, before and after meals, at bedtime, and during rounds at night. Rounds at night were at midnight, 2:00 a.m., and 4:00 a.m.</p> <p>Surveyor: 35237 Preceptor: 20031</p>	F 309		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 309	<p>Continued From page 59</p> <p>10. Interview on 2/10/15 at 1:45 p.m. with resident 2 revealed she:</p> <ul style="list-style-type: none"> <li>*Had an indwelling Foley catheter.</li> <li>*Stated she "had it a long time. It's because I had sores from my diapers not being changed like they should."</li> <li>*Stated it would be too much trouble to put her on the toilet because she needed the lift (equipment) to be moved.</li> <li>*Had not tried a commode (portable toilet) since she had been there.</li> <li>*Used a bed pan maybe once a week.</li> <li>*Sometimes just went in her pants.</li> </ul> <p>Interview on 2/10/15 at 1:30 p.m. with LPN D revealed resident 2 used a bed pan for bowel movements and did not use the toilet. She stated the resident had a history of pressure ulcers and was admitted with the catheter. She further stated the catheter was in place due to incontinence, and she needed the total lift for transfers.</p> <p>Observation on 2/10/15 at 5:42 p.m. of catheter care for resident 2 revealed she had a Foley catheter in place and was incontinent of bowel.</p> <p>Interview at that same time with CNAs S and R revealed the resident was frequently incontinent of bowel, and she occasionally used a bed pan. The CNAs stated "Resident does not use a commode or the toilet and does not know when she goes."</p> <p>Interview on 2/11/14 at 11:30 a.m. with the wound care nurse revealed the resident preferred to use a bed pan due to contractures (a condition that changes the body causing a difference in appearance and stiffness in the joints). She had pain when she sat for too long. The nurse was</p>	F 309		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 309	<p>Continued From page 60</p> <p>unsure if staff had ever tried to use the toilet or a commode for the resident. She knew the resident had worked with therapy in the past but did not know if therapy had worked on toileting with the resident. She stated the resident had been aware of when she needed to have a bowel movement. She stated the only open area the resident had now was on her left middle finger, all the other open areas had healed.</p> <p>Interview on 2/11/15 at 2:30 p.m. with the DON revealed resident 2 was unable to sit on the toilet or a commode due to her contractures. She used the bed pan for bowel movements. When asked about a toileting schedule or program he stated staff checked on her frequently, and she would put the call light on when she had to go or already had a bowel movement.</p> <p>Review of the resident 2's Minimum Data Set (MDS) assessments dated 9/29/14 and 12/15/14 revealed she:</p> <ul style="list-style-type: none"> <li>*Was mentally aware.</li> <li>*Needed extensive assist of staff to be toileted.</li> <li>*Needed assistance of two or more staff to be toileted.</li> <li>*Had an indwelling catheter.</li> <li>*Was not on a urinary toileting program.</li> <li>*Was frequently incontinent of bowel.</li> <li>*Was not on a bowel toileting program.</li> </ul> <p>Review of the resident 2's current care plan initiated on 10/7/14 and last revised on 12/31/14 revealed:</p> <ul style="list-style-type: none"> <li>*Focus area of "alteration in elimination of bowel and bladder"</li> <li>- "Indwelling Urinary Catheter."</li> <li>- "Constipation."</li> <li>- "Bowel incontinence."</li> </ul>	F 309			

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 309	<p>Continued From page 61</p> <p>-"Assistance required with toileting." *Interventions related to bowel and bladder: -"Check and change frequently." -"Provide extensive assistance to toilet, uses bed pan at times." -"Use of briefs for incontinence protection." -"Monitor and report changes in ability to toilet or continence status to IDT [interdisciplinary team]." *Focus area of "potential for alteration in hydration" related to diabetes and constipation. -Intervention to "monitor BM [bowel movement] per care tracker." *Focus area of "pressure ulcer actual and at risk." -Intervention to "provide thorough skin care after incontinent episodes and apply barrier cream." *It did not mention the reason for the catheter. *It did not mention the resident's ability to use the call light to ask for assistance when incontinent.</p> <p>Review of resident 2's 9/23/14 Bladder Evaluation form revealed: *The section for admission information regarding urinary continence status had two boxes to indicate if the resident was currently continent or incontinent of bladder. Neither box had been checked. *The section for evaluation of residents with indwelling catheters stated to skip that section if the resident did not have an indwelling catheter. Nothing had been checked in that section. *The section for treatment program had been checked that the resident was not appropriate for toileting or retraining program. *The summary indicated the resident had been: -Alert and oriented (mentally aware) with periods of confusion noted. -Able to make needs known to staff. -Continent of bowel. -Continent of bladder.</p>	F 309		

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

PRINTED: 03/05/2015  
FORM APPROVED  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 309	<p>Continued From page 62</p> <ul style="list-style-type: none"> <li>-Wore a brief for security.</li> <li>-Not appropriate for toileting or retraining program.</li> </ul> <p>*Another summary dated 1/7/15 for a quarterly review indicated she had been:</p> <ul style="list-style-type: none"> <li>-Alert and oriented.</li> <li>-Able to make needs know to staff.</li> <li>-Incontinent of bowel.</li> <li>-Continent of bladder with a Foley catheter in place.</li> <li>-Wore a brief for security.</li> <li>-Not appropriate for toileting or retraining program at this time.</li> </ul> <p>Review of resident 2's 9/23/14 Bowel Evaluation form revealed:</p> <ul style="list-style-type: none"> <li>*The section for admission information regarding bowel continence status had two boxes to check indicating if she was currently continent or incontinent of bowel. Neither box was checked.</li> <li>*She recognized the appropriate time and place to have a bowel movement.</li> <li>*She was able to feel the urge sensation for a bowel movement.</li> <li>*The section for treatment program had been checked that she was unable to participate in a program due to continent of bowel at that time.</li> <li>*That form was signed by the nurse under the review section on 1/7/15.</li> <li>-The reason for review was listed as quarterly</li> <li>-The box "No" was checked for able to participate in a bowel program.</li> </ul> <p>Review of the resident's bowel and bladder detail report from 1/12/15 through 2/11/15 revealed:</p> <ul style="list-style-type: none"> <li>**"Appliances" was listed for the description of the resident's continence on all the bladder activity entries.</li> <li>**"Continent" was listed for the description of the</li> </ul>	F 309		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 309	<p>Continued From page 63</p> <p>resident's bowel activity three times. **"Incontinent" was listed for the description of the resident's bowel activity fourteen times.</p> <p>Surveyor: 23059 11. Review of resident 8's medical record revealed a bowel and bladder evaluation form had been completed upon admission on 8/1/14. That evaluation indicated she was continent of both bowel and bladder. Under the section "Incontinence Symptom Profile" it indicated she had functional urinary incontinence. That statement conflicted with the previous statement that she was currently continent of bladder. The summary continued to state she was: *Alert and oriented. *Able to make her needs known to staff. *Used her call light appropriately. *Wore briefs for security. *Not appropriate for a toileting program at that time. No evaluation of her bowel and bladder function had been completed since that time.</p> <p>Review of her medical record revealed she had fallen on 11/26/14. That fall had resulted in a left leg fracture. Review of her nurse's notes from that time through 2/10/15 revealed she was both continent and incontinent of bowel and bladder. Those notes stated she would use a bedpan or would choose to urinate in her brief.</p> <p>Review of the provider's reviewed 1/19/15 Incontinence Management/Bladder Function Guideline revealed: *The purpose of the bladder management program was to: -Enable the resident to control urination without a catheter whenever possible.</p>	F 309		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 309	Continued From page 64 -Avoid possibility of a urinary infection. -Prevent skin problems such as pressure areas and excoriation. -Improve the morale of the resident. -Restore the residents dignity. -Manage urinary incontinence, restore or maintain as much normal bladder function as possible. *Upon admission complete the bowel and bladder tracking tool. *Choose a program that would fit the resident after evaluation. Those programs could include: -Scheduled toileting. -Prompted voiding. -Pelvic floor muscle rehabilitation. -Medication therapy. -Absorbent products. *The interdisciplinary care plan team would evaluate the effectiveness of the program and make recommendations to continue, change, or discontinue the program with the quarterly MDS review. *The following elements were to be in place to demonstrate satisfactory compliance with the guide. That monitoring would have included: -Incontinent residents would have been assessed per guideline. -Evaluation of casual factors determined the program initiated. -Care plan reflected individualized program. -Observations of care provided matches the plan of care.	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the	F 314		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 314	<p>Continued From page 65</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, interview, record review, and protocol review, the provider failed to assess, identify, and implement interventions for residents at risk of developing pressure ulcers (injury to skin and tissue from prolonged pressure on the skin) for 2 of 11 residents (8 and 17) with pressure ulcers acquired in the facility. Findings include:</p> <p>Surveyor: 23059 1. Review of resident 8's medical record revealed she fell on 11/26/14. That fall had resulted in a fracture to the left femur (upper leg bone). She had been placed in a leg brace to prevent movement in that leg.</p> <p>Review of a 12/23/14 fax revealed the nurse had questioned resident 8's primary physician as to whether or not she should have a follow-up appointment with the orthopedic doctor. Her primary physician replied on 12/24/14 "Please have the pt [patient] follow-up with _____ [name of facility] asap [as soon as possible]. I would like to see her get a less obtrusive [large] brace for leg. Or better yet be given the OK to remove completely."</p> <p>Review of her 12/25/14 nurses notes revealed</p>	F 314	<p><b>F 314</b></p> <ol style="list-style-type: none"> <li>1. Resident's 8 and 17 care plans have been updated to reflect their current woundcare plan. Residents with pressure ulcers will have their care plans reviewed.</li> <li>2. DNS or designee will educate all staff on pressure ulcers, prevention, treatment, and care planning by March 21, 2015.</li> <li>3. DNS or designee will audit the care plans and charts of all residents with pressure ulcers for accuracy and completeness weekly for 4 weeks and then monthly thereafter. DNS or designee will report results at monthly QAPI for review, recommendation and continuation or discontinuation of audits.</li> <li>4. March 21, 2015</li> </ol>	3/21/15

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 314	<p>Continued From page 66</p> <p>resident 8 had complained frequently the brace was too large. A skin assessment on that day revealed an open area to the left back upper thigh that "appears to be from brace worn to left leg." A fax had been sent to the physician on that day for a follow-up appointment with the orthopedic doctor. Continued review of the nurse's notes revealed an open area was first noted on her upper thigh on 12/28/14. That area was reported to the wound care nurse and was described as "possibly related to the leg immobilizer. Does not appear to be pressure related." The measurement of the "slit" at that time was 0.2 centimeters (cm) by 2 cm by 0.1 cm. A Mepilex border dressing had been applied for protection.</p> <p>Review of the 1/1/15 skin assessment revealed "Top of brace rubbing on skin near peri [upper inner thigh] area and left thigh. Mepilex bandages applied to left inner thigh and top of rear left thigh. Follow up appt [appointment] scheduled for brace evaluation. No other skin concerns at this time."</p> <p>Review of her 1/2/15 nurse's note revealed the resident was at risk for pressure areas. No current pressure areas were being treated at that time. Review of her 1/5/15 nurse's note revealed she had a follow-up visit that day with the physician "re: [regarding] brace-breakdown from brace-will monitor." Review of the 1/5/15 clinic referral note revealed she had been seen that day by her psychologist. The leg brace had not been addressed during that visit.</p> <p>Review of her 1/6/15 nurse's note revealed the wound care nurse continued to follow the "thigh wound r/t [related to] the brace."</p> <p>Review of her 1/7/15 progress notes from her</p>	F 314			

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 314	<p>Continued From page 67</p> <p>visit to the orthopedic physician revealed the nurse had alerted the physician to the open areas on the upper thigh. The physician had not addressed the need for a different leg brace. He had ordered an increase in the range of motion in the hinged knee brace by 10 to 20 degrees weekly.</p> <p>Review of her 1/8/15 weekly nurse's skin review revealed a dressing was "replaced to the posterior [back] left thigh where the brace irritates the skin." Those nurse's notes also stated the physician had been notified of the resident's skin issues on the last visit.</p> <p>Review of her 1/15/15 nurse's skin assessment revealed she continued to have a "sore area to upper rear left thigh." No other skin issues were noted.</p> <p>Review of her 1/16/15 occupational therapy treatment notes revealed "Pt was found by PT [physical therapist] to have wounds on her L [left] foot/ankle on the anterior [front] and posterior [back] sides from the brace. Wound care has dressed the pt at this time; pt's brace is being adjusted by maintenance.</p> <p>Interview on 2/18/15 at 2:10 p.m. by telephone with the director of therapy revealed she had seen resident 8 on 1/16/15. She stated her leg brace was to have been worn "around the clock" at that time. She stated the resident complained of her leg and ankle hurting. She stated she had complained of leg pain before but had not complained of ankle pain prior to that time. She stated she noted two "large" wounds, one on the top of her foot and the other on the back of her ankle. She stated she immediately notified the</p>	F 314		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 314	<p>Continued From page 68</p> <p>second floor resident care coordinator and the wound care nurse. They removed the brace, and it slid down easily on the leg when the resident was in bed. The brace was adjusted by maintenance at that time, and two inches were removed from the top of the brace. She stated she felt the brace fit the resident well at that point. She also stated she did not feel a wound of that size could have developed within one day.</p> <p>Review of the resident's 1/16/15 change of condition report revealed "resident has unstageable [covered by scab and not able to measure the depth or severity] pressure ulcers to anterior (1.5 x 4 cm) and posterior ankle (0.7 x 5 cm). Pressure ulcers are a result of immobilizer brace rubbing." The physician was notified by fax on that day. The physician had replied regarding treatment for the pressure ulcers. He did not address the issue of the brace causing the pressure ulcers.</p> <p>Review of her 1/21/15 nurse's notes revealed dressings were intact to the sore areas on her ankle and thigh. Review of her 1/23/15, 1/27/15, and 1/30/15 nurse's notes revealed she continued to wear a stabilizing brace at all times. Wound care was to follow the pressure ulcer areas on her left ankle related to the brace.</p> <p>Review of the 1/30/15 weekly skin care note revealed "Left anterior and posterior ankle pressure ulcers remain present. Both wounds noted to be getting smaller. Left leg immobilizer brace remains in use and repositioned prn [as needed] to prevent further skin breakdown."</p> <p>Review of the 2/6/15 weekly skin care note revealed " Pressure ulcer to left anterior and</p>	F 314		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 314	<p>Continued From page 69</p> <p>posterior ankle remain present. Both wounds continue to decrease in size." Review of her 2/6/15 nurse's notes revealed "Resident went to _____ [name of orthopedic provider] earlier in the day and received a new smaller brace and new orders for TTWB [toe touch weight bearing] and brace on when up." Review of the physician's notes from that day revealed he had not mentioned the change to a smaller brace.</p> <p>Review of the weekly wound evaluation flow sheets for the ankle ulcers from 1/16/15 through 2/17/15 revealed they had been measured weekly and had remained unstageable. The areas had decreased in size from the original measurement.</p> <p>Observation on 2/10/15 at 8:45 a.m., 10:55 a.m., and 1:40 p.m. revealed resident 8 was laying on her back in her bed. The leg brace was on her left leg.</p> <p>Observation on 2/10/15 at 1:45 p.m. with the wound care nurse revealed the wounds on both ankles had remained unstageable and had scabbed over. The measurements of those wounds at that time were: *Anterior ankle: 1 cm x 2.5 cm. *Posterior ankle: 1.5 cm x 2.8 cm.</p> <p>Interview on 2/18/15 at 2:15 p.m. with the second floor resident care coordinator revealed she could not find documentation to support: *The orthopedic physician had been notified of the primary physician's 12/24/14 concern of the need for a different leg brace or complete removal of the brace. *The orthopedic physician had been notified of the irritation from the leg brace prior to the 1/7/15 visit.</p>	F 314		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 314	<p>Continued From page 70</p> <p>*The nurse had contacted the orthopedic physician after receiving the consultation report back from the above visit regarding the concerns related to the leg brace.</p> <p>*The nurse had contacted the physician regarding the ill-fitting leg brace after his reply did not address it.</p> <p>*A physician had been notified prior to 2/6/15 regarding the continuation of the leg brace and clarification of whether or not it could have been changed to a different brace.</p> <p>*In that same interview the care coordinator confirmed:</p> <ul style="list-style-type: none"> <li>-Resident 8 should not have been wearing the leg brace when in bed as indicated in the 2/6/15 physician's orders.</li> <li>-The use of the leg brace had not been care planned for use.</li> <li>-The ill-fitting brace should have been addressed sooner and may have prevented the sores from developing on the ankles.</li> </ul> <p>Surveyor:26632</p> <p>2a. Review of resident 17's medical record and right heel wound evaluation flow sheet revealed:</p> <ul style="list-style-type: none"> <li>*She had been admitted on 9/3/14.</li> <li>*She had diagnoses that included a left lower leg fracture, diabetes mellitus, peripheral neuropathy (decreased sensation in extremities).</li> <li>*On 11/18/14 an unstageable pressure ulcer was noted to her right heel.</li> <li>*The measurements were 3.5 cm in length by 5.5 cm in width.</li> <li>*It was an intact fluid filled blister.</li> <li>*A Prevalon boot was initiated at that time.</li> <li>*She was admitted to the local hospital due to an infection in her left heel pressure ulcer.</li> <li>*On re-admission the pressure ulcer measured 6 cm in length by 6.5 cm in width and 0.2 cm in</li> </ul>	F 314			

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 314	<p>Continued From page 71 depth. *It had a moderate amount of drainage. *A foam heel lift boot was in place. *A specific turn and reposition program of every one to two hours was in place.</p> <p>Interview on 2/12/15 at 10:30 a.m. with licensed practical nurse (LPN) E/resident care coordinator revealed: *Her left heel pressure ulcer had been discovered when the physician had removed the splint. *She believed the right pressure ulcer had resulted in resident 17 resting her heel against the foot plate of her electric wheel chair. *She agreed the pressure ulcer was preventable. *She agreed the clinical interdisciplinary reviews did not have the diabetic foot screenings completed. *She agreed that did not follow the care plan for pressure ulcers.</p> <p>b. Review of resident 17's medical record and 9/16/14 initiated wound evaluation flow sheet revealed: *She had a left leg fracture. That leg including her foot and heel had been in a splint. *There were physician's orders not to remove the splint. *On 9/16/14 she was seen by the orthopedic physician, and the splint was removed. *It revealed an unstageable (Full thickness tissue loss in which the base of the ulcer is covered by yellow, tan, gray, green, or brown tissue, and/or eschar (scab), deep tissue injury (purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure) deep tissue injury pressure ulcer. *A unstageable pressure ulcer to her left heel.</p>	F 314			

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 314	<p>Continued From page 72</p> <p>*It measured 1.8 cm in length by 2.4 cm in width. *It was not open at that time and was described as a blood-filled blister. *On 11/18/14 it measured 1 cm in length by 2 cm in width. *It was not open but had been marked as 100% necrotic (dead) tissue. *She was re-admitted to the local hospital on 11/21/14 due to an infection in the left heel pressure ulcer. *She was placed on intravenous (medication given directly into a vein) antibiotics while in the hospital and on wound care treatment of the pressure ulcer.</p> <p>Review of resident 17's Braden score assessments (evaluates skin for the risk of breaking down) revealed: *A 9/3/14 admission assessment with a score of 16 (at risk for developing a pressure sore). *A 11/26/14 re-admission assessment with a score of 15 (at risk for developing a pressure sore). *A 12/22/14 quarterly assessment with a score of 15 (at risk for developing a pressure sore).</p> <p>Review of resident 17's clinical health status/interdisciplinary assessments revealed: *The 9/3/14 admission assessment indicated "If diabetic proceed to diabetic foot screen." *That screen had not been completed. *There was no preventative foot care initiated. *The 11/26/14 re-admission assessment for skin conditions had not been completed. It only had documentation of a pressure ulcer to the left and right heels. There were no measurements. *The diabetic foot screen had not been completed. *The 12/22/14 quarterly assessment under skin</p>	F 314		

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

PRINTED: 03/05/2015  
FORM APPROVED  
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NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - PRAIRIE HILLS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702</b>		
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F 314	<p>Continued From page 73</p> <p>concerns had "Yes" checked. Written in was "L [left] heel, R [right] heel, Abd pad [thick dressing], heel lift boots, and reposition." *The diabetic foot screen had not been completed.</p> <p>Review of resident 17's 9/19/14 care plan revealed: *All interventions for the reduction of pressure ulcers had been initiated after the left heel pressure ulcer had been found. *Diabetic foot monitoring quarterly and with change in condition had been started. *Encourage resident to float (keep the pressure off) right heel with pillow while in bed or in recliner. *Encourage turning and repositioning frequently. *The interventions for her diabetes mellitus included: -Assessment of skin and foot condition weekly by licensed nurse. -Diabetes foot screen upon admission, quarterly, and with change in condition. *The interventions for her nutritional risk was initiated on 9/11/14. *There were no goals or interventions related to her pressure ulcers.</p> <p>Review of the provider's revised 2013 Skin Integrity Guideline policy and Skin Care protocol revealed: *Residents were to have been observed daily by CNAs for reddened/open areas. Any changes were to have been reported to the licensed nurse and documented. *If there was a decline in skin integrity (condition) pressure redistribution surfaces (devices used to relieve pressure) were to have been reviewed for appropriateness.</p>	F 314			

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 314	Continued From page 74 *All residents would be assessed/observed for risk of skin breakdown within twenty-four hours of admission, quarterly, and as necessitated by change in condition. *The interdisciplinary plan of care would address problems, goals, and interventions directed toward the prevention of pressure ulcers. *If identified at risk or with actual alterations in skin integrity of feet footwear would be addressed for appropriateness.	F 314			
F 315 SS=D	<b>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</b>  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review, interview, and policy review, the provider failed to have supporting documentation for the continued use of a urinary catheter (tube to drain urine from bladder) for two of two sampled residents (2 and 5). Findings include:  1. Review of resident 5's medical record revealed: *She had a 12/9/14 physician's order to have a	F 315	<b>F 315</b>  1. Resident #5's MD was contacted regarding catheter. MD advised facility that resident does have urinary retention and wants to have the catheter left in. Resident's careplan has been revised so that it is accurate. Resident #2 no longer has a catheter. Resident #2 has a new bowel and bladder assessment and her care plan has been updated. Residents with catheters will be reviewed to ensure that the catheter is appropriate and they have proper documentation.  2. DNS or designee will educate all nursing staff regarding catheters, justification, and appropriate documentation by March 21, 2015.  3. DNS or designee will audit all catheters monthly for appropriateness and accurate documentation for three months. DNS or designee will report results to monthly QAPI for review, recommendations, and continuation/discontinuation of audits.  4. March 21, 2015	3/21/15	

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

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F 315	<p>Continued From page 75</p> <p>urinary catheter inserted due to a pressure ulcer (pressure sore) to her buttock (side of bottom). *A facsimile was sent to her physician on 1/12/15 for the continued use of the urinary catheter after the pressure ulcer had healed. *The diagnosis given for the use of the urinary catheter was unspecified retention of urine. *The physician agreed with that on 1/12/15. *The diagnosis had been from a 4/21/08 physician's order. *That diagnoses listed the diagnosis of urinary incontinence and urine retention. *A 7/28/10 history and physical had listed urinary retention as her past medical history. *Her previous urinary catheter had been discontinued on 8/3/10 after a hospitalization from 7/28/10 through 8/3/10. *Physician's progress notes from 4/24/14, 6/25/14, 7/11/14, 9/9/14, and 11/11/14 revealed no documentation of urinary retention.</p> <p>Review of resident 5's 7/25/14 quarterly interdisciplinary resident bladder review revealed: *A complete bowel and bladder assessment had been completed. *She did not have a urinary catheter in use.</p> <p>Review of resident 5's 10/2/14 significant change in status clinical health evaluation revealed she was frequently incontinent of urine.</p> <p>Review of resident 5's 2/2/15 quarterly interdisciplinary resident bladder review revealed: *A urinary catheter was in use. *Inability to manage urinary retention with intermittent catheterization was checked. *There was no documentation she had undergone any intermittent catheterization's or had problems with urinary retention.</p>	F 315			

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

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F 315	Continued From page 76  Review of resident 5's incontinence care plan initiated on 3/30/10 revealed: *Focus area included: -Incontinent of urine (changed to just bowel on 1/16/15. Had a colostomy (artificial opening) for bowels. Goals included: -Will not develop signs or symptoms of a urinary tract infection. -Skin around colostomy intact (without sores) and free from breakdown/redness. *Interventions included: -Wears briefs to help manage incontinent episodes and maintain dignity. -Check and change brief upon rising, before and after meals, bedtime, night rounds (checking on the residents), and as needed.  Review of the provider's undated Indwelling Catheter Justification/Decision Diagram revealed: *It was completed for new admissions and re-admission of a resident with an indwelling catheter. *Diagnoses that were deemed appropriate for the use of an indwelling catheter included: -Urinary retention that could not be medically or surgically corrected. -Care of a terminally ill or severely impaired resident for whom bed and clothing changes were uncomfortable/painful or disruptive. *A yes answer would have the following: -A physician's order with the diagnosis for use. -Clinical conditions/underlying factors present that made the indwelling catheter unavoidable. -Summarization of the need for the indwelling catheter.  Interview on 2/19/14 at 9:00 a.m. with the director	F 315			

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

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F 315	<p>Continued From page 77 of nursing revealed: *Resident 5's use of the urinary catheter was related to her urinary retention. *There was an appropriate diagnosis of urinary retention. *Agreed that diagnosis was from 4/21/08. *Agreed her previous urinary catheter had been discontinued on 8/3/10. *Agreed there was no documentation in the physician's progress notes or nursing notes of urinary retention.</p> <p>Surveyor: 35237 Preceptor: 20031 2. Observation and interview on 2/10/15 at 1:45 p.m. with resident 2 revealed she had an indwelling Foley (type of bladder catheter). She stated she "had it a long time. It's because I had sores from my diapers not being changed like they should."</p> <p>Interview on 2/10/15 at 1:30 p.m. with licensed practical nurse (LPN) D revealed resident 2 had a history of pressure ulcers and was admitted with the catheter. She further stated the resident's catheter was in place due to incontinence, and the resident needed a total lift (mechanical lift used to move a person from one place to another) for transfers.</p> <p>Review of resident 2's 8/27/14 History and Physical documentation from the hospital stated: -"1. Complicated urinary tract infection. She has chronic (long term) indwelling Foley." -"2. Decubitus ulcers [open areas from too much pressure] involving the coccygeal [tail bone], sacral area [lower back/pelvis area], bilateral [both] buttock area, lateral aspect of the left</p>	F 315			

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

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F 315	<p>Continued From page 78 thigh.."</p> <p>Review of resident 2's 9/22/14 Discharge with Transfer Orders from the hospital stated "Urinary Cath [catheter] Justification: Chronic Indwelling Cath, Prolonged Immobilization [lack of movement]."</p> <p>Review of resident 2's 9/23/14 Bladder Evaluation Form revealed the following instruction: *"Resident's with indwelling catheters must have at least one of the following conditions, check all that apply." -It listed terminal illness or severe impairment and movement causes intractable pain, Stage 3 or 4 pressure ulcers (open area to skin caused by too much pressure) in an area affected by incontinence that prevented ulcer healing, urinary retention that could not be treated or corrected medically or surgically, and need for exact measurement of urine output. -There was nothing checked for any of those areas.</p> <p>Review of resident 2's 10/14/14 History and Physical documentation from the hospital stated "chronic Foley catheter due to severe debility [physical weakness]" in the past medical history.</p> <p>Review of resident 2's 10/20/14 Discharge with Transfer Orders from the hospital stated "chronic Foley catheter due to severe debility."</p> <p>Review of resident 2's 12/31/14 Quarterly Interdisciplinary Resident Review assessment revealed the: *Section on bladder evaluation indicated the resident had a Foley catheter. *Indwelling catheter evaluation section was</p>	F 315			

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

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F 315	Continued From page 79 completed and marked "No" for all the questions. *Summary had two options and specified to check one. Neither option was checked. *First summary option stated "at least one question is checked "Yes" and/or the resident has an appropriate diagnosis..." *Second summary option stated "all questions are checked "No" and there is no appropriate diagnosis."  Review of the resident's Wound Evaluation Flow sheet indicated her last pressure ulcer on her buttock was healed on 10/28/14.  Review of resident 2's care plan initiated on 10/7/14 and last revised on 12/31/14 revealed the resident had an indwelling urinary catheter. There was no mention of an indication for use.  Interview on 2/11/15 at 2:30 p.m. with the DON regarding resident 2's Foley catheter revealed the catheter had initially been for healing the resident's pressure ulcers. He would look for the current diagnosis.  Further interview on 2/11/15 at 4:25 p.m. with the DON revealed there was no current indication for the use of the catheter. He had contacted the physician and received an order to remove the Foley catheter.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 80  This REQUIREMENT is not met as evidenced by: Surveyor: 32572 A. Based on observation, interview, and policy review, the provider failed to ensure the safe use of side rails or assistance (assist) bars for 5 of 23 sampled residents (3, 8, 11, 23, and 26) with side rails or assist bars. Findings include:  1. Observation on 2/10/15 at 8:30 a.m. revealed resident 11 had one-half side rails at head of the bed on both sides. *Review of her medical record revealed: -She had been admitted on 1/23/15. -There were no assessments for those side rails. *Review of the 1/26/15 comprehensive care plan revealed no mention of the side rails.  2. Observation on 2/10/15 at 8:30 a.m. revealed resident 23 had assist bars on both sides of the head of the bed. *Review of her medical record revealed: -The resident had been admitted on 1/22/15. -The side rail assessment had been completed on 2/16/15. -The care plan for the assist bars had been initiated on 2/11/15.  Interview on 2/10/15 at 10:40 a.m. with the director of nursing confirmed the Side Rail Assessment Screen had to be completed when side rails or assist bars were used.  Review of the provider's revised 2013 Side Rails Guideline revealed:	F 323	<b>F 323</b>  1. Residents # 11, 23, 3, 8, and 26 have a complete side rail assessment. Therapy table has been ordered. ✓  2. ED or designee will inservice all nursing staff on side rails and side rail assessments, and reporting safety issues to maintenance by March 21, 2015. ED or designee will educate Maintenance on maintaining the facility free of safety hazards by March 21, 2015.  3. DNS or designee will audit 10 residents per week with siderails for accurate and complete assessments. ED or designee will audit facility weekly for safety hazards. Audits will be completed weekly for 4 weeks and then monthly thereafter. DNS or designee and ED or designee will present results of audits for discussion at monthly QAPI for further review and recommendations and/or continuation/discontinuation of audits.  4. March 21, 2015  <i>*ED or designee will educate therapy staff on maintaining their equipment by March 21, 2015. ED will ensure that the new therapy table is ordered by March 21, 2015. KWISDDOHI/ME</i>	3/21/15

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 81</p> <p>**The purpose of the side rail utilization (use) may be to:</p> <ul style="list-style-type: none"> <li>-Remind resident not to get out of bed when medically contraindicated and/or medical equipment is attached to the patient.</li> <li>-Aid in turning and repositioning while in bed.</li> <li>-Providing a hand-hold for getting in or out of bed."</li> </ul> <p>**Monitoring compliance will include the following elements are in place for the facility to demonstrate satisfactory compliance with the guide:</p> <ul style="list-style-type: none"> <li>-Residents with side rails have appropriate assessments completed.</li> <li>-There is evidence of multidisciplinary approach to side rail utilization."</li> </ul> <p>Surveyor: 23059</p> <p>3. Observation beginning on 2/10/15 at 9:30 a.m. through 2/12/15 at noon revealed resident 3 had a grab bar on the outside of his bed by the head of the bed. Review of his 9/2/14 admission Side Rail Assessment Screen revealed the objective assessment portion indicated he:</p> <ul style="list-style-type: none"> <li>*Was ambulatory.</li> <li>*Did not have changes in safety awareness due to mental decline.</li> <li>*Was not able to get in or out of bed unassisted.</li> <li>*Was able to turn from side-to-side unassisted or with side rails while in bed.</li> <li>*Did not attempt to get in or out of bed unassisted.</li> <li>*Was not able to lower the side rail.</li> <li>*Was currently using the side rail for positioning and support.</li> <li>*Was able to use the call light to request assistance.</li> <li>*Was taking medications that would require increased safety precautions.</li> </ul>	F 323		

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

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F 323	<p>Continued From page 82</p> <p>The side rail safety portion of the above form had been left blank. The side rails had not been measured to ensure there were no gaps between the mattress and the rails that would pose a danger. That area had also been left blank. Based on the assessment findings it was determined the resident would use bilateral one-half assist rails.</p> <p>The above assessment was re-evaluated on 12/17/14. The side rail safety portion of the assessment was again left blank.</p> <p>4. Observation beginning on 2/10/15 at 8:45 a.m. through 2/11/15 at 8:00 a.m. revealed resident 8 had grab bars on both sides of her bed. Review of her Side Rail Assessment Screen revealed it had been completed on 10/22/14. A quarterly assessment or assessment upon significant change had not been done since that time. Since that initial assessment was completed the resident had fallen on 11/16/14 resulting in a leg fracture. The assessment screen had not been reviewed at that time.</p> <p>Surveyor: 26632</p> <p>5. Observation on 2/10/15 at 11:30 a.m. revealed resident 26 had a grab bar on the outside of her bed by the head of the bed. Review of her 2/6/15 re-admission side rail assessment screen revealed the objective assessment portion indicated she:</p> <ul style="list-style-type: none"> <li>*Was ambulatory.</li> <li>*Did not have changes in safety awareness due to mental decline.</li> <li>*Was able to get into bed unassisted.</li> <li>*The question for the ability to get out of bed unassisted was not answered.</li> </ul>	F 323			

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

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F 323	<p>Continued From page 83</p> <p>*Was able to turn from side-to-side unassisted or with side rails while in bed. *Did at times attempt to get in or out of bed unassisted. *Was not able to lower the side rail. *Was currently using the side rail for positioning and support. *Was able to use the call light to request assistance. *Was not taking medications that would require increased safety precautions. *The portion to determine if the side rail use was indicated for this resident had not been filled out.</p> <p>Surveyor: 20031 B. Based on observation, testing, and interview, the provider failed to ensure one of one occupational skills table in west physical therapy was kept in good condition without sharp edges that could pinch, rip, and/or cut fragile skin. Findings include:</p> <p>1. Observation on 2/18/15 at 1:20 p.m. in the west physical therapy room revealed a laminated table in-use by two unidentified residents for hand therapy exercises. Three of four edges on that table had cracked and broken laminate. Pieces of laminate the size of fifty cent pieces were missing and part of the laminate had cracked and pulled away from the wood beneath the laminate. Those cracked and broken edges were sharp to the touch on the surveyor's fingers. The unglued laminate created a pinch or skin hazard between the wood and laminate surface.</p> <p>Interview at the time of the observation with the director of therapy confirmed those findings. She stated the table was very old and had been in-use for years. She stated the laminate continued to</p>	F 323			



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 85</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32572</p> <p>A. Based on observation, interview, policy review, and manufacturer's review, the provider failed to ensure:</p> <ul style="list-style-type: none"> <li>*Two of two (11 and 26) sampled residents with clostridium difficile (C-Diff) (contagious infection of the bowel) had precautions posted, staff were aware of those precautions, and personal protective equipment (PPE) was available.</li> <li>*One of five observations of wound care for resident (15) revealed improper handwashing and glove use by one of four licensed nurses (licensed practical nurse (LPN) E.</li> <li>*Three of three observations of foley catheter (tube in the bladder to drain urine) care and personal care for sampled residents (2, 3, and 8) revealed improper handwashing and glove use.</li> <li>*Two of two observed residents (17 and 27) with heel lift boots that were single-resident use items were used for multiple residents.</li> </ul> <p>Findings include:</p> <p>1. Observation on 2/10/15 at 8:30 a.m. of resident 11's room revealed the room had two large hampers in the room. One was red in color, and the other one was white in color. Interview with the resident and her roommate at that time indicated resident 11 had an infection and all her laundry and garbage was to go into those hampers. Upon closer examination of the entrance it had been noted to have a small red magnetic sign applied to the doorway of the room. That sign had been in the upper left corner above eye sight level. That sign had been the</p>	F 441	<p>* All residents who use heel lift boots will have their own and they will be labeled with their names on them. KW/SDDOH/MF</p> <p>*Therapy exercise balls will be cleaned daily at the end of the day. Therapy exercise balls will be sanitized after each resident if the resident has a communicable disease. KW/SDDOH/MF</p> <p>* Education to all staff included specific training on C-diff. All therapy and housekeeping/laundry staff were included. KW/SDDOH/MF</p> <p>* No immediate action could be taken for the catheter care. All nursing staff will be educated on proper catheter care by March 31, 2015. KW/SDDOH/MF</p>	

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F 441	<p>Continued From page 86</p> <p>size of a deck of cards and difficult to read from the doorway.</p> <p>*Review of resident 11's 1/26/15 comprehensive care plan did not include any mention of the infection present. Upon further investigation it had been determined the resident had a C-Diff infection upon admission. The resident had been admitted on 1/23/15.</p> <p>Surveyor: 26632</p> <p>2. Observation and interview on 2/16/15 at 4:30 p.m. of registered nurse (RN) L revealed: *She entered resident 11's room with medication. *She had not used any personal protective equipment. *She stated she was not aware resident 11 was still under contact precautions for C-Diff. *She stated they were waiting for the physician to lift the contact precautions.</p> <p>Surveyor: 35237 Preceptor: 20031</p> <p>3. Observation on 2/10/15 at 8:30 a.m. of resident 26's room revealed *She had two large clothing hampers in the room. *One was red in color and the other one was white in color. *There was no sign outside her room to indicate she was on infection precautions. *She was laying in bed. *She had a breakfast tray on her bedside table. *She had not eaten any of her breakfast.</p> <p>Surveyor: 26632</p> <p>Review of resident 26's medical record revealed: *She had been admitted on 1/6/15. *She had been admitted to the hospital on 1/27/15.</p>	F 441	<p>*DNS or designee will audit 5 instances of catheter care per week for proper procedure. This audit will be done weekly for 4 weeks and then monthly thereafter. DNS or designee will report results to OAPI for review, recommendations and continuation/discontinuation of audit. KN/SDDH/ME</p> <p>*ED or designee to audit therapy ball cleaning schedule, transfer poles and linen chute weekly for cleanliness. This audit will be weekly for 4 weeks and then monthly thereafter. ED or designee will report results of audit to monthly OAPI for review, recommendation and continuation/discontinuation of audit. KN/SDDH/ME</p>	

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 441	<p>Continued From page 87</p> <p>*She had been re-admitted to the facility on 2/4/15.</p> <p>*She had diagnoses that included C-Diff.</p> <p>*Her 2/6/15 bowel and bladder care plan had been revised on 2/16/15 stating the C-Diff precautions had been lifted.</p> <p>Surveyor: 35237</p> <p>Interview on 2/10/15 at 8:40 a.m. with the infection control nurse revealed he did not know why there were hampers in resident 26's room. He stated she had C-Diff in the past, but thought it had been resolved.</p> <p>Observation on 2/10/15 at 5:22 p.m. revealed the infection control nurse brought personal protective equipment, including disposable gowns, gloves, and masks, to resident 26's room. He walked into resident's room without wearing any of those items and closed the door.</p> <p>Observation on 2/10/15 at 5:25 p.m. revealed:</p> <p>*There was now a small red magnetic sign applied to the door frame up in the exterior top right corner. That sign had been the size of a deck of cards and stated to stop and see the nurse before entering.</p> <p>*An unidentified staff member exited the room carrying a bag that appeared to be garbage with one of the disposable gowns in it.</p> <p>4. Observation on 2/17/15 at 3:50 p.m. of resident 15's wound care by LPN E revealed she:</p> <p>*Applied gloves.</p> <p>*Removed the resident's sock and brace to her left foot/ankle.</p> <p>*Removed the soiled dressing and laid it down on the resident's bedspread.</p> <p>*Picked up the soiled dressing and placed it</p>	F 441		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 441	<p>Continued From page 88</p> <p>against the resident's open area to mark the size of the open area with a pen.</p> <p>*Put the soiled dressing back down on the resident's bedspread.</p> <p>*Cleansed the wound with normal saline.</p> <p>*Applied a non-sting barrier film on the surrounding tissue.</p> <p>*Applied the new dressing over the wound.</p> <p>*Re-applied the foot/ankle brace and sock.</p> <p>*Removed her gloves</p> <p>*Picked up the soiled dressing and wrapped it into one of her soiled gloves.</p> <p>*Carried the glove with the dressing out of the resident's room and entered the hallway.</p> <p>*Used the hand sanitizer dispenser on the wall to apply sanitizer to her hands.</p> <p>*Carried the soiled glove with the soiled dressing to the lounge down the hall where the medication (treatment) cart was stored.</p> <p>*Retrieved a measuring strip to measure the marked area.</p> <p>*Placed the soiled glove with the soiled dressing into the garbage on that cart.</p> <p>*Walked to her office and filled out the wound evaluation flow sheet.</p> <p>At no time during the above observation did LPN E wash her hands or change gloves.</p> <p>5. Observation and interview on 2/10/15 at 5:25 p.m. of resident 2's catheter care and transfer from bed to wheelchair by certified nursing assistant (CNA) R and CNA S revealed:</p> <p>*CNA S did not wash her hands prior to the start of care.</p> <p>*CNA S applied gloves and assisted CNA R to roll the resident to her side.</p> <p>*They removed the resident's shorts and disposable undergarment.</p>	F 441			

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 441	<p>Continued From page 89</p> <p>*CNA S performed catheter care and used a disposable wet wipe. -With those soiled gloves she retrieved extra wet wipes from the package and continued catheter care. *They assisted the resident to her side. *Both CNAs stated the resident was incontinent of bowel frequently and was changed as needed. *CNA S cleaned the resident's private area with wet wipes. *With those same soiled gloves she retrieved extra wet wipes from the package and continued cleaning the resident's private area. *CNA S placed the package on the resident's dresser, removed her gloves, and applied a new pair of gloves. *CNA S applied a new disposable undergarment and the resident's shorts. *CNA S retrieved a plastic container from the resident's bathroom and placed it on the carpet by the resident's bed. -She emptied the urine from the resident's catheter bag into the container. -She took the plastic container with urine into the bathroom to empty it and returned to the bedside. *The CNAs transferred the resident from her bed into her wheelchair. -CNA R held the resident's catheter tubing/bag at the time of the transfer. She then placed the catheter bag into a holder under the seat of the resident's wheelchair.</p> <p>Surveyor: 23059 6. Observation on 2/10/15 at 11:25 a.m. of resident 3 revealed CNA G entered his room. She: *Did not wash her hands prior to putting on</p>	F 441			

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>	
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - PRAIRIE HILLS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702</b>		
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F 441	<p>Continued From page 90</p> <p>gloves.</p> <p>*Obtained a plastic container from a plastic bag hanging on a rod in the resident's toilet room.</p> <p>*Placed that container on the floor without a barrier underneath it.</p> <p>*Proceeded to empty urine from the resident's catheter (tube to drain urine from the bladder) leg bag.</p> <p>After measuring the amount of urine in the container, CNA G dumped the urine into the toilet. She then:</p> <p>*Ran about an inch of water in the container, swished it around, and dumped the water into the toilet.</p> <p>*Placed that container back into its original plastic bag. Also stored within that plastic bag was the resident's night time catheter bag. The contaminated base of the container rested upon the tubing in the catheter bag.</p> <p>After replacing the container, CNA G removed her gloves and left the room. Immediately upon leaving the room she re-entered and washed her hands. She stated all of the above was her usual practice.</p> <p>7. Observation on 2/10/15 at 1:45 p.m. of resident 8 revealed CNA F entered the room to assist the wound care nurse with a dressing change. She put on gloves without washing her hands. She assisted with moving resident 8 into position, so her dressing could be changed. Following the dressing change she removed her gloves and left the room. She had not washed her hands after removing those gloves and before leaving the room.</p> <p>8. Review of the provider's 12/1/14 Preventing Spread of Infection policy revealed times at which hand hygiene was required included:</p>	F 441		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 441	<p>Continued From page 91</p> <ul style="list-style-type: none"> <li>*Before and after direct resident contact.</li> <li>*Before and after changing a dressing.</li> <li>*Before and after assisting a resident with personal care.</li> <li>*After contact with a resident's body fluids.</li> <li>*After handling soiled equipment or utensils.</li> <li>*After handling catheters or urinals.</li> <li>*After removing gloves.</li> </ul> <p>Review of that policy also revealed:</p> <ul style="list-style-type: none"> <li>*Alcohol based hand rubs could be used for cleaning hands for direct patient care.</li> <li>*Gloves were not a substitute for hand hygiene.</li> </ul> <p>Review of the provider's revised August 2014 Hand Washing/Hand Hygiene Policy revealed:</p> <ul style="list-style-type: none"> <li>**2. All personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents, and visitors."</li> <li>**7. Use an alcohol based hand rub containing at least 62% alcohol, or, alternatively, soap (anti-microbial or non-anti-microbial) and water for the following situations:" <ul style="list-style-type: none"> <li>-"a. Before and after direct contact with residents."</li> <li>-"g. Before handling clean or soiled dressings, gauze pads, etc."</li> <li>-"h. Before moving from a contaminated body site to a clean body site during resident care;"</li> <li>-"j. After contact with blood or bodily fluids;"</li> <li>-"k. After handling dressings, contaminated equipment, etc."</li> <li>-"m. After removing gloves."</li> </ul> </li> <li>**9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice of preventing healthcare-associated infections."</li> </ul>	F 441		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - PRAIRIE HILLS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702</b>		
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F 441	<p>Continued From page 92</p> <p>Surveyor: 28057</p> <p>9. Observation and interview on 2/18/15 at 2:50 p.m. with resident 3 revealed and confirmed:</p> <ul style="list-style-type: none"> <li>*A catheter leg bag hanging in a clear bag from the assist bar in resident 3's bathroom.</li> <li>*The catheter tubing had yellow colored fluid in the tubing and bag.</li> <li>*LPN P stated: <ul style="list-style-type: none"> <li>-The catheter bag appeared to have not been cleaned before it had been placed in the clear bag in the bathroom.</li> <li>-It should have been cleaned before it had been stored in the bathroom.</li> <li>-The resident had refused his leg bag for several days.</li> <li>-She agreed the leg bag had not been dated.</li> <li>-After she had looked at the resident's large catheter bag in-use and attached to his catheter she confirmed it had not been dated either.</li> <li>-The policy had been to date a catheter bag when it was put into use.</li> <li>-The drainage bag was to be changed every month or sooner if needed.</li> </ul> </li> <li>*Resident 3 agreed he had not used the leg bag for about three days.</li> </ul> <p>Review of the provider's reviewed 1/26/15 Insertion and Removal of a Catheter policy revealed it had not directed the nurse to date the catheter bag when it had been put into use.</p> <p>Review and interview with the director of nursing (DON) of the provider's 2/19/15 Catheter Drainage Bag and Tubing policy received from the DON at 10:45 a.m. revealed:</p> <ul style="list-style-type: none"> <li>*The catheter drainage bag was to have been emptied if it contained urine.</li> <li>*It was to have been cleaned with a 50:50 (fifty to</li> </ul>	F 441		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 441	<p>Continued From page 93</p> <p>fifty percent) solution of water and vinegar. *That was to ensure all urine had been removed from the drainage bag. *He confirmed he had just written the above policy. *There had not been a policy that had addressed the cleaning and storage of catheter drainage bags before he wrote the above policy.</p> <p>Surveyor: 26632 10. Observation on 2/18/15 at 10:30 a.m. of residents 17 and 27 revealed they had foam heel lift boots on. Resident 17 had them on both feet and resident 27's was on her right foot.</p> <p>Interview on 2/18/15 at 10:45 a.m. with LPN E revealed: *Those boots were used for residents if they had a risk of or had a pressure ulcer on their heels. *They were not labeled for each resident. *They were sent to laundry when they were soiled. *The resident might not have received the same heel lift boot(s) back. *She agreed resident 17 had a diagnosis of methicillin resistant staphylococcus aureous (MRSA) (contagious organism that was resistant to many antibiotics) to the pressure ulcer on her right heel. *She was not aware the heel lift boots were labeled as single-use items and should not have been shared between residents.</p> <p>Review of the Heelift Glide Suspension Boot manufacturer's instructions revealed the boot was a single-use only boot.</p> <p>Interview on 2/18/15 at 11:00 a.m. with housekeeping supervisor F revealed:</p>	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 441	<p>Continued From page 94</p> <ul style="list-style-type: none"> <li>*The heel lift boots were laundered with the towels and had a bleach disinfectant.</li> <li>*The heel lift boots were not labeled as to which resident had been using them.</li> <li>*She was not aware resident 17 had been diagnosed with MRSA.</li> <li>*She was not aware the heel lift boots were labeled as single-use items and should not have been shared between residents.</li> </ul> <p>Surveyor: 20031</p> <p>B. Based on observation and interview, the provider failed to maintain the cleanliness for:</p> <ul style="list-style-type: none"> <li>*Three of three resident use items in resident room 115.</li> <li>*All exercise balls and balloons used in physical therapy (PT) and activities.</li> <li>*One of two wedges (elevation pillows) in east PT.</li> <li>*The soiled linen chute between three floors.</li> </ul> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Observation on 2/11/15 at 9:25 a.m. revealed in resident room 115 the following: <ul style="list-style-type: none"> <li>*A white transfer pole next to the bed had splotches of brown and tan dried liquid, dirt, debris, and soiled hand prints.</li> <li>*A white transfer pole next to the toilet had splotches of brown, tan, and yellow dried liquid, dirt, debris, and soiled hand prints.</li> <li>*An over-the-bed table next to the bed was layered with spilled food debris and various unknown colored substances.</li> </ul> </li> </ol> <p>Interview with the executive director (ED) at the time of the observation confirmed the above findings. She agreed all three items were heavily soiled and should have been kept clean. She revealed there was no policy on the cleanliness of</p>	F 441		

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 441	Continued From page 95 resident-use items in the residents' rooms. She also revealed she was unsure if the contracted housekeeping service was responsible or the provider's staff were responsible for the cleanliness of resident-use equipment and other items in their rooms.  2. Observation on 2/11/15 from 11:00 a.m. to 11:20 a.m. of the west and east PT rooms revealed: *All multiple bright colored exercise balls and balloons appeared dull and had a tinge of brown and tan on them. *One of the vinyl covered wedges used by residents had cracks in the vinyl and had a thread bare area the size of a softball that was not cleanable.  Interview with the director of therapy at the time of the observation confirmed those findings. She stated both therapy and activities used the exercise balls and balloons. Thus no one had ownership of them to keep them clean.  3. Observation on 2/11/15 at 11:30 a.m. revealed the soiled linen chute that traveled between three floors to the basement was heavily soiled with dried, layered, unknown, and colorful debris. Interview with the maintenance supervisor and ED at the time of the observation confirmed that finding. They stated they were not aware the soiled linen chute was grossly contaminated. The MS revealed the chute was not on a preventative maintenance (PM) program but he would have the chute professionally cleaned and then keep it on a PM.	F 441			
F 464 SS=E	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS	F 464			

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

PRINTED: 03/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>	
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - PRAIRIE HILLS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702</b>		
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F 464	<p>Continued From page 96</p> <p>The facility must provide one or more rooms designated for resident dining and activities.</p> <p>These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32572 A. Based on observation, interview, testing, and policy review, the provider failed to ensure: *Adequate space had been available for all residents to eat or socialize in all of the dining rooms during two of two meal observations. *Meals had been maintained at a palatable temperature during testing for one of one testings. Findings include:</p> <p>1. On 2/10/15 at 8:00 a.m. the administrator revealed the current resident census was 101.</p> <p>Observation on 2/10/15 from 4:45 p.m. through 5:45 p.m. revealed twelve hot plates had been heated in the kitchen oven. Those hot plates were then used to serve room trays. The eleven residents on the first floor received room trays with the hot plates. All foods were at the correct temperatures when leaving the dining room. A test tray for room trays was obtained. The test tray for first floor foods remained within palatable temperatures.</p> <p>Interview on 2/11/15 at 9:25 a.m. with the dietary manager revealed there were twelve hot plates.</p>	F 464	<p><b>F 464</b></p> <p>1. Facility has ordered enough hot plates for all room trays. The facility is not storing equipment in the small dining rooms. Facility has arranged for enough seating for 101 residents. The therapy gym has been rearranged with the equipment not being used removed.</p> <p>2. ED or designee will educate all staff on the above plan for the facility by March 21, 2015.</p> <p>3. ED or designee will audit the facility to ensure that the facility provides adequate dining and therapy space for the residents weekly for 4 weeks and then monthly thereafter. ED or designee will report results of audit to monthly QAPI for review, recommendations and continuation/discontinuation of audits.</p> <p>4. March 21, 2015</p> <p><i>x Social Services will speak with all residents to ensure that they are aware that they can eat in the dining room if they want. KW/SDDH/ME</i></p>	3/21/15

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 464	<p>Continued From page 97</p> <p>She stated she was not aware there were not enough for all room trays. She confirmed she would "need to order some more."</p> <p>On 2/11/15 at 10:00 a.m. a list of residents that received room trays was obtained by the dietary manager. That list contained 11 residents from the first floor. There had been five residents from the second floor that received room trays. The dietary manager confirmed this was the "usual" room tray list.</p> <p>Surveyor 32573: Random family interview on 2/11/15 at 2:45 p.m. revealed: *Her family member resided on the second floor. *She visited every evening. *He ate breakfast and lunch in the dining room. *He had a room tray for dinner every night because she didn't feel there was enough room for both of them in the dining room.</p> <p>2. Observation on 2/10/15 at 5:45 p.m. revealed: *The small dining room on the first floor had seating for eight residents. -In that dining room equipment had been stored out in the open where some of the residents sat such as: --Two mechanical lifts. --One electronic blood pressure machine. --One nurses treatment cart. --One over-bed table. *All of the equipment in the small dining room on the first floor made the room crowded when the residents were in the dining room eating. *The large dining room had seating for thirty-eight residents. *The first floor dining room seating available was for forty-six residents, however there were fifty</p>	F 464	<p>*Director of Dining Services (DDS) or designee will audit 10 room trays for appropriate temperature and that hot plates were used. This audit will be done weekly for 4 weeks and then monthly thereafter. DDS or designee will report results to monthly QAPI for review, recommendation, and continuation/discontinuation of audit. KW/SDDO/H/MF</p> <p>* Hot plates have already arrived at the facility. DDS or designee will educate all dietary staff to the use of these hot plates by March 31, 2015. KW/SDDO/H/MF</p>	

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

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F 464	<p>Continued From page 98 residents living on the first floor.</p> <p>Surveyor: 32573 3. Observation on 2/11/15 at 9:00 a.m. of the small dining room on the second floor revealed: *Three square tables that would seat four residents each. *Five dining room chairs. *Four resident mechanical lifts being stored around the dining room tables. *Two blood pressure machines next to dining room table. *One wheelchair. *One bedside table next to dining room table. *Space for twelve residents total. *Space very crowded with the above items and during meal service had to move residents to get others in or out.</p> <p>Observation at the same time of the large dining room on the second floor revealed: *Six square tables that would seat four residents each. *Four square tables that would seat three residents each. *Space for thirty-six residents total. *Had to move some residents during meal service to get other residents in or out of their places at some tables.</p> <p>4. Observation on 2/10/15 at 5:30 p.m. of the supper meal service on the second floor revealed: *Room meal trays were filled from 5:25 p.m. to 5:45 p.m. *The first room tray had been served at 5:58 p.m. *Staff had not checked the temperatures of any food upstairs.</p>	F 464		

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

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F 464	<p>Continued From page 99</p> <p>When the last room tray had been delivered to a resident this surveyor had staff check the food temperatures of an extra room tray. Temperatures were: *Mashed potatoes- 126 degrees Fahrenheit (F). *Peas- 109 degrees F. *Turkey- 120.5 degrees F. *Jello- 49.5 degrees F.</p> <p>Interview on 2/10/15 at 6:05 p.m. with the dietician revealed food was not usually checked for temperature after it was brought upstairs in a steam table from the kitchen. Temperatures were checked down in the kitchen. Room trays were not checked for food temperature.</p> <p>Surveyor: 23059 5. Interview on 2/10/15 at 10:30 a.m. with a resident who requested not to be identified revealed he ate most of his meals in his room per his choice. He stated "I have never received a warm meal. All the food here is cold by the time it reaches my room." He stated he had never asked to have the food warmed up. He stated he was unsure if staff would have done that for him.</p> <p>Interview on 2/10/15 at 11:30 a.m. with the same resident revealed he stated his food was "warm for the first time in ages."</p> <p>Surveyor: 35237 6. Observation on 2/10/15 at 5:25 p.m. of the small dining room on the 100 unit revealed the following equipment out in the open: *Two Arjo stand lifts. *One Arjo total lift. *Two vital sign machines on wheels. *One treatment cart. *One four-wheeled cart with a red cooler sitting</p>	F 464		

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

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F 464	<p>Continued From page 100 on the top labeled "water pass cooler only." *One large vending machine. *One unidentified male resident sitting in a wheelchair attempting to move one of the Arjo lifts away from his spot at the dining room table. *Two dining room tables with enough space for eight residents to dine.</p> <p>7. Observation on 2/11/15 at 11:30 a.m. of the small dining room on the 200 unit revealed: *Two Arjo stand lifts. *Two vital signs machines on wheels. *One wheelchair. *One four-wheeled cart with a red cooler sitting on the top labeled "water pass cooler only." *Three dining room tables with enough space for twelve residents to dine. *Eleven residents in the dining room with one open space unoccupied at the middle table.</p> <p>Surveyor: 26632</p> <p>8. Observation on 2/10/15 from 11:30 a.m. through 12:30 a.m. of the second floor small dining room revealed: *Three square tables that would seat four residents each. *Five dining room chairs. *Four resident mechanical lifts. *Two blood pressure machines. *One wheelchair. *One bedside table. *Space for twelve residents total. *Staff had to remove two residents while they were eating as resident 23 had requested to use the bathroom. This was due to the mechanical lifts that were in the way.</p> <p>9. Review of the provider's 2/3/15 Nursing</p>	F 464		

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

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F 464	<p>Continued From page 101</p> <p>Responsibilities at Meal Service policy revealed: *Staff from the nursing and dining services departments work cooperatively to ensure that each resident would have a pleasant dining experience and was served according to regulations. *Adapt space and equipment to assist residents in maintaining independent functioning, dignity, well-being, and self-determination. *Encourage residents to eat in the dining areas, encourage and assist them to consume food and beverages.</p> <p>Review of the provider's 3/19/12 Director of Dining job description revealed an essential job duty of "maintain records, manage budget, and supplies."</p> <p>Review of the provider's revised 2/12/15 Nursing Responsibilities at Meal Service policy revealed: **Staff from the Nursing and Dining Services departments work cooperatively to ensure that each patient [resident] has a pleasant dining experience and is served according to regulations." **"Adapt space and equipment to assist patients in maintaining independent functioning, dignity, well-being and self-determination." **"Encourage patient to eat in the dining areas, and encourage and assist them to consume food and beverages."</p> <p>Surveyor: 20031 B. Based on observation and interview, the provider failed to maintain two of two physical therapy (PT) areas to meet the needs of staff and residents due to overcrowding by excessive and outdated equipment and one of one PT (east)</p>	F 464			

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

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F 464	<p>Continued From page 102 was used to store unused resident equipment. Findings include:</p> <p>1. Observation on 2/18/15 at 1:20 p.m. revealed the small west PT room that measured approximately 14 feet by 20 feet was overcrowded with:</p> <ul style="list-style-type: none"> <li>*Exercise equipment, both stationary and free moving.</li> <li>*Padded treatment tables.</li> <li>*Occupational tables.</li> <li>*Exercise balls.</li> <li>*Staircases.</li> <li>*Parallel bars.</li> <li>*Rolling stools.</li> <li>*Pulley sets.</li> </ul> <p>That room also had five residents in wheelchairs, one visitor in the room, and five therapy staff who were assisting those residents.</p> <p>Additional observation revealed the small east PT room that measured approximately 8 feet by 15 feet was overcrowded with:</p> <ul style="list-style-type: none"> <li>*Padded treatment tables.</li> <li>*Exercise balls.</li> <li>*Pulley sets.</li> <li>*Unused wheelchairs.</li> <li>*Wheelchair parts.</li> <li>*Unused walkers.</li> <li>*Cardboard boxes of extra supplies for the nursing staff.</li> </ul> <p>Interview at the time of the above observations with the director of rehabilitation confirmed both rooms were over crowded. She stated the exercise table in the west PT room could not adjust to a required specific height use for the residents. The exercise table in the east room was a hi-lo table, and she should remove the</p>	F 464		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 464	Continued From page 103 obsolete table in the west room. She stated they only used two of the three of the Nautilus machines, and she should remove the big leg press that was not used by the residents. The unused wheelchairs and walkers were not used by therapy. She stated those items including the boxes of supplies were used by nursing staff, and they used a large part of the east PT room for storage. She stated they did the best they could with the area they had, but it was hard for staff and residents to move freely through the PT areas.	F 464		
F 490 SS=K	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: 26632  Surveyor: 20031 Based on observation, interview, record review, testing, and policy 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 of all 101 residents. Findings include:  1. Interview on 2/19/15 at 1:30 p.m. with the administrator confirmed the overall operation and administration of the facility was her	F 490	<b>F 490</b>  Please see abatement plan and Plan of Correction for other deficiencies.  * Administrator is reporting weekly to Area Vice President or Field Services Clinical Director on overall progress of plan of correction. KW/SDDCH/ME  * Field Services Clinical Director educated Administrator on API and how to identify deficient practices and correction of these practices. KW/SDDCH/ME	3/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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F 464	Continued From page 103 obsolete table in the west room. She stated they only used two of the three of the Nautilus machines, and she should remove the big leg press that was not used by the residents. The unused wheelchairs and walkers were not used by therapy. She stated those items including the boxes of supplies were used by nursing staff, and they used a large part of the east PT room for storage. She stated they did the best they could with the area they had, but it was hard for staff and residents to move freely through the PT areas.	<del>F 464</del>	*Field Services Clinical Director or Area Vice President will audit facility monthly for progress on plan of correction and that the residents are attaining or maintaining their highest practicable physical, mental, and psychosocial well-being. This audit will be monthly for 3 months. Field Services Clinical Director or Area Vice President will report results to monthly QAPI for review, recommendations, and continuation/discontinuation of audit. KW/SDDH/MF	
F 490 SS=K	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: 26632  Surveyor: 20031 Based on observation, interview, record review, testing, and policy 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 of all 101 residents. Findings include:  1. Interview on 2/19/15 at 1:30 p.m. with the administrator confirmed the overall operation and administration of the facility was her	F 490		

104a

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

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F 490	Continued From page 104 responsibility.  Interviews, observations, record reviews, testing, and policy reviews throughout the course of the survey from 2/10/15 through 2/12/15 and from 2/17/14 through 2/19/15 revealed the administration had not ensured all 101 residents attained and/or maintained their highest practicable physical, mental, and psychosocial well-being.	F 490		
F 514 SS=F	Refer to F176, F221, F241, F273, F278, F280, F281, F309, F314, F315, F323, F441, F464, F490, F514, and F520. <b>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</b>  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on record review, interview, and policy review, the provider failed to ensure complete and accurate documentation was maintained for	F 514	<p><b>F 514</b></p> <p>1. No immediate action could be done for the inconsistencies in documentation. Refer to plan of correction for other deficiencies.</p> <p>2. DNS or designee will educate all staff on documentation and the expectation for complete and accurate documentation on all residents by March 21, 2015.</p> <p>3. DNS or designee will audit all progress notes with start up to ensure that documentation is complete and accurate. DNS or designee will audit all clinical health assessments for accurateness and completeness. These audits will be done weekly for 4 weeks and then monthly thereafter. DNS or designee will report results of audits to monthly QAPI for review, recommendations, and continuation/discontinuation of audits.</p> <p>4. March 21, 2015</p> <p>* Resident 9 had a side rail assessment and a new clinical health assessment completed. CNA sheet has been updated. Refer to plan of correction for deficiencies F490 and F309. kw/800H/MF</p>	3/21/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - PRAIRIE HILLS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>916 MOUNTAIN VIEW ROAD 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 105</p> <p>10 of 23 sampled residents (2, 5, 9, 11, 13, 15, 17, 23, 24, and 25). Refer to F 309, findings 5, 6, 7, 8, and 9. Findings include:</p> <p>1. Review of resident 9's medical record revealed: *The 8/15/14 Annual Clinical Health Status assessment revealed: -Side rails were to be used. -The resident smoked or had the desire to smoke. *Review of the 2/1/15 revised comprehensive care plan did not indicate he used side rails. That care plan indicated he was unsafe to smoke, and smoking assessments were to be completed quarterly. -Current smoking assessment were not found within the medical record. -Interview on 2/12/15 at 10:10 a.m. with the director of nursing confirmed the resident did not smoke, but family would allow him to smoke when they took him on outings. *Inconsistencies in documentation of bowel and bladder continence or incontinence. *Refer to F 309, finding 5.</p> <p>2. Review of 11's medical record revealed: *The 1/10/15 Minimum Data Set (MDS) assessment revealed a BIMS (testing of thought processes) score of 15. That score indicated her thought processes were intact. *The 1/23/15 Admission Clinical Health Status assessment revealed she was unable to ambulate and transfer independently, and she had not requested to self-administer medications. That assessment also indicated she did not use side rails on her bed. *The 2/4/15 CNA Report Sheet indicated she used bilateral assist bars and she was to have</p>	F 514	<p>* Refer to plan of correction for deficiencies F309, F309 and F309 for resident # 11. KW/SDDOH/MF</p> <p>* Resident 13 had a side rail assessment and a new Clinical Health Assessment completed. The CNA sheet has been updated. Resident's care plan for surgical wound has been updated. Refer to F309. KW/SDDOH/MF</p> <p>* Resident 23 had a new clinical health assessment done with the diabetic foot screen completed. No immediate action could be taken for the surgical wound as it is healed. Refer to F176, F309 and F309. KW/SDDOH/MF</p>	

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

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F 514	<p>Continued From page 106 been transfered with the assistance of two staff; there was no mention of a mechanical lift. *Review of the 1/26/15 comprehensive care plan revealed she was to have been transferred with a Hoyer lift (equipment to assist the resident to transfer from place to place). An intervention stated to use a "gait belt with all transfers and ambulation." That comprehensive care plan did not address self-administration of medications and side rail use. *A 1/26/15 Medication Self-Administration Assessment stated "The resident is deemed unable to safely self-administer medications, for the following reasons: Depression/Anxiety." *Observation on 2/10/15 at 8:30 a.m. revealed medications sitting in a med cup on her breakfast tray. No nurse or medication aide had been in the room. One-half side rails were up on both sides of her bed at the head of her bed. -A side rail/safety assessment was not found in the record. *Inconsistencies in documentation of bowel and bladder continence or incontinence (unable to hold urine). *Refer to F 309, finding 6.</p> <p>3. Review of 13's medical record revealed: *The 11/13/14 MDS assessment revealed a BIMS score of 14 that indicated his thought processes were intact. *The 2/9/15 Re-admission Clinical Health Status assessment indicated he had a surgical wound on his left lower leg, and he did not use side rails, devices or restraints. *The 2/4/15 CNA Report Sheet did not indicate any skin issues, but indicated assist bars were used. *Observation on 2/10/15 from 8:30 a.m. through 11:00 a.m. revealed there were assist bars on</p>	F 514	<p>*Resident 814 has an updated care plan with transfers and fall risk identified. Refer to F309. KW/SDDDH/ME</p> <p>*Resident 15 had a new Clinical Health Assessment completed with section E complete. KW/SDDDH/ME</p> <p>*Resident 17 had a new Clinical Health Assessment completed with the areas for diabetic foot screen and pressure ulcer complete.</p> <p>*Resident 255's care plan was updated after her foley was taken out. No immediate action could be taken for the inconsistencies. KW/SDDDH/ME</p> <p>*Refer to F315 for resident 2. KW/SDDDH/ME</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	<p>Continued From page 107</p> <p>both sides at the head of the bed.</p> <p>*The 2/9/15 Side Rail Assessment Screen revealed the safety portion of the assessment had not been completed.</p> <p>*The 2/17/15 revised comprehensive care plan or any immediate plan of care (IPOC) did not indicate the resident had a surgical wound and the care provided for that.</p> <p>-Interview on 2/10/15 at 10:40 a.m. with the director of nursing confirmed when the forms were completed all sections were to have been completed. Also when the form had been reviewed any updating or changes would have been documented on the form.</p> <p>*The 2/4/15 CNA Report Sheet did not indicate the surgical wound on the lower leg.</p> <p>*Inconsistencies in documentation of bowel and bladder continence or incontinence. Refer to F 309, finding 7.</p> <p>4. Review of resident 23's medical record revealed:</p> <p>*The 1/29/15 MDS assessment revealed a BIMS score of 14 that indicated her thought processes were intact.</p> <p>*The 1/22/15 Admission Clinical Health Status assessment revealed she had a surgical wound. There had been no documentation as to the length, width, and depth of the wound. That form also indicated she was a diabetic however the diabetes foot screen had not been completed. That assessment also did not indicate if the resident requested to self-administer her medications or not. It did indicate she had requested to use side rails, devices, or restraints.</p> <p>*The February 2015 treatment administration record (TAR) revealed the resident had care performed on a surgical wound on her left breast.</p> <p>*The weekly wound assessments revealed she</p>	F 514		

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 514	<p>Continued From page 108</p> <p>had a left breast wound. There was no documentation as to the length, width, or depth of the wound.</p> <p>*The Medication Self-Administration Assessment revealed "The resident is deemed [considered] unable to safely self-administer medications, for the following reasons: Depression/COPD [breathing difficulties]."</p> <p>-Observation on 2/10/14 at 8:30 a.m. revealed medications sitting on her breakfast tray with no nurse or medication aide in the room.</p> <p>*The 2/17/15 CNA Report Sheet revealed no areas of skin issues. It indicated she used bilateral assist bars on her bed.</p> <p>-A side rail/safety assessment for use of the assist bars was not found in the medical record.</p> <p>*The 2/11/15 comprehensive care plan revealed no care plan for the surgical wound or that and care to be provided for it.</p> <p>*Inconsistencies in documentation of bowel and bladder continence or incontinence.</p> <p>*Refer to F 309, finding 8.</p> <p>5. Review of resident 24's medical record revealed:</p> <p>*The 11/24/14 MDS assessment revealed a BIMS score of 15 that indicated her thought processes were intact.</p> <p>*The 12/2/14 revised comprehensive care plan physical functioning care plan indicated she needed limited to extensive assistance with her ADLs (activities of daily living). In the interventions sections for that care plan indicated she needed stand-by assistance for transfers. The at risk for falls care plan indicated she needed assistance of one staff member with transfers it did not list the assistance needed.</p> <p>*Inconsistencies in documentation of bowel and bladder continence or incontinence.</p>	F 514			

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

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FORM APPROVED  
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F 514	<p>Continued From page 109 *Refer to F 309, finding 9.</p> <p>Surveyor: 26632 6. Review of resident 5's 10/22/14 significant change in status clinical assessment revealed: *In the gastrointestinal(stomach and bowel) section E revealed it had not been completed. *Review of her medical chart revealed she had an ostomy (artificial opening into the bowel) in place.</p> <p>7. Review of resident 17's clinical health status/interdisciplinary assessments revealed: *The 9/3/14 admission assessment indicated "If diabetic proceed to diabetic foot screen." -That screen had not been completed. *There was no preventative foot care initiated. *The 11/26/14 re-admission assessment for skin conditions had not completed. It only had documented a pressure ulcer to the left and right heels without measurements. -The diabetic food screen had not been completed. *The 12/22/14 quarterly assessment under skin concerns had "Yes" checked. Written in was "L [left] heel, R [righ] heel, Abd pad (thick dressing), heel lift boots, and reposition." -The diabetic foot screen had not been completed.</p> <p>Surveyor: 20031 8. Review of resident 25's 2/7/15 at 13:05 (1:05 p.m.) timed progress note revealed "Verbal order to D/C [discontinue] Foley [urinary catheter (tube inserted into bladder to drain urine)] was received from ____ [physician assistant]. Foley balloon was deflated and catheter removed. Patient tolerated procedure well."  Review of the 2/10/15 progress note revealed "...</p>	F 514		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	<p>Continued From page 110 has foley cath, yellow and cloudy."</p> <p>Review of the current bowel and bladder detail report revealed the following: *2/10/15 at 3:16 a.m., "Appliances" was noted for resident's incontinence. *2/11/15 at 12:15 p.m.: "Appliances" was noted for resident's incontinence. *2/17/15 at 2:44 a.m.: "Appliances" was noted for resident's incontinence. *2/18/15 at 9:47 a.m.: "Appliances" was noted for resident's incontinence. *2/18/15 at 8:28 p.m.: "Appliances" was noted for resident's incontinence.</p> <p>Review of resident 25's 10/22/14 care plan revealed several handwritten notes under focus, goals, and interventions. Under interventions was the description "Change Foley catheter per MD [medical doctor] orders." Directly behind that typed intervention was a handwritten note: "change monthly 1/12/15." No other handwritten notes could be located regarding a physician's order to discontinue the Foley.</p> <p>Surveyor: 35237 Preceptor: 20031 9. Review of resident 2's medical record revealed: *She had been admitted on 9/22/14. *She had a Foley catheter (type of tube into the bladder to drain urine) present on admission.</p> <p>Review of resident 2's 9/23/14 Bladder Evaluation form revealed: *The section for admission information regarding urinary continence status had two boxes to indicate if the resident was currently continent or</p>	F 514		

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

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F 514	<p>Continued From page 111 incontinent of bladder. -Neither box had been checked. *The section for evaluation of residents with indwelling catheters (such as the Foley catheter) stated to skip that section if the resident did not have an indwelling catheter. -Nothing had been checked in that section.</p> <p>Review of resident 2's 9/23/14 Bowel Evaluation form revealed the section for admission information regarding bowel continence status had two boxes to check indicating if the resident was currently continent or incontinent of bowel. Neither box had been checked.</p> <p>Review of resident 2's 12/31/14 Quarterly Interdisciplinary Resident Review revealed: *The bladder evaluation section had not been fully completed. -The summary gave instructions to check one of two boxes. -Neither box had been checked.</p> <p>10. Review of resident 15's 12/31/14 Bladder Evaluation form revealed: *The section for admission information regarding urinary continence status had two boxes to indicate if the resident was currently continent or incontinent of bladder. -Both boxes had been checked. -The first box instructed no further evaluation necessary at that time, but two check marks were noted for "impaired mobility and dependent transfer." -The second box instructed to check all signs and symptoms that applied and to complete the rest of the form. -The options that could have been checked were urine leakage, clothes or incontinence pad wet,</p>	F 514		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	Continued From page 112 urgency, daytime frequency, nocturia (frequent need to urinate during the night), nocturnal enuresis (bedwetting), difficulty during urination, post void dribbling (continued wetting after urination). -None of those areas had been checked.  11. Interview on 2/18/15 at 3:15 p.m. with the DON revealed: *He confirmed the forms were not consistent, complete, or accurate. *He was "ok with nurses using copy and paste in the electronic medical record as long as they edited and accurately reflected the resident's status." *He would have expected an assessment of the resident by the nurse prior to charting. *The unit managers (resident care coordinator) reviewed notes from the previous twenty-four hours daily. -If they had concerns they would ask the nurse to clarify and make a late entry if needed.  Review of the undated Charting/Documentation Guide policy revealed: *"Nursing documentation should be clear, timely, accurate, reflective of observations, permanent and legible." **"Documentation is a matter of good clinical practice and is an expectation of trained and licensed health care professionals."	F 514			
F 520 SS=F	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	F 520			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 520	<p>Continued From page 113</p> <p>nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on observation, record review, interview, and policy review, the provider failed to ensure the quality assurance performance improvement (QAPI) program identified concerns, needed improvements, and corrective actions to maintain the overall welfare of all the residents, the environment, and the buildings. Findings include:</p> <p>1. Interview on 2/19/15 at 3:35 p.m. with the executive director (ED) confirmed she was responsible for the QAPI program. She stated the current program used the following to determine concerns: audits, resident chart reviews, quality measure indicators (QMI), graphs, visual and</p>	F 520	<p><b>F 520</b></p> <ol style="list-style-type: none"> <li>No immediate action could be taken.</li> <li>Field Services Clinical Director will inservice ED and DNS on QAPI policy and procedure by March 21, 2015. ED or designee will educate all staff on QAPI procedures by March 21, 2015.</li> <li>Field Services Clinical Director or designee will audit QAPI minutes monthly for 6 months to ensure. Field Services Clinical Director or designee will present results of audits for discussion at monthly QAPI for further review and recommendations and/or continuation/discontinuation of audits.</li> <li>March 21, 2015 * Field Services clinical Director or designee will audit QAPI minutes monthly for 6 months to ensure that the facility is identifying areas of concern in the building and plans for correcting these identified areas. KW/SDDO/H/MF</li> </ol>	3/21/15

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 520	<p>Continued From page 114</p> <p>paper competencies, resident council, infection control tracking and trending, Minimum Data Set (MDS) reviews with triple checks, and past surveys conducted by the state Department of Health. Front line staff were not involved in the QAPI committee but could present any concerns to their supervisor or the QAPI committee. Staff and department managers that had attended the QAPI committee meetings were the ED, director of nursing (DON), assistant DON, medical director, dietary, social services, activities, pharmacy, medical records, wound care nurse, unit care nurses, and charge nurses. She confirmed the current style of implementing corrective action would be team discussion, poor outcomes of department paper and visual audits, trends in QMIs, decline in resident status, improper coding of MDSs, and any other important resident care item.</p> <p>2. The ED stated QAPI met monthly. She confirmed QAPI was in the process of identifying concerns at the facility at the time of the survey. She stated she had become the administrator in August 2014. She confirmed several of the concerns found by the survey team in the past had not been implemented into QAPI by the past administrator.</p> <p>3. The current survey has the following deficiencies cited: F176, F221, F241, F273, F278, F280, F281, F309, F314, F315, F323, F441, F464, F490, F514, and F520. To include an immediate jeopardy finding at F309. Please refer to the above deficiencies.</p>	F 520		

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

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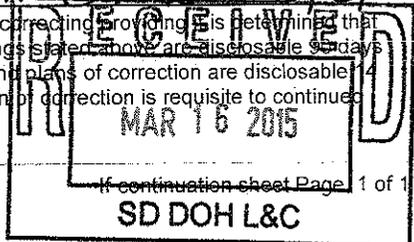
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 20031 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted from 2/11/15 through 2/12/15. Golden LivingCenter - Prairie Hills was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Executive Director</i>	(X6) DATE <i>3/13/2015</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.



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10669</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - PRAIRIE HILLS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>916 MOUNTAIN VIEW RD RAPID CITY, SD 57702</b>
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S 000	Initial Comments  Surveyor: 26632  Surveyor: 20031 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 2/10/15 through 2/12/15 and 2/17/15 through 2/19/15. Golden LivingCenter-Prairie Hills was found not in compliance with the following requirements: S210 and S236.	S 000		
S 210	44:04:04:06 EMPLOYEE HEALTH PROGRAM  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 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: 20031 Based on record review, document review, and interview, the provider failed to ensure seven of	S 210	<p><b>S210</b></p> <ol style="list-style-type: none"> <li>1. All Healthcare Services staff have completed the health screening form. All employees files will be reviewed for a health screening form.</li> <li>2. ED or designee will inservice all department heads regarding completing the health screening form on all new hires by March 21, 2015.</li> <li>3. ED or designee will audit all new hires for appropriate health screenings weekly for 4 weeks and then monthly thereafter. ED or designee will present results of audits for discussion at monthly QAPI for further review and recommendations and/or continuation/discontinuation of audits.</li> <li>4. March 21, 2015</li> </ol>	3/21/15

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

TITLE

(X6) DATE

STATE/FORM

6899

3Y7E11

Executive Director

MAR 16 2015

SD DOH L&C

If continuation sheet 1 of 1

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10669</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/19/2015</b>
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S 210	<p>Continued From page 1</p> <p>seven contracted housekeeping employees (F, G, H, I, J, O, and Q) had been evaluated by a health professional to determine they were free from a reportable communicable disease. Findings include:</p> <p>1. Review of contracted housekeeping employee O's file revealed: *He had been hired by the contractor on 12/18/14. *There was no documented health evaluation reviewed and signed by a health professional in his employee file.</p> <p>Interview on 2/12/15 at 11:30 a.m. with the contracted housekeeping supervisor revealed she had contacted her parent company. They did not have their employees obtain or did not provide their employees with a physical or health evaluation. She confirmed employee O and the other six contracted employees F, G, H, I, J, and Q had not had a health assessment evaluation completed by a health professional.</p> <p>Review of the provider's services agreement with the contracted company dated 10/1/14 revealed: **5.5.1. Audit of Records. (bb) pre-Employment Screening requirements..." ** "Employment Screening means and includes prohibited communicable disease screening as required by applicable state law or regulation;" **8.1.2. Regulatory Compliance. Vendor shall at all times use commercially reasonable efforts to comply with all State and Federal regulations applicable to its provision of the Services. Such regulations shall include but not be limited to applicable state department of health regulations, and any and all other regulations which govern the provision of the services herein (collectively the "Regulations")."</p>	S 210		

South Dakota Department of Health

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S 210	Continued From page 2  *"10.1 Background Checks and Testing. "... in compliance with all applicable federal, state, and local laws are the responsibility of the _____ [provider's] party." *"10.4.8 Health physical will be billed at _____ [provider's] cost."	S 210	<b>S236</b>  1. All staff and residents noted are current with their TB assessments and testing. All residents and staff will be reviewed for a TB testing/assessments.	
S 236	44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS  Tuberculin screening requirements for healthcare workers or residents are as follows:  (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;  This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 35237 Preceptor: 20031 Based on record review, interview, and policy review, the provider failed to ensure: *Three of five sampled employees (M, N and O) had a two-step tuberculin (TB) screening done	S 236	2. ED or designee will inservice all nursing staff on TB testing for new admissions by March 21, 2015. ED or designee will inservice all staff on TB testing for employees by March 21, 2015.  3. DNS or designee will audit all new residents for appropriate TB testing weekly for 4 weeks and then monthly thereafter. ED or designee will audit all new hires for appropriate TB testing weekly for 4 weeks and then monthly thereafter. DNS or designee and ED or designee will present results of audits for discussion at monthly QAPI for further review and recommendations and/or continuation/discontinuation of audits.  4. March 21, 2015	3/21/15

South Dakota Department of Health

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S 236	<p>Continued From page 3</p> <p>within fourteen days of their employment. *Two of twenty-five sampled residents (2 and 15) had a two-step TB screening done within fourteen days of admission. *One of twenty-five sampled residents (9) had documentation of screening completed annually for a positive TB reactor. Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of certified nursing assistant (CNA) M's employee file revealed she had been hired on 12/16/14. She had the first part of her two-step TB skin test given on 12/18/14, and it had been read on 12/20/14. Her second step had not been administered until 2/12/15, and it had been read on 2/14/15.</li> <li>2. Review of nursing assistant N's employee file revealed he had been hired on 12/3/14. No documented TB skin test could be located in his file.</li> <li>3. Review of housekeeper O's employee file revealed he had been hired on 12/18/14. The initial TB skin test was documented as given on 12/12/14 and had been read on 12/14/14. The second step had not been administered until 1/10/15 and had been read on 1/12/15.</li> </ol> <p>Interview on 2/18/15 at 3:15 p.m. with the director of nursing revealed TB skin tests should have been started during the employee's orientation with the first step given the first day and the second step approximately one week later. He confirmed CNA M's second step was past the fourteen days.</p> <ol style="list-style-type: none"> <li>4. Review of resident 2's medical record revealed: *She was admitted on 9/22/14.</li> </ol>	S 236		
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South Dakota Department of Health

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S 236	<p>Continued From page 4</p> <p>*Was re-admitted to the hospital from 10/14/14 until 10/20/14. *She received the first step TB skin test on 10/20/14, and the second step on 10/29/14.</p> <p>5. Review of resident 15's medical record revealed: *She was admitted on 12/10/14. *Received the first step TB skin test on 1/2/15, and the second step on 1/9/15.</p> <p>Interview on 2/18/15 at 3:15 p.m. with the director of nursing confirmed TB skin tests should have been started on the resident on the first or second day after admission.</p> <p>Review of the provider's 12/1/14 Tuberculosis, Screening Residents for policy revealed "any resident without a documented negative TST (tuberculin skin test), BAMT (blood assay for Mycobacterium tuberculosis) or CXR (chest x-ray) within the previous 12 months will receive a baseline (two-step) TST or (one-step) BAMT upon admission. If the first TST is negative, a follow up TST will be administered 1 to 3 weeks after the initial test is read."</p> <p>Surveyor: 20031 Review of the provider's service agreement with the contracted company dated 10/1/14 revealed: **"5.5.1. Audit of Records. (bb) pre-Employment Screening requirements..." ** "Employment Screening means and includes prohibited communicable disease screening as required by applicable state law or regulation; TB test;..." Surveyor: 28057</p> <p>Surveyor: 32572 6. Review of resident 9's medical record</p>	S 236		

South Dakota Department of Health

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S 236	Continued From page 5  revealed: *In 2012 a two step TB testing confirmed positive test results. *Review of the medical record did not indicate a screening had been completed annually for signs and symptoms of TB.  Surveyor 28057 Interview on 2/18/15 at 2:50 p.m. with the infection control nurse confirmed there had been no documentation resident 9 had been assessed for signs and symptoms of tuberculosis since 2012. He agreed there had been no copies of chest x-rays in his record since May 2012. He offered documentation of chest x-rays completed since then for resident 9. He had requested and received those today by facsimile from the hospital.  Review of the provider's 12/1/14 Tuberculin Infection Control Program policy revealed screening and surveillance of residents and employees for latent tuberculosis infection and active TB as appropriate.	S 236		