

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/28/2015
NAME OF PROVIDER OR SUPPLIER FOUNTAIN SPRINGS HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 WESLEYAN BLVD RAPID CITY, SD 57702	
(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 000	INITIAL COMMENTS <i>Addendums noted with an asterisk per 7/13/15 telephone to facility administrator. N5/S000H/JJ</i> Surveyor: 23059 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/27/15 through 5/28/15. Fountain Springs Healthcare was found not in compliance with the following requirements: F157, F166, F221, F226, F241, F250, F253, F280, F323, F332, F333, F364, F368, F387, F431, and F441	F 000	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157	F157 1. No immediate action could be taken for Resident #10. Facility will have a care conference with resident's family before July 17, 2015 to discuss resident's current plan of care. All other residents are at risk. 2. The Director of Nursing (DON) or designee will educate all nurses by July 17, 2015 on proper notification of	

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

TITLE

(X8) DATE

[Handwritten Signature]

Administrator

6/18/15

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

JUN 22 2015
SD DON L&C

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F 157	<p>Continued From page 1 this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review and interview, the provider failed to ensure the family and/or physician were updated regarding 18 of 22 incidents for 1 of 1 sampled resident (10). Those incidents included exiting the building, falls, resident-to-resident physical abuse, and behavioral difficulties. Findings include:</p> <p>1. Review of resident 10's revised 4/21/15 care plan focus area of mood and behavior issues revealed interventions that included: *Staff were to have anticipated her needs to due poor cognition (memory problem). *Watch for signs of anger and if safe leave her alone as she may have struck out. *Staff were to have provided her with redirection and reassurance if she was agitated. She may or may not take medications for mood and behavior issues. Staff were to notify my family and physician if there were concerns regarding mood and behavior.</p> <p>Review of resident 10's revised 6/27/14 care plan focus area of safety and vulnerability (defenseless) revealed interventions that included: *Staff were to have monitored her whereabouts in the facility. *Continue to maintain contact with family</p>	F 157	<p>physicians and responsible parties of change of conditions.</p> <p>3. DON or designee will audit 4 residents for appropriate communication to MD and responsible party of changes in conditions. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to Quality Assurance Process Improvement (QAPI) by the DON for review and recommendations of continuation/discontinuation.</p> <p>4. July 17, 2015</p>	7/17/15

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F 157	<p>Continued From page 2 regarding her behaviors. *Notify her physician of changes or concerns. *Continue with psychotropic (mood altering) medications as needed. Family aware that alternate placement (another facility) may have been required for safety.</p> <p>Review of resident 10's entire medical record and the interdisciplinary progress notes revealed the following incidents had occurred without the notification of either the physician, family, or both from 6/13/14 through 5/23/15: *6/13/14 9:46 p.m. Resident was found outside of the facility. No documentation of either physician or family having been notified. *6/15/14 10:56 p.m. Resident exited the facility three times through three different doors. No documentation of either physician or family having been notified. *6/19/14 7:04 p.m. Resident was found transferring another resident out of the shower. No documentation of either physician or family having been notified. *7/29/14 9:04 p.m. Resident was found outside of the facility. No documentation of either physician or family having been notified. *8/29/15 3:20 p.m. Resident got out of the door onto the patio. No documentation of either physician or family having been notified. *9/12/14 10:14 p.m. "Resident has been exit seeking most of the evening shift, she had several of her things packed also, she has attempted to get out of 3 different doors this evening, she did get out of the Dunn (wing) exit X (times) 1, staff needed to go out and bring her back inside." No documentation of either physician or family having been notified. *9/25/14 6:54 p.m. "Resident got out of first emergency exit door @ (at) end of hall on Miller</p>	F 157			

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F 157	<p>Continued From page 3</p> <p>hall can (CNA) [certified nursing assistant] redirected her back from 2nd door set off alarms resident has been wandering into other residents room using their bathroom meds given for increased agitation and was not effective." No documentation of either physician or family having been notified.</p> <p>*10/4/14 10:22 p.m. "At 2115 [9:15 p.m.] resident was wandering in and out of other resident's rooms and she was found on the floor in front of another resident's recliner. Will pass on to the AM (morning) shift to call the family due to it being a late hour, will fax [facsimile] the MD [medical doctor]." Review of the next shift's progress notes revealed no documentation resident 10's family had been notified of the fall.</p> <p>*10/18/14 10:30 p.m. "Dr. [name] here to see resident, new orders noted..... 1. Change Tramadol [pain medication] to 50 mg [milligram] 1 po [by mouth] BID [twice daily]" Review of the next shift's progress notes revealed no documentation resident 10's family had been notified of the new physician's orders.</p> <p>*10/24/14 5:15 p.m. "Resident continues to exit seek, getting out of the Miller exit." No documentation of either physician or family having been notified.</p> <p>*11/7/14 3:16 p.m. "Resident is exit seeking, got out the Miller hall door." No documentation of either physician or family having been notified.</p> <p>12/3/14 8:07 p.m. "Resident wandering throughout the halls..... Resident exited side exit door on Dunn hall. Door alarmed, this writer [nurses name] immediately assisted resident back into the facility without any difficulty." No documentation of either physician or family having been notified.</p> <p>*1/2/15 3:00 a.m. "Resident self reported she had just fallen out of her chair. As resident entered</p>	F 157		
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F 157	<p>Continued From page 4</p> <p>her room CNA noticed rocking chair tipped over sideways....Morning shift will be asked to call resident family to report fall." Review of the next shift's progress notes revealed no documentation resident 10's family had been notified of the fall.</p> <p>*3/30/15 3:28 p.m. "Can [CNA] reports to nurse resident caught slapping another resident in the face no bruising noted can (CNA) stopped resident." No documentation of either physician or family having been notified.</p> <p>*4/11/15 1:37 p.m. "Resident was noted to be slapping another resident on the left side of her face. Both residents were redirected from each other." No documentation of either physician or family having been notified.</p> <p>*4/20/15 9:42 p.m. "Heard the alarm on the Garmen exit sound and this writer (nurse) and CNA went down to see why and resident had gotten out and started to walk down the sidewalk." No documentation of either physician or family having been notified.</p> <p>*5/8/15 3:23 p.m. Fax communication to physician. "Resident has been evaluated for _____[name of another healthcare facility] and the paperwork is in progress." There was no documentation the family had been notified of this evaluation. There was no follow-up documentation on whether resident 10 had been accepted to move to that facility.</p> <p>*5/23/15 4:30 p.m. "Resident fell in the dining room trying to sit on a rolling stool. Unable to notify family this evening, Asked that day shift get ahold of family to inform them of the fall." Review of the next shift's progress notes revealed no documentation resident 10's family had been notified of the fall.</p> <p>Interview on 5/28/15 at 3:00 p.m. with the administrator and the interim director of nursing</p>	F 157		

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F 157	Continued From page 5 agreed timely notifications for resident 10 had not been completed. A policy for notification of family and physician had been requested on 5/28/15. No policy was given to this surveyor up until the end of the survey.	F 157			
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on document review, resident group interview, and staff interview, the provider failed to inform five of five residents (13, 21, 23, 24, and 25) of any resolution to resident council grievances and/or individual resident concerns for the previous eleven months (June 2014 through May 2015). Findings include: 1. Review of the following resident council meeting minutes revealed: *6/30/14: -Council would like to talk to department heads at meeting like the resident council meetings. --No response back for concern. -Wanted fresh fruit cart back. Bored with menu. --Response brought back to council regarded the fresh fruit cart and menus. *9/23/14: -Faucets were running and needed to be	F 166			

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F 166	<p>Continued From page 6</p> <p>re-caulked. Several complaints on leaking faucets in rooms.</p> <p>-Clothes still missing.</p> <p>-Toilets needed to be flushed and sometimes needed to be wiped off.</p> <p>--No response back for the above three concerns. *12/30/14:</p> <p>-Make sure they were informed about the issues before they voted.</p> <p>-Would like to see the bells group again and the lady singers.</p> <p>-Food was cold, kitchen was cold.</p> <p>-Would like fresh apples once in a while.</p> <p>-Faucets still running constantly.</p> <p>-Pink pair of slippers missing. Would like to have their clothes sorted by lights and darks and not everything thrown together. Bras looked gray.</p> <p>--No response back for the above six concerns. *1/27/15:</p> <p>-Residents wished crackers and pepper would not run out so quickly as they enjoyed the soups.</p> <p>-Housekeeping could clean a little better especially the bathrooms.</p> <p>--No response back for above two concerns. *2/24/15:</p> <p>-Would like more activities, card games, and music.</p> <p>-Did not like having the same dish option two times in one day.</p> <p>-One resident had a leaky faucet.</p> <p>-Housekeeping/Laundry had room for improvement.</p> <p>--No response back for the above four concerns. *3/24/15:</p> <p>-Too spicy foods.</p> <p>-Would like to see beds made nicer.</p> <p>*4/28/15:</p> <p>-Would like to have more outdoor time once the weather was nicer and van rides.</p>	F 166	<p>F166</p> <p>1. Facility has implemented a new resident council form and a department head response form for when grievances are brought up in resident council. Facility will continue to work with ombudsman on improving resident council processes. All residents are at risk.</p> <p>2. Administrator has reviewed the facility procedure on grievances and has implemented the above forms. Administrator or designee will educate all activity staff on resident council processes and on following up on grievances brought up in resident council by June 24, 2015.</p> <p>3. Administrator or designee will attend resident council for three months, if invited by residents, to ensure that all grievances are recorded and followed up on. Administrator or designee will audit grievances and grievance log to ensure grievances are recorded, documented and followed up on appropriately. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the Administrator for review and recommendations of continuation/discontinuation.</p> <p>4. July 17, 2015</p>	7/17/15

Audits will continue monthly for an additional 3 months after the administrator or designee is no longer attending the meetings.

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F 166	<p>Continued From page 7</p> <ul style="list-style-type: none"> -Food too spicy. -Call lights were slow to be answered. --No response back for the above three concerns. 5/26/15: -Try to do more outdoor things. -More activities. More games in the afternoon. -Old menu was liked better. --No response back for the above three concerns. <p>Resident group meeting at 2:00 p.m. on 5/27/15 with residents 13, 21, 23, 24, and 25 revealed:</p> <ul style="list-style-type: none"> *They wanted more activities. They wanted more card games. Resident 25 stated they had asked several times for those items, but nothing got done. *Some of the faucets were still leaking. They had brought the concern to council at least three times. *The beds were still not made very well. They had brought it up two times in the past and nothing got done. *Call lights could take over an hour to answer. They had brought it up in the past and nothing was done. *Food was not hot enough when it was served. Needed to have soups reheated all the time. Had relayed this at council meetings. *Wanted the fresh fruit brought back in the afternoon and more apples. They had brought it up in the past, and nothing was done. *Had no variety on the menus, and did not like the new menus. *There was no need to be on resident council as nothing got done. None of the concerns addressed had ever been acted on or answered by the particular person in charge of the area of concern or the department. <p>Interview on 5/28/15 at 8:15 a.m. with the</p>	F 166			

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F 166	Continued From page 8 administrator revealed she was aware of the concerns with resident council and the meetings. She stated she and the director of activities had talked with the ombudsman to help with council, leadership at the council, and resolution to the grievances. Interview on 5/28/15 at 8:40 a.m. with the director of activities revealed: *She had helped with activities and taken the course to become a qualified activity coordinator (QAC) in September 2014. She had taken the test and passed for the QAC in December 2014. *She had no idea and had no guidance on how to run a resident council meeting. *She had no idea what type of topics should be presented at the council meetings. *She was not aware how to address resident and council concerns. *She was not aware of the resident council department response form. *She had not asked any department heads to attend any resident council meetings. *She had realized the poor attendance to resident council meetings. The reason no one wanted to be elected was due to the lack of responses to their concerns. She said they had stated they did not want to come to council or be elected as "nothing gets done."	F 166			
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	F 221			

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F 221	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, record review, interview, and policy review, the provider failed to identify two of two sampled residents (5 and 11) as having a restraint, and complete quarterly assessments for the use of restraints were not completed for both residents 5 and 11. Findings include:</p> <p>1. Observation of resident 5 on 5/27/15 from 8:00 a.m. through 12:00 noon revealed: *He was seated in his wheelchair in his room after breakfast. *He had a self-releasing wheelchair belt on. *He was in the Miller dining room for lunch at 10:45 a.m. *That belt had not been released while he was assisted with his meal. *He had not been repositioned during those four hours between breakfast and lunch.</p> <p>Observation of resident 5 on 5/27/15 from 4:55 p.m. through 5:30 p.m. revealed: *He was seated in his wheelchair in the Miller dining room. *He had a self-releasing wheelchair belt on. *That belt had not been released while he was assisted with his meal.</p> <p>Review of resident 5's entire medical record revealed: *He had been admitted on 5/13/09. *He had diagnoses that included dementia (memory problem) with behavioral issues. *A 9/8/14 physician's order for a front releasing seat belt on his wheelchair.</p>	F 221	<p>F221</p> <p>1. Resident #5 has a self-releasing belt on that is considered a restraint. Resident has a MD order for the belt, appropriate assessment, consent, his care plan reflects this. There is documentation on the TAR that it is released and resident is repositioned at least every two hours with toileting and ADL's. No immediate action could be taken for resident #11 as he is no longer residing in the facility. All residents with seat belts were evaluated to ensure that they have proper documentation, plan of care, physician order, and releasing schedule.</p> <p>2. DON and IDT have reviewed the policy on restrictive devices. DON or designee will educate all nurses and CNAs on facility's policy on restraints by June 24, 2015.</p> <p>3. DON or designee will audit all restraints for proper documentation and that they are released per policy. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the DON for review and recommendations of continuation/discontinuation.</p> <p>4. July 17, 2015</p>	7/17/15	

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F 221	Continued From page 10 Review of the physical device assessments for resident 5 revealed assessments had been completed on 9/5/14, 2/23/15, and 5/27/15. The 9/5/14 physical device assessment revealed: *Use of the seatbelt to wheelchair leans over often to touch feet/sock/legs/and or pants. This is not considered a restraint as he has not been able to rise unassisted since admit." *It was to be used when he was alone in his wheelchair. *He was unable to demonstrate the ability to utilize the device. *He was unable to remove the device upon command. There were physical device assessments for quarter one after the 9/5/14 physical device assessment but it had not been dated. The next physical device assessment was on 1/8/15 but had not been dated until 2/23/15. The next physical device assessment for resident 5 had been completed on 5/27/15 and it indicated at that time it was a restraint. Review of resident 5's May 2015 treatment administration record (TAR) revealed: *An entry with a start date of 9/8/14. "Front release seat belt on w/c (wheelchair. every shift please provide release of w/c seat belt and repositioning at least every two hours and with toileting and ADLs [activities of daily living]= for resident." *Each of the three shifts from (6:00 a.m. through 2:00 p.m., 2:00 p.m. through 10:00 p.m., and 10:00 p.m. through 6:00 a.m. had documentation the order had been followed. 2. Observation of resident 11 on 5/27/15 at 1:30	F 221			

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F 221	<p>Continued From page 11</p> <p>p.m. revealed he had the left side of a Velcro seat belt on his wheelchair. Interview with certified nursing assistants J and K at that time revealed the other half of the seat belt had been missing for over a month. They stated they had informed the restorative therapy aide about it, as she was the one who fixed them.</p> <p>Review of resident 11's medical record revealed a 6/12/12 physician's order for a self-releasing seat belt as needed (PRN) for anxiety and agitation. It was to have been released every two hours when being worn. Review of 1/1/15 through 5/28/15 TARs revealed no documentation the self-releasing seat belt had been used.</p> <p>Review of resident 11's physical device assessment revealed it had had not been completed until 4/5/15. The assessment revealed the seat belt was used for positioning, was used for fall prevention, and not applicable had been checked for the resident demonstrating how to utilize or remove the device.</p> <p>Review of resident 11's 7/9/14 care plan with a focus on his mobility and fall prevention revealed no goal or interventions in relationship to the seat belt.</p> <p>3. Interview on 5/28/15 at 11:00 a.m. with the medicare coordinator agreed:</p> <ul style="list-style-type: none"> *The quarterly physical device assessments had not been signed and dated to ensure they had been completed for both residents. *Resident 5's seat belt was a restraint. *The care plan for releasing every two hours and repositioning had not been followed. *Resident 11's seat belt had not been care planned, and she was not aware it was not being 	F 221		

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F 221	Continued From page 12 used. Review of the provider's revised March 2013 Physical Restraints policy revealed: *A physician's order needed to specify the following: -The medical reason for the restraint. -Where, when, and how long it was to be used. -Timing of monitoring, releasing, and repositioning specified. -Whenever possible a restraint would have been released when staff were present such as mealtimes and activities. *They should have provided ongoing assessments and evaluation as to the use of a restraint including less restrictive methods of providing safety.	F 221			
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review, interview, and policy review, the provider failed to follow abuse investigation policies and procedures for incident investigation for 3 of 14 sampled residents (4, 10, and 14). Findings include: 1. Review of resident 10's entire medical record and the interdisciplinary progress notes revealed	F 226			

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F 226	Continued From page 13 incidents that occurred without the investigation or possible reporting of those incidents from 6/13/14 through 5/23/15 were: *6/13/14 at 9:46 p.m. Resident was found outside of the facility. *6/15/14 at 10:56 p.m. Resident exited facility three times through three different doors. *7/29/14 at 9:04 p.m. Resident was found outside of the facility. *9/12/14 at 10:14 p.m. "Resident has been exit seeking most of the evening shift, she had several of her things packed also, she has attempted to get out of 3 different doors this evening, she did get out of the Dunn (wing) exit X (times) 1, staff needed to go out and bring her back inside." *10/4/14 at 10:22 p.m. "At 2115 (9:15 p.m.) resident was wandering in and out of other resident's rooms and she was found on the floor in front of another resident's recliner. Will pass on to the AM (morning) shift to call the family due to it being a late hour, will fax (facsimile) the MD (medical doctor)." *11/7/14 at 3:16 p.m. "Resident is exit seeking, got out the Miller hall door." *1/2/15 at 3:00 a.m. "Resident self reported she had just fallen out of her chair. As resident entered her room CNA noticed rocking chair tipped over sideways....Morning shift will be asked to call resident family to report fall." *3/30/15 at 3:28 p.m. "Can (CNA) reports to nurse resident caught slapping another resident in the face no bruising noted can (CNA) stopped resident." *4/11/15 at 1:37 p.m. "Resident was noted to be slapping another resident on the left side of her face. Both residents were redirected from each other." *4/20/15 at 9:42 p.m. "Heard the alarm on the	F 226	F226 1. No immediate action could be taken for resident's #4, 10 and 14. All residents are at risk. 2. Administrator and DON have reviewed the policy on investigating and reporting resident incidents. Administrator or designee will educate all staff regarding reporting events to Administrator or DON in a timely fashion by June 24, 2015. Administrator or designee will educate DON on completing investigation on events and proper documentation of investigation by June 24, 2015. 3. Administrator or designee will audit 4 reportable events or falls to ensure that proper investigation, documentation and interventions are completed. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the Administrator for review and recommendations of continuation/discontinuation. 4. July 17, 2015	7/17/15	

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F 226	<p>Continued From page 14</p> <p>Garmen exit sound and this writer (nurse) and CNA went down to see why and resident had gotten out and started to walk down the sidewalk."</p> <p>*No documentation was found of any investigations for abuse or neglect or an elopement report to the South Dakota Department of Health (SD DOH) having been completed.</p> <p>Interview on 5/28/15 at 2:00 p.m. with the social services director revealed: *She was aware of some of the incidents that involved resident 10. *She had not been involved in any investigations regarding reportable incidents with any residents. *The previous director of nursing (DON) had been responsible for all the investigations and reporting to the SD DOH.</p> <p>Interview on 5/28/15 at 3:00 p.m. with the administrator and the director of clinical services revealed: *They were aware many items had not been investigated and reported as required by the SD DOH. *The previous DON had been responsible for the investigations and reporting of incidents. *The administrator had only been at the facility for approximately six weeks.</p> <p>Review of the provider's undated Abuse Prohibition policy revealed: *The provider required that all suspected maltreatment would have been reported to the SD DOH promptly. *All staff were required to report any suspected maltreatment to the administrator or DON. *The administrator or DON would have made</p>	F 226			

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F 226	Continued From page 15 sure a report was made out, and the internal investigation began immediately. *Maltreatment was defined as abuse, neglect, involuntary seclusion, financial exploitation, and misappropriation of property. *The administrator was ultimately in charge of the Abuse Prohibition plan and should have been informed of all incidents. Surveyor: 32573 2. Review of resident 4's complete medical record revealed: *A fall on 3/23/15 in the bathroom that had resulted in a skin tear. *A skin tear had been discovered on 4/23/15. *A skin tear had been discovered on 4/27/15. The resident had been unsure where it came from. *She had an unwitnessed fall on 5/24/15. 3. Review of resident 14's complete medical record revealed he had: *Been found on the floor of his bathroom on 1/25/15. *An unwitnessed fall on 2/15/15. *An unwitnessed fall and hit his head on 2/20/15. *An unwitnessed fall and hit his head on 3/15/15. 4. Review of incident investigation reports from June 2014 to May 2015 revealed the above mentioned incidents had not had an investigation report filled out. 5. Interview on 5/28/15 at 2:15 p.m. with the administrator revealed she would have expected nursing staff to document any unwitnessed fall or any incident on an investigation form.	F 226			
F 241	483.15(a) DIGNITY AND RESPECT OF	F 241			

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F 241 SS=E	Continued From page 16 INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on observation, interview, and policy review, the provider failed to ensure randomly observed residents' dignity was honored and maintained during two of two observed meal services in three of three dining rooms (Main, Miller, and Simpson). Findings include: 1. Observation on 5/28/15 beginning at 11:52 a.m. and until in the main dining room revealed several residents were seated at tables, and drinks had been served. Upon being seated at their tables residents completed their menus for the meal. Staff picked up those menus and took them to the kitchen counter. Residents were not all served in the order they arrived in the dining room. At some tables residents who arrived last at their tables had been served before others who had been waiting longer. 2. Observation on 5/28/15 beginning at 5:50 p.m. and until in the main dining room revealed twenty-four residents had been seated at their tables at that time. Residents completed their menus upon being seated at their tables. When they had completed those menus some of the residents held them up for staff to pick up. Two residents each held up menus for greater than eight minutes before staff came to get them. One	F 241	F241 1. No immediate action could be taken for residents. All residents are at risk. 2. Administrator, DON and IDT have reviewed the facility procedure for meal times. DON or designee will educate all staff on resident meals being served timely, tablemates being served together, staff assisting with resident's menus, and staff appropriately assisting and interacting with residents during meal times by June 24, 2015. 3. DON or designee will audit 4 meals per week to ensure that residents are served timely, tables mates are served together and that staff assist and interact appropriately with residents during meal time. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the DON for review and recommendations of continuation/discontinuation. 4. July 17, 2015	7/17/15

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F 241	<p>Continued From page 17</p> <p>of those residents had to support her arm with her other hand, because it had been held up so long. Multiple staff walked by both of those residents without picking up their menu. One resident waved the menus in an attempt to gain the staff member's attention with no result.</p> <p>Observation at the same time revealed another resident who had been seated and had turned in her menu waited six minutes longer for her meal to be served than a resident seated after her.</p> <p>Surveyor: 32573</p> <p>3. Observation on 5/27/15 at the noon meal in the Simpson dining room revealed:</p> <ul style="list-style-type: none"> *One resident had her food while three others at the table did not. *That resident had asked to have her soup warmed up. *A staff member had warmed it up but had not waited or asked to make sure it was warm enough. *The resident had to have it warmed up two more times before it was hot. *Two of the residents without food at that table received their meals at 12:25 p.m. *The fourth resident at that table had to ask for her food. *The aide had responded she was the only one working and was behind. *That resident received her food and juice at 12:35 p.m. <p>4. Observation on 5/27/15 at 6:00 p.m. of the evening meal in the Main dining room revealed:</p> <ul style="list-style-type: none"> *Three of four randomly observed residents at a table had their meals. *One of those residents had not gotten hers. -That resident stated, "Maybe they forgot about 	F 241		

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F 241	<p>Continued From page 18 me."</p> <p>-She also stated she had arrived before 6:00 p.m. and had turned her menu in early.</p> <p>-She received her meal at 6:25 p.m.</p> <p>*The other residents at that table had finished about seventy-five percent of their meals when she got hers.</p> <p>Surveyor: 26632</p> <p>5. Observations of resident 5 on 5/27/15 from 11:00 a.m. through 12:00 noon and from 4:55 p.m. through 5:30 p.m. revealed:</p> <p>*The resident was in the Miller dining room.</p> <p>*Certified nursing assistant (CNA) J was assisting him to eat his meal from 11:00 a.m. through 12:00 noon.</p> <p>-She fed him without any interaction with him during the meal. She did not explain to him what he was eating or ask him if he wanted another bite of food or drink.</p> <p>*CNA I from 4:55 p.m. through 5:30 p.m. had resident 5, who was seated in his wheelchair, facing away from the table.</p> <p>-Interview with CNA I at 5:15 p.m. revealed she had positioned him that way as he would try to move things on the table.</p> <p>-CNA I also did not interact with him while she fed him his meal.</p> <p>Surveyor 23059</p> <p>6. Review of the provider's undated Nursing Responsibilities at Meal Service policy revealed:</p> <p>*Staff from the nursing and dining services departments were to have worked cooperatively to ensure each resident had a pleasant dining experience.</p> <p>*A meal sequence would be used in dining rooms, so all residents at a table would have been served at the same time.</p>	F 241		

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F 241	Continued From page 19 *Staff were to personally ensure the dining experience was enhanced through observation and conversation with residents.	F 241			
F 250 SS=D	Review of the provider's undated Resident Bill of Rights revealed each resident had the right to receive care and treatment in a manner and in an environment that promoted the maintenance or enhancement of each resident's quality of life and dignity. 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services 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 Based on observation, interview, record review, and policy review, the provider failed to initiate referrals for mental health services or evaluation of behavioral issues for 1 of 14 sampled residents (10) with increased behavioral symptoms that included exit seeking, elopement (leaving the building), and physical aggression towards staff and other residents. Findings include: 1. Observation on 5/27/15 from 10:45 a.m. through 11:00 a.m. revealed resident 10 had let resident 31 out the Miller door to the outside. The inside alarm had not gone off as resident 10 was able to avoid having it go off by gently taking the alarm down without releasing the string that	F 250			

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F 250	<p>Continued From page 20</p> <p>would have set off the alarm. Resident 31 was on the sidewalk in her wheelchair when certified nursing assistant (CNA) K noticed her as she walked by the door. CNA K then brought resident 31 back into the building. The outer door had alarmed at the nurses station, but no staff had responded to the alarm.</p> <p>Review of resident 10's interdisciplinary progress notes from 6/12/14 through 5/26/15 revealed: *She had multiple exit seeking behaviors, elopements, resident-to-staff hitting, resident-to-resident hitting, and wandering episodes. *She had medications administered as above for those behaviors (see F157). *She had been evaluated at the hospital twice on 5/6/15 and 5/27/15 for possible admission to the behavioral health unit and had not been admitted. *She had been evaluated for admission to a memory care unit on 5/8/15 and had not been admitted.</p> <p>Review of the social service designee's (SSD) written notes for resident 10's concerns revealed: *A 8/14/14 note "Meds [medications] for mood, agitation." *A 11/13/14 note "Discussed medication, wandering." *A 1/22/15 note "Discussed medications." *A 4/30/15 note with no documentation of any behaviors.</p> <p>Review of a 5/21/15 care conference note with resident 10's family revealed: **"Nursing to fax [facsimile]for medication for agitation." **"Requested another follow up meeting in one month."</p>	F 250	<p>F250</p> <ol style="list-style-type: none"> 1. Resident #10 has had her care plan reviewed and revised by Social Services. Facility will have care conference with Resident #10's family by July 17, 2015 to review current plan of care. 2. Facility has implemented a behavior committee that will review residents with behaviors. Administrator or designee will educate social services on follow up on residents with changes in behaviors and ensuring their care plans are accurate by June 24, 2015. 3. Administrator or designee will audit 4 residents with behaviors for social services follow up and that their care plan is accurate. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the Administrator for review and recommendations of continuation/discontinuation. 4. July 17, 2015 	7/17/15
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F 250	<p>Continued From page 21</p> <p>***Discussed behaviors, aggression. Discussed requesting medication for agitation. Family okay w/this [with] The family aware that if any more physical behaviors, will need to request mental health hold."</p> <p>Review of resident 10's revised 4/21/15 care plan focus area of mood and behavior issues revealed interventions that included: *Staff were to anticipate her needs to due poor cognition (poor memory). *Watch for signs of anger and if safe leave her alone as she may strike out. *Staff were to provide her with redirection and reassurance if she was agitated. She may or may not take medications for mood and behavior issues. Staff were to have notified her family and physician if there are concerns regarding mood and behavior.</p> <p>Review of resident 10's revised 6/27/14 care plan focus area of safety and vulnerability revealed interventions that included: *Staff were to monitor her whereabouts in the facility. *Continue to maintain contact with family regarding her behaviors. *Notify her physician of changes or concerns. *Continue with psychotropic (mood alterations) medications as needed. *Family were aware that alternate placement might be required for safety.</p> <p>Review of resident 10's medication administration records and physician's orders from 6/12/14 through 5/26/15 revealed: *She had been admitted on 12/1/13 with a diagnosis that included Alzheimer's (disease that affects memory and mood).</p>	F 250			

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F 250	Continued From page 22 *She had received lorazepam (anti-anxiety) 0.5 milligram (mg) one tablet every two hours as needed (PRN): -Three times in June 2014. -Two times in July 2014. -Five times in August 2014. -Fifteen times in September 2014. -Thirty-two times in October 2014. -Forty-two times in November 2014. *Her lorazepam order had been changed to 0.5 mg one tablet three times daily on 12/4/14. She also received the PRN dose: -Five times in December 2014. -One time in January 2015. -Three times in February 2015. -Two times March 2015 -Two times in April 2015. -Eight times from 5/1/15 through 5/27/15. *She also had a 4/3/14 physician's order for Seroquel (anti-psychotic) 12.5 mg every eight hours PRN for agitation. She had received that medication: -Eighteen times in June 2014. -Fourteen times in July 2014. -Ten times in August 2014. -Twenty-one times in September 2014. -Twenty-two times in October 2014. -Twenty-seven times in November 2014. *The Seroquel order was changed to 12.5 mg two times daily for exit seeking and agitation on 12/4/14. In addition to the PRN Seroquel order. She received the PRN Seroquel: -Three times in December 2014. -None in January 2015. -None in February 2015. -One in March 2015. -None in April 2015.	F 250			

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F 250	Continued From page 23 *The Seroquel order was changed again on 5/22/15 to 37.5 mg two times daily with no PRN dose. Interview on 5/27/15 at 1:30 p.m. with the social service designee revealed she: *Was aware resident 10 had many behaviors. *Had not consulted any behavioral health professional to review and make recommendations. *Agreed resident 10 was one-on-one care for staff when she had behaviors. Interview on 5/28/15 at 3:30 p.m. with the administrator, interim director of nursing, and the director of clinical services revealed they were aware of resident 10's behaviors. She had been sent to the emergency department on 5/27/15 for evaluation for admission to the behavioral health unit, but there was no bed available. They were aware resident 10 required more specialized interventions for behaviors, and those interventions had not been provided. Review of the 2/12/13 signed SSD Job Description revealed the SSD's duties included: *Identify the psychosocial needs and problems of the residents and the family members. *To develop a care plan that identified medically related social and emotional problems and needs with realistic goals and specific actions to have been taken.	F 250			
F 253 SS=E	Refer to F157. 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and	F 253			

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F 253	<p>Continued From page 24 maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on random observation, interview, manufacturer's recommendations, and policy review, the provider failed to ensure: *Toilet base caulking was maintained in a cleanable, smooth condition for approximately 50 percent (%) of residents' rooms and two of two bathing rooms (Dunn/Watson and Miller/Garmen/Simpson). *Caulking around sinks was maintained in a cleanable, smooth condition for approximately 25% of resident rooms. *Towel cabinet and cabinet shelves in one of two bathing rooms (Dunn/Watson) in a durable and cleanable condition. *Privacy curtains in two of two bathing rooms (Dunn/Watson and Miller/Garmen/Simpson) were kept clean. *The wall round the sink in the bathroom in one of two bathing rooms (Dunn/Watson) had a cleanable surface. *Standing lifts in two of two bathing rooms (Dunn/Watson and Miller/Garmen/Simpson) were kept clean. *Chemicals used for cleaning and disinfection were used appropriately and according to manufacturer's recommendations. Findings include:</p> <p>1. Random observations during the survey on 5/27/15 from 1:00 p.m. through 3:00 p.m. and on 5/28/15 from 3:30 p.m. through 4:00 p.m. revealed:</p>	F 253	<p>F253</p> <p>1. All toilets and sinks were assessed by Maintenance and those that need new caulking were re-caulked. The towel cabinet and shelves in the Dunn/Watson bathing room were repaired. The privacy curtains in the Dunn/Watson and Miller/Garmen/Simpson bathing rooms were replaced. The wall around the sink in the bathroom of the Dunn/Watson bathing room was repaired. The bases of the two standing lifts were cleaned. No immediate action could be taken for the cleaning of the bathroom and bathing room floors.</p> <p>2. Administrator or designee will educate all housekeeping and maintenance staff on keeping the facility in proper repair, on proper procedure for cleaning bathing/bathroom floors, and on the appropriate amount of time to leave disinfectant on by June 24, 2015.</p> <p>3. Administrator or designee will audit 4 resident rooms for caulking around the toilet and sinks to ensure it is in good repair, that storage surfaces are durable and cleanable, that privacy curtains and resident equipment is kept clean, and that manufacturer directions are followed when using disinfectants. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the Administrator for review and recommendations of continuation/discontinuation.</p>	7/17/15	

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F 253	<p>Continued From page 25</p> <ul style="list-style-type: none"> *Approximately 50% of the toilet base caulking in residents' room bathrooms were stained, uneven, or pulled away from the toilet base making them uncleanable surfaces. *Approximately 25% of the resident room sinks caulking was uneven or pulled away from the wall making them uncleanable surfaces. *The towel cabinet and shelves in the cabinet in the Dunn/Watson bathing room had multiple areas of the laminate on the surface and edging of the shelves missing. Exposed particle board made the surface uncleanable. *The privacy curtains in the Dunn/Watson and Miller/Garmen/Simpson bathing rooms in front of the bathtubs dragged approximately six to nine inches on the floor. The bottoms of those privacy curtains were grossly soiled and brown/black in color. *The wall around the sink in the bathroom in the Dunn/Watson bathing room was missing the paint, and only the paper covering on the gypsum board was present. That surface was uncleanable. *The bases of the two standing lifts in the Dunn/Watson and Miller/Garmen/Simpson bathing rooms had a large amount of debris on the standing portion. Residents were transferred with bare feet when those lifts were used. <p>Interview on 5/28/15 at 10:00 a.m. with the maintenance supervisor revealed he:</p> <ul style="list-style-type: none"> *Had been aware the caulking around the residents' rooms and bathing rooms toilet bases and around the resident rooms sinks were in need of replacement. *Was not aware of the towel shelf in the Dunn/Watson bathing room but agreed it would be an uncleanable surface. *He had just became aware of the wall behind the 	F 253	4. July 17, 2015	

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F 253	<p>Continued From page 26</p> <p>bathroom sink in the Dunn/Watson bathing room when he had replaced the faucet. *Had just been in the position full-time for about one month. *Had just hired two more maintenance assistants and had already planned to replace the caulking.</p> <p>2. Interview on 5/28/15 at 7:45 a.m. with housekeeper L revealed: *She used HB 25 L (disinfectant) on the sink and toilet surfaces. *She would have sprayed the HB 25 L on the surface, and then wiped it dry. *She used 3M 3L (neutral cleaner) to mop all bathroom and bathing room floors.</p> <p>Review of the manufacturer's recommendations for HB 25 L revealed it was to have been applied to the surface. It should have been left wet for ten minutes and then wiped off from surface for it have had a disinfecting result.</p> <p>Review of the manufacturer's recommendations for 3M 3L revealed it was not a disinfectant but only a cleaner.</p> <p>Review of the provider's 5/6/09 Mopping Shared Resident Bathroom Floors policy revealed: *All shared resident bathrooms and whirlpool bath area floors should have been disinfected. *"First mop the floor with a neutral cleaner then apply an over-spray on the entire floor using bleach water at a 1 to 10 ratio [1 part bleach 10 parts water]."</p> <p>Interview on 5/28/15 at 4:00 p.m. with the housekeeping supervisor revealed he: *Agreed the privacy curtains were heavily soiled and needed to be replaced.</p>	F 253			

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F 253	Continued From page 27 *Confirmed housekeeping was responsible for cleaning the standing lifts. *Agreed the bathroom and bathing room floors had not been disinfected. *Agreed the time for the HB 25 L to have stayed wet on the surface was ten minutes.	F 253	F280	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, interview, record review, and policy review, the provider failed to review, revise, and individualize care plans for 2 of 14 sampled residents (4 and 11). Findings include:	F 280	1. No immediate action could be taken for resident #11 as he no longer resides in the facility. Resident #4 had her care plan updated to ensure that her vision problems in regards to activities and care have been addressed. All residents are at risk. 2. DON or designee will educate all staff on care plans and ensuring they are kept accurate and up to date with each resident's individual needs by June 24, 2015. 3. DON or designee will audit 4 care plans per week to ensure that the care plan reflects the care and services provided to the resident. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the DON for review and recommendations of continuation/discontinuation. 4. July 17, 2015	7/17/15

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F 280	<p>Continued From page 28</p> <p>1. Observation of resident 11 on 5/27/15 at 1:30 p.m. revealed he had the left side of a Velcro seat belt on his wheelchair. Interview with certified nursing assistants J and K at that time revealed the other half of the seat belt had been missing for over a month. They stated they had informed the restorative therapy aide about it, as she was the one who fixed them.</p> <p>Review of resident 11's medical record revealed a 6/12/12 physician's order for a self-releasing seat belt as needed (PRN) for anxiety and agitation. It was to have been released every two hours when being worn. Review of 1/1/15 through 5/28/15 treatment administration records revealed no documentation the self-releasing seat belt had been used.</p> <p>Review of resident 11's physical device assessment revealed no assessment had been completed until 4/5/15. The assessment revealed the seat belt was used for positioning and for fall prevention. The not applicable box was checked for the resident demonstrating how to utilize or remove the device.</p> <p>Review of resident 11's last updated 3/27/15 care plan revealed no focus area, goal, or intervention for the use of his self-releasing wheelchair belt.</p> <p>Surveyor: 32573</p> <p>2. Interview on 5/27/15 with resident 4 during the initial tour revealed she was blind and hard of hearing.</p> <p>Review of resident 4's medical record revealed she had a diagnosis of Glaucoma.</p>	F 280		

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F 280	Continued From page 29 Review of resident 4's 2/25/15 care plan revealed her vision problems had not been addressed on the care plan. There had been no information in regards to special activities, care, goals or interventions that would be appropriate for her eye condition. Interview on 5/27/15 at 10:50 a.m. with the activities director revealed she kept a communication book in the activities office that had special instructions for residents. She would have expected the activities staff to know to look in the book for resident 4's needs but maybe not nursing staff. She would have expected something about resident 4's vision to have been included in her care plan. Interview on 5/28/15 at 2:15 p.m. with the administrator revealed she would have expected care plans to be individualized and reflected each resident's needs. Review of the provider's undated Care Plan policy revealed: *Nursing and the interdisciplinary team was responsible for keeping care plans updated. *Care plans should have set realistic, specific, and achievable goals. *The care plans should have been updated as there were changes in the resident's condition. *Changes might be health, mood, behavior, activities of daily living, activity related, or other things.	F 280			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323			

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F.323	<p>Continued From page 30</p> <p>environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632</p> <p>A. Based on observation, testing, and interview, the provider failed to ensure one of four hall (Miller) exit doors alarms was responded to in a timely manner by staff. Findings include:</p> <p>1. Observation on 5/27/15 from 10:45 a.m. through 11:00 a.m. revealed resident 10 had let resident 31 out the Miller door to the outside. The inside alarm had not gone off as resident 10 was able to avoid having it go off by gently taking the alarm down without releasing the string that would have set off the alarm. Resident 31 was on the sidewalk in her wheelchair when certified nursing assistant (CNA) K noticed her as she walked by the door. CNA K then brought resident 31 back into the building. The outer door had alarmed at the nurses station, but no staff had responded to the alarm.</p> <p>Testing of that door alarm on 5/27/15 at 11:30 a.m. revealed the inner door alarm was easily bypassed by gently holding the alarm. When the outer door was opened surveyor 20031 was standing at the nurses station. She stated the alarm was very hard to hear.</p> <p>Interview on 5/27/15 at 11:30 a.m. with licensed practical nurse C revealed she had barely heard</p>	F 323	<p>F323</p> <p>1. Alarms on doors are audible and answered timely. All doors that present a hazard will have a door edge protector placed on by July 17, 2015. Additionally all other doors will be done by August 31, 2015. Maintenance or designee will inspect all lift slings to ensure they are in good repair.</p> <p>2. Administrator, DON and IDT have reviewed the facility procedure for safety concerns in the facility. Administrator or designee will educate all staff on door alarms and response, reporting potential hazards (such as door edges) to maintenance, proper use of lifts, and ensuring that lift belts and slings are in good repair by June 24, 2015.</p> <p>3. Administrator or designee will audit 4 instances of a door alarming for appropriate response, 4 resident doors to ensure they are in good repair, and 4 lifts and slings to ensure they are used correctly and are in good repair. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the Administrator for review and recommendations of continuation/discontinuation.</p> <p>4. July 17, 2015</p>	7/17/15	

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F 323	<p>Continued From page 31</p> <p>the alarm when this surveyor had opened the door. She confirmed no staff had responded to the earlier alarm when resident 31 had been let out of the door. She agreed resident 31 was not to have been outside without supervision as she had cognition (poor memory and judgement). She called the maintenance supervisor at the above time and he placed a new portable door alarm on the inner door.</p> <p>B. Based on observation, testing, and interview, the provider failed to ensure the edges of approximately fifty percent (%) of residents' doors had been maintained in a safe manner, Findings include:</p> <p>1. Random observations during the survey on 5/27/15 from 1:00 p.m. through 3:00 p.m. and on 5/28/15 from 3:30 p.m. through 4:00 p.m. revealed approximately 50% of the residents' door edges had rough areas on the bottom one-quarter of the door. Those door edges were on the latching side of the door. They had gouged out pieces of the wood. Testing by running a hand along those rough areas revealed the wood could catch on residents' legs and ankles causing skin tears or lacerations.</p> <p>Interview on 5/28/15 at 10:00 a.m. with the maintenance supervisor confirmed the above finding.</p> <p>Surveyor: 32573</p> <p>C. Based on record review and interview, the provider failed to ensure lift equipment had been operated in a manner to ensure resident safety for 1 of 14 sampled residents (2). Findings include:</p>	F 323			

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F 323	<p>Continued From page 32</p> <p>1. Review of resident 2's complete medical record revealed: *She had a diagnosis of unspecified debility (physical weakness), lack of coordination, muscle weakness, contracture (shortening of muscles) of joint, osteoporosis (bone weakness), and rheumatoid arthritis. *She had a fall from a sit-to-stand lift (electric device to lift and transfer a person that can not move independently) on 2/24/15. *The incident investigation stated the waist belt had not been hooked and resident had fallen from the lift onto the floor. *The incident investigation report had a corrective action of re-educating staff on proper lift use.</p> <p>Review of resident 2's Minimum Data Set (MDS) revealed: *She had a Brief Interview for Mental Status (BIMS) score of 15 indicating she was cognitively (knowing or understanding things) intact. *She had limited range of motion (ability to move) in both of her arms and one of her legs. *She required physical assistance of two or more for transfers.</p> <p>Observation on 5/27/15 at 10:30 a.m. of resident 2 revealed: *The fingers of her left hand were formed into a fist due to contracture (condition causing deformity). *Her left foot and ankle had been in a walking boot. *She propelled herself in her wheelchair with her feet.</p> <p>Interview on 5/27/15 at 10:30 a.m. with resident 2 revealed:</p>	F 323		

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F 323	<p>Continued From page 33</p> <p>*Staff did not have the lift sling hooked correctly and she "slipped out of it."</p> <p>*She had been told before that "it was a pain in the butt" to hook up all parts of the lift sling.</p> <p>*She had slipped out of the sling again not long ago.</p> <p>-Her wheel chair had been behind her, so she had not fallen to the ground "thank goodness."</p> <p>*Parts of the lift had been worn out, and that was why she had "fallen" the second time.</p> <p>Review of resident 2's progress notes from 2/24/15 through 5/27/15 revealed no information about the second sit-to-stand lift incident.</p> <p>Interview on 5/28/15 at 8:45 a.m. with the administrator revealed she had spoken to the aide involved in the second incident. Part of the lift had come off, and resident 2 had fallen back into her chair. The administrator would not have considered that a fall because she had not fallen to the ground. She would not have expected that information to be put in the progress notes or in an incident report. She would have expected certified nursing assistants (CNAs) to notify maintenance if there had been problems with a lift or sling.</p> <p>Review of the Stand Inspections sheet revealed a 2/15/15 note stating all stands were in good condition. There had not been any mention of the condition of the lift slings.</p>	F 323		
F 332 SS=E	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p>	F 332		

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F 332	<p>Continued From page 34</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on observation, interview, and policy review, the provider failed to ensure medications were administered according to the five rights for medication administration for 13 of 39 medications administered by 3 of 5 licensed nurses, licensed practical nurses (LPN) A and C, and registered nurse (RN) B for 6 of 14 residents (11, 18, 19, 20, [redacted] for the following medications resulting in a 34.2% medication error rate: *LPN C had administered insulin to resident 30 outside of the time frame required related to a meal. *RN B had administered eleven medications one hour after the scheduled time frame for one randomly sampled resident (20). *LPN A had administered an eye drop improperly to one resident 29. *LPN A would have given the wrong laxative to a resident (19) if the surveyor had not questioned it and intervened. *LPN A would have administered insulin without first priming the insulin pen if the surveyor had not intervened to ensure the correct dose would have been injected for a resident (11). *LPN A would have administered the wrong dose of acetaminophen to a resident (11) if the surveyor had not questioned it and intervened. *Findings include:</p> <p>1. Observation on 5/27/15 at 11:20 a.m. revealed: *LPN C checked resident 18's blood sugar. *The resident's blood sugar had been 195. *LPN C administered two units of Novolog insulin</p>	F 332	<p>F332</p> <p>1. No immediate action could be taken for residents #11,18,20, and 29. <i>All residents are at risk. Residents 11 and 20 are no longer at the facility. NS/SODH/JJ</i></p> <p>2. All nurses and med aides will have a med competency completed by July 17, 2015. <i>NS/SODH/JJ</i></p> <p>3. DON or designee will audit 4 medication administrations per week to ensure that the medication administration policy is followed appropriately, including the 5 rights of medication administration. This audit will be done weekly for 4 weeks and then monthly for two months. <i>NS/SODH/JJ</i> Audit will be brought to QAPI by the DON for review and recommendations of continuation/discontinuation.</p> <p>4. July 17, 2015 <i>Audits will include monitoring medication administration for residents 18, 19, 29, and 30 who are currently residing within the facility. NS/SODH/JJ</i></p> <p><i>Included in those competencies will be: timeliness of administration of insulin and all medications; and correct procedure for administration of eye drops. NS/SODH/JJ</i></p>	7/7/15

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F 332	<p>Continued From page 35 to the resident per sliding scale. *The resident went to the dining room after receiving her insulin. *She had not received anything to eat until 12:07 p.m.. *That had been forty-seven minutes after she had received her insulin.</p> <p>Review of resident 18's 3/5/15 physician's orders revealed Novolog insulin was to have been given per sliding scale three times a day with meals.</p> <p>Review of resident 18's 3/5/15 May 2015 medication administration record (MAR) revealed Novolog insulin was to have been given per sliding scale three times a day with meals.</p> <p>Review of the provider's revised July 2013 Medication Pass policy revealed: *Medications were to be administered according to the five rights. *The five rights were the right resident, the right medication, the right time, the right dose, and the right route.</p> <p>Review of the provider's undated Subcutaneous Injections policy revealed it had not addressed the administration of insulin specifically.</p> <p>Interview on 5/28/15 at 4:00 p.m. with the director of clinical services confirmed she would have expected the insulin to have been given within fifteen minutes of the meal or a snack offered with the insulin.</p> <p>2. Observation and interview on 5/28/15 at 10:15 a.m. revealed RN B: *Opened the electronic MAR for resident 20. *The resident's list of medications had been</p>	F 332			

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F 332	<p>Continued From page 36 highlighted in red.</p> <p>*RN B stated they had been highlighted in red, because they had not been given and were late.</p> <p>*She said it had been one of those days.</p> <p>*She then prepared eleven medications that had included medications for blood pressure, anxiety, muscle spasms, and depression.</p> <p>*She took them into the resident and administered them.</p> <p>Review of the resident's May 2015 MAR revealed the above medications had been scheduled to be given at 8:00 a.m.</p> <p>Review of the provider's revised July 2013 Medication Pass policy revealed:</p> <p>*Medications were to have been given at the right time.</p> <p>*Medications were to have been administered within one hour before or after the time indicated.</p> <p>Interview on 5/28/15 at 4:00 p.m. with the director of clinical services confirmed she expected medications to have been given one hour before or one hour after the scheduled time.</p> <p>3. Observation and interview on 5/27/15 at 4:26 p.m. revealed LPN A administered Timolol eye drops to resident 29. The first drop went into the resident's right eye as ordered. When LPN A went to put the second drop into the resident's left eye the resident resisted and tilted her head down rather than up as needed. The eye drop rolled down the resident's cheek rather than going into her eye. LPN A agreed it had not gotten into the resident's eye as ordered and had rolled down her cheek. She agreed that happened other times when the eye drop was administered. She further agreed it would have been easier to administer</p>	F 332			

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F 332	<p>Continued From page 37</p> <p>the eye drops if the resident had been lying down or in her recliner instead of her wheelchair. She had not attempted to put another eye drop into the resident's left eye.</p> <p>Review of the provider's undated Ophthalmic (eye) Drops policy revealed the resident was to be sitting or lying down. The head was to be tilted back and tilted to the affected eye.</p> <p>Interview on 5/28/15 at 4:00 p.m. with the director of clinical services confirmed she expected the eye drops to be administered into the eye as ordered.</p> <p>4. Observation and interview on 5/27/15 at 4:37 p.m. revealed LPN A had placed a sennoside 8.6 milligram (mg)/docusate 50 mg tablet in a medication cup. She then explained to me that the medication ordered (sennoside) and listed on the resident's MAR had run out a few days ago. She stated the former director of nursing had told her to substitute the medication she had placed in the medication cup for the medication ordered and planned on giving that medication in place of the ordered medication. This surveyor informed her they were not the same medication. She then asked RN D who was on duty if it had been the same medication. RN D stated it was not the same medication and assisted her to get the correct medication.</p> <p>Review of the provider's revised July 2013 Medication Pass policy revealed: *Medications were to be administered according to the five rights. *The five rights were the right resident, the right medication, the right time, the right dose, and the right route.</p>	F 332			

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F 332	<p>Continued From page 38</p> <p>5. Observation and interview on 5/27/15 at 4:37 p.m. revealed LPN A had prepared six units of Novolog insulin from a flex pen to give resident 11. She had not primed the insulin pen prior to dialing the six unit dose to be given to the resident. When asked by this surveyor if she needed to prime the pen before she gave the insulin to the resident she replied "Oh yeah" I need to prime it before I give the insulin. She then primed the pen with two units of insulin. She then redialed the six unit dose of insulin and administered it to the resident.</p> <p>Interview on 5/28/15 at 4:00 p.m. with the director of clinical services confirmed she had expected the flex pen to be primed prior to dialing the dose to be given a resident. That would have ensured the correct dose was received.</p> <p>Review of the provider's undated Subcutaneous Injections policy revealed it had not addressed the administration of insulin or the use of an insulin flex pen specifically.</p> <p>Review of the manufacturer's instructions for use of the Novolog insulin flex pen revealed the pen was to have been primed with two units of insulin before dialing the dose to be given.</p> <p>6. Observation and interview on 5/27/15 at 4:37 p.m. revealed LPN A had prepared one 500 mg tablet of acetaminophen by crushing it and putting it in pudding for resident 11. When questioned by this surveyor if that was what was listed on the resident's MAR to be given she re-checked the MAR. She then stated the resident was to have received two 500 mg tablets of the acetaminophen, not one as she had prepared.</p>	F 332		

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F 332	Continued From page 39 She then crushed a second one and added it to the other one. She then gave the resident the two acetaminophen tablets as listed on the resident's MAR. Review of resident 11's May 2015 MAR revealed acetaminophen 500 mg, two tablets were to have been given twice every day. Review of resident 11's 7/5/13 physician's orders revealed acetaminophen 500 mg, two tablets were to have been given twice every day. Review of the provider's revised July 2013 Medication Pass policy revealed: *Medications were to be administered according to the five rights. *The five rights were the right resident, the right medication, the right time, the right dose, and the right route.	F 332	F333 1. Resident #14 has his Exelon patch and is receiving it per MD order. DON or designee will audit all residents with patches to ensure their MD order is transcribed accurately. 2. DON or designee will educate all nurses on ensuring that orders are transcribed accurately, especially stop and start dates by July 17, 2015. 3. DON or designee will audit 4 residents to ensure their medication orders are transcribed correctly. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the DON for review and recommendations of continuation/discontinuation. 4. July 17, 2015	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on record review and interview, the provider failed to ensure medications were administered according to physicians' orders for 1 of 14 sampled residents (14). Findings include: 1. Review of resident 14's nursing progress notes revealed: *A 5/22/15 late entry stating the resident had not	F 333		7/17/15

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F 333	Continued From page 40 received his medication Exelon (used to treat alzheimers) patch for five doses. The physician was notified. *A 5/14/15 physician's visit note stating the physician had written to continue the resident's Exelon patch. Review of resident 14's May 2015 medical administration record (MAR) revealed: *His Exelon patch had not been marked as given from 5/15/15 to 5/21/15. *A second order for Exelon patches had been started 5/21/15. Review of resident 14's physician's orders revealed: *A 4/15/15 order for Exelon patches 4.6 milligrams (mg) to be applied to the skin every day in the evenings for thirty days. *A 5/14/15 order to continue Exelon patches 4.6 mg/24 hours. Interview on 5/28/15 at 2:15 p.m. with the administrator revealed the most current order for Exelon patches had "fallen off" the electronic MAR, because the first order had an end date. Giving the medication had been missed.	F 333			
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced	F 364			

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F 364	<p>Continued From page 41</p> <p>by: Surveyor: 20031</p> <p>Surveyor: 32573 Surveyor: 20031 Based on observation, testing, interview, and policy review, the provider failed to ensure hot food remained hot for palatability (acceptable to taste) for two of two meal services in two of two dining rooms. Soup temperatures for one of one dining room (Simpson) and meal temperatures for one of one supper tray meal were not held at acceptable temperatures for four of four randomly observed residents. Findings include:</p> <p>Surveyor: 32573 1. Observation on 5/27/15 at the noon meal in the Simpson dining room revealed: *One resident had asked to have her soup warmed up. *A staff member had warmed it up but it was still not hot. *The resident had to have it warmed up two more times in the microwave before it was hot. *Another resident had to ask for her soup to be warmed up immediately after she got it because it was not hot.</p> <p>Surveyor: 20031 2. Resident group meeting at 2:00 p.m. on 5/27/15 with residents 13, 21, 23, 24, and 25 revealed the food was not hot when they ate in the Simpson and main dining room. Room trays were always "lukewarm."</p> <p>Interview at 3:45 p.m. on 5/27/15 with resident 13 revealed the food temperatures were not hot enough. Especially in the Simpson dining room. She stated residents were constantly asking for</p>	F 364	<p>F364</p> <p>1. Facility has ordered new room tray covers that will assist with keeping room trays at appropriate temperature. No other immediate action could be taken for residents.</p> <p>2. Administrator and Dietary Services Manager have reviewed the facility procedure for food temps. Dietary Services Manager (DSM) or designee will educate all dietary staff on appropriate food temperatures, especially soup, and on room tray temps and procedures by June 24, 2015.</p> <p>3. DSM or designee will audit 4 meal passes a week for appropriate temperature of food and 4 room trays per week for appropriate temperatures. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the DSM for review and recommendations of continuation/discontinuation.</p> <p>4. July 17, 2015</p>	7/17/15	

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F 364	Continued From page 42 food to be re-warmed. 3. Observation at 5:45 p.m. on 5/27/15 revealed a room tray had been dished at 5:45 p.m. and delivered to residents 26 and 27 at 6:15 p.m. in their room. Observation and interview at 6:25 p.m. after the tray delivery with resident 26 revealed she and resident 27 had just began to eat their meal. Resident 26 was asked to check the temperature of her meal which included a hot dog. She stated "The dog's barely warm! I like my food hot." The surveyor relayed to the certified dietary manager (CDM) the timing of the tray for residents 26 and 27, and she had another tray delivered immediately. Testing of the hot food temperatures at that time revealed they were at least 160 degrees Fahrenheit or above. 5. Interview at 7:45 a.m. on 5/28/15 with the CDM revealed she had over twenty trays last night for supper. She was aware the tray service was disorganized. They needed to implement a system. She was not aware the food temperatures were not hot enough. Staff had not relayed to her about reheating meals. She stated she had not done any food temperature checks herself in the two other dining rooms. Nor had she done any tray monitoring of food temperatures. Review of the provider's undated Food Service distribution policy revealed no information for the pleasure and taste of hot and cold food temperatures.	F 364			
F 368 SS=F	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at	F 368			

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F 368	<p>Continued From page 43</p> <p>least three meals daily, at regular times comparable to normal mealtimes in the community.</p> <p>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Surveyor: 20031 Based on resident interviews, family interview, group interview, and policy review, the provider failed to offer a bedtime snack to all residents. Fifteen of fifteen resident 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 13, 21, 23, 24, and 25's charts reviewed revealed an evening snack had not been offered to all residents. Findings include:</p> <p>Surveyor: 28057 1. Interview on 5/27/15 at 8:00 a.m. with resident 21 revealed: *She had not been offered snacks in the evening after the supper meal. *The provider had talked about having a snack cart for the residents in the evening at one time. *That had never occurred.</p>	F 368	<p>F368</p> <p>1. Facility has revamped the bedtime (HS) snack procedure. HS snacks will be passed out by dietary staff and resident's acceptance or refusal of the snack will be documented each evening.*</p> <p>2. Administrator and DSM have reviewed the procedure for HS snacks. Administrator or designee will educate dietary staff and CNAs on this new procedure by June 24, 2015.</p> <p>3. Administrator or designee will audit 4 residents a week to see if they received their HS snack and that there is proper documentation of acceptance/refusal. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the Administrator for review and recommendations of continuation/discontinuation.</p> <p>4. July 17, 2015</p> <p><i>This will be completed for all residents including 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 21, 23, 24, and 25. Resident 13 no longer resides in the facility. NS/SD004/JS</i></p>	7/17/15

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F 368	<p>Continued From page 44</p> <p>Surveyor: 32573 Interview on 5/27/15 at 10:20 a.m. with resident 2 revealed she had not been offered a bedtime snack every night.</p> <p>Surveyor: 20031 Interview on 5/27/15 at 11:30 a.m. with resident 3 revealed she was alert and oriented to person, place, and time. She had never been offered a snack at bedtime. There were times when she would have liked to have been offered a bedtime snack. Interview with resident 3's son who was a visitor at the time of the interview revealed he had been back to visit his mother for about three weeks. He stated he had stayed until about 8:00 p.m. almost every night, and he had never seen a bedtime snack offered to his mother. He stated he would get up and take a walk between 7:00 p.m. and 8:00 p.m. in the evenings. He had never seen any staff offering a snack or even a snack cart in any other hallways. He stated it appeared most residents were asleep by 8:00 p.m. So if the snack was offered at that time or after most of them were asleep or at the least in bed.</p> <p>Resident group interview at 2:00 p.m. on 5/27/15 with residents 13, 21, 23, 24, and 25 revealed all six had not been offered a bedtime snack. Residents 13 and 25 revealed most people were asleep or in bed by 8:00 p.m., so the snack might come after that time. Residents 23 and 24 stated they had snacks in the afternoon sometimes, but not at night.</p> <p>Review of residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 13, 21, 23, 24, and 25's charts for documentation of a bedtime snack for the month of May 2015 revealed: *A total of twenty-seven days were charted since</p>	F 368		

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F 368	<p>Continued From page 45</p> <p>the end of survey.</p> <p>*Ninety-three days had been charted at 9:30 p.m. or after for a bedtime snack. The latest documentation had been at 21:59 (9:59 p.m.).</p> <p>*Seventy-four days were listed with no documentation.</p> <p>*Twenty-one days had been charted between 15:07 (3:07 p.m.) and 16:47 (4:47 p.m.) for residents 2, 23, and 24.</p> <p>Interview on 5/27/15 at 5:40 p.m. with the certified dietary manager revealed:</p> <p>*Dietary staff supplied the bedtime snack cart and delivered it to the nurses station. Nursing staff were responsible for offering the snacks.</p> <p>*She stated there was a large variety of snacks. There were also high protein snacks for those residents who had an order for a bedtime snack.</p> <p>*She was not aware the residents had stated they had not been offered a bedtime snack.</p> <p>*She stated she had thought the provider had received a citation for residents not offered bedtime snacks last year.</p> <p>Review of the recertification surveys conducted on 4/30/14 and on 7/17/13 revealed the same citation had been written for residents not offered a bedtime snack.</p> <p>Interview on 5/28/15 at 8:15 a.m. with the administrator revealed she was not aware residents were not offered a bedtime snack. She was also not aware the same citation had been written for the past two years.</p> <p>Review of the provider's 3/1/13 bedtime snack-residents policy revealed</p> <p>"4. The nurse or designee is responsible to offer the residents he/she delivers medications to a</p>	F 368			

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F 368	Continued From page 46 bedtime snack."	F 368	F387	
F 387 SS=D	<p>Surveyor: 28057</p> <p>Surveyor: 32573</p> <p>483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT</p> <p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 28057</p> <p>Surveyor: 23059 Based on record review, interview, and policy review, the provider failed to ensure the required physicians' recertification visits were completed for three of fourteen sampled residents (1, 7, and 8). Findings include:</p> <p>1. Review of resident 7's medical record revealed she had been admitted on 1/14/15. She had been seen by her physician on 2/3/15, 3/6/15, and 5/1/15. No record of a visit was found between</p>	F 387	<p>1. Residents #1, 7, and 8 are current on their physician visits. All residents will be audited to ensure they are current on their physician visits.</p> <p>2. DON or designee will educate nurses and (Health Unit Clerks) HUCs on physician visit schedules and making sure that residents are in compliance by July 17, 2015.</p> <p>3. DON or designee will audit 4 residents per week for physician visit compliance. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the DON for review and recommendations of continuation/discontinuation.</p> <p>4. July 17, 2015</p>	7/17/15

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F 387	<p>Continued From page 47 3/6/15 and 5/1/15.</p> <p>2. Review of resident 8's medical record revealed she had been admitted on 2/16/15. She had been seen by her physician on 2/20/15 and 4/22/15. No record of a visit was found between 2/20/15 and 4/22/15.</p> <p>Surveyor 28057</p> <p>3. Review of resident 1's medical record revealed the only physician's progress notes present in the record had been dated 9/3/14.</p> <p>Interview on 5/28/15 at 10:00 a.m. with the interim director of nursing confirmed she had requested physician's progress notes from the clinic for the past nine months. The notes received from the clinic had been dated 2/9/15 and 4/8/15. No other progress notes had been received from the clinic or offered to this surveyor. There had been no record of physician's visits found between 9/3/14 and 2/9/15. That time period had extended five months.</p> <p>Surveyor 23059</p> <p>4. Interview on 5/28/15 at 9:45 a.m. with the interim director of nursing (DON) confirmed physicians were to have seen residents every thirty days for the first ninety days of stay at the nursing facility. Interview with her on the same day at 4:45 p.m. confirmed she was unable to find documentation visits had occurred for the above residents as required.</p> <p>Review of the provider's undated Physician's Visits policy revealed the primary physician was to have seen residents every thirty days for the first ninety days, and every sixty days thereafter.</p>	F 387		

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F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 28057</p>	F 431	<p>F431</p> <p>1. All medications are properly stored and secured in a manner that prevents unauthorized persons from accessing them. <i>*Medications will no longer be stored in the DON's office. NS/SD004/JJ</i></p> <p>2. DON or designee will educate all nurses on proper medication storage and access by July 17, 2015.</p> <p>3. DON or designee will audit facility 4 times per week for proper storage of medications and that they are secured in a manner that prevents unauthorized persons from accessing them. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the DON for review and recommendations of continuation/discontinuation.</p> <p>4. July 17, 2015</p>	7/17/15

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F 431	<p>Continued From page 49</p> <p>Based on observation, interview, and policy review, the provider failed to ensure medications had been stored in a secured manner to prevent unauthorized persons from accessing those medications. Findings include:</p> <p>1. Observation during the survey from 5/27/15 through 5/28/15 revealed the assistant director of nursing' (DON) office door had been open. In that office had been a brown metal cabinet. Further observation on 5/28/15 at 11:25 a.m. revealed the cabinet had contained a large assortment of over-the-counter stock medications. Those medications had included acetaminophen, stool softeners, senna syrup (a laxative), muscle rub cream, vitamin C, prenatal vitamins, Milk of Magnesia, Pepto Bismol, cranberry extract, simethicone (used for upset stomach/gas), sennosides (a laxative), Vitamin D, and generic Mylanta (for upset stomach). The cabinet had not been locked during the observations.</p> <p>Interview on 5/28/15 at 3:20 p.m. with the maintenance supervisor confirmed he had a key to unlock the interim DON's office.</p> <p>Interview on 5/28/15 at 3:25 p.m. with the interim DON confirmed the medications listed above had not been secured. She agreed the maintenance supervisor and others should not have had access to those medications. She confirmed she did not have a key to lock that cabinet, and the door had been open.</p> <p>Review of the provider's revised 1/1/13 Storage and Expiration of Medications, Biologicals, Syringes and Needles policy revealed all medications were to have been secured and inaccessible from residents or visitors.</p>	F 431			

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F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>F441</p> <p>1. No immediate action could be taken for the bath disinfectant, resident #11, Resident #30, or the spilled meds. All residents are at risk.</p> <p>2. DON has reviewed the facility procedures in regards to infection control. DON or designee will educate all CNAs on proper disinfectant of the bath, all nurses and med aides about proper infection control with the glucometers and proper infection control procedures during medication administration by June 24, 2015.</p> <p>3. DON or designee will audit 4 resident baths per week for proper disinfection after the bath is complete, 4 samples of blood sugar testing for proper infection control procedures with the glucometer and 4 instances of med pass for proper infection control procedures. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the DON for review and recommendations of continuation/discontinuation.</p> <p>4. July 17, 2015</p>	7/17/15

to include following the manufacturer's instructions, NS/SODDH/JJ

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F 441	<p>Continued From page 51</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632</p> <p>Based on observation, interview, and policy review, the provider failed to ensure:</p> <ul style="list-style-type: none"> *Two of two whirlpool tubs were disinfected per manufacturer's recommendations and provider policy. *Disinfection of the blood glucose monitors had been done between residents use by two of two observed licensed practical nurses (LPN) (A and E) . *One of one observed registered nurse (RN) (B) had not used her bare hands to pick-up medications spilled on the top of the medication cart and administered those same medications to a randomly observed resident resident. <p>Findings include:</p> <p>1. Observation and interview on 5/28/15 at 11:20 a.m. with certified nursing assistant (CNA) F revealed:</p> <ul style="list-style-type: none"> *She was one of the bath aides on the day shift. *She usually gave baths in the Dunn/Watson bathing room. *She would have cleaned the whirlpool tubs in between residents' baths and disinfected them at the end of her shift. *The product she used for cleaning the whirlpool tub was Apollos Turbo Clean-Pre-Disinfectant Detergent. *The product she used for disinfecting the whirlpool tub was Apollos Cid-L-II. *She stated the product was dispensed by pushing either the cleaning or disinfecting dispenser buttons. *She was unsure of how much of each product was to have been used. 	F 441			

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F 441	<p>Continued From page 52</p> <p>Observation and interview on 5/28/15 at 11:40 a.m. with CNA G revealed she would have used the same products as CNA F and would have used the same method. She was one of the bath aides on the day shift and gave baths in the Miller/Garmen/Simpson bathing room.</p> <p>Both CNAs F and G revealed they had been instructed on how to clean and disinfect the whirlpool tubs. The video for cleaning the tubs had been shown to them, and the manual and instructions were in each of the bathing rooms.</p> <p>Review of the undated Apollo Whirlpool Cleaning and Disinfection instructions revealed tub, whirlpool intake jet nozzles, chairs, and restraints should have been cleaned and disinfected between each resident's bath.</p> <p>Interview on 5/28/15 at 3:30 p.m. with the administrator, interim director of nursing, and the director of clinical services agreed the proper disinfection of the whirlpool bathing tubs had not been followed.</p> <p>Surveyor: 28057</p> <p>2. a. Observation on 5/27/15 at 4:45 p.m. revealed LPN A took the shared glucometer case with the glucometer into resident 11's room. She placed the case on the resident's shared sink vanity without a barrier under the case. She checked the resident's blood sugar with the glucometer. She then placed the soiled glucometer in the case with the soiled test strip still attached to the glucometer. She put the case with the soiled items in the top drawer of the medication cart without cleaning the glucometer or the case.</p>	F 441		

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F 441	<p>Continued From page 53</p> <p>b. Observation and interview on 5/27/15 at 5:05 p.m. revealed LPN E took the shared glucometer into resident 30's room to check her blood glucose. She placed the glucometer on her bedside table without a barrier underneath it while she checked the resident's blood glucose with the glucometer. She then went back out to the medication cart and placed the glucometer on top of the cart without a barrier underneath it. She prepared the glucometer without cleaning it and entered resident 22's room. She placed the glucometer on the resident's bedside table without a barrier underneath it. She stated he had just gotten over an infection. After she had taken the glucometer out of the resident's room she had cleaned the glucometer with a disinfectant wipe. She had wiped the glucometer with the wipe for less than thirty seconds before she had placed the glucometer into the case, and then in the drawer of the medication cart.</p> <p>c. Review of the provider's revised January 2015 Blood Glucose Monitor Disinfection policy revealed: *Shared glucometers were to be cleaned between residents. *A barrier was to have been used between the glucometer and the bedside table. *A paper towel could be used as the barrier. *When cleaning the glucometer a Micro-Kill One wipe was to be used. *Contact time was to be for one minute.</p> <p>3. Observation and interview on 5/28/15 at 10:10 a.m. confirmed RN B: *Had placed six plus medication tablets into a medication cup in the top drawer of the medication cart. *Had picked up one or two tablets that had spilled</p>	F 441		

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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 54</p> <p>out of the tipped medication cup with her bare hands.</p> <p>*Had placed those one or two tablets back into the medication cup and administered those medications to the unidentified resident.</p> <p>*Agreed she had not worn a glove to pick up those medications, and they had been touching the surface of the medication cart drawer.</p> <p>*Agreed other items had been stored in that drawer.</p> <p>*Agreed the medications were possibly contaminated.</p> <p>Interview on 5/28/15 at 4:00 p.m. with the director of clinical services confirmed:</p> <p>*She would have expected unwrapped medications to be handled with gloves.</p> <p>*If gloves had not been worn then for RN B to have replaced the above medications with new ones.</p> <p>Review of the provider's revised July 2013 Medication Pass policy revealed it had not addressed the handling of unwrapped or dropped medications.</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER FOUNTAIN SPRINGS HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 WESLEYAN BLVD RAPID CITY, SD 57702	
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K 000	INITIAL COMMENTS <i>Addendums noted with an asterisk per 6/23/15 email from facility administrator. CKUL5000H1JJ</i> Surveyor: 20031 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 6/2/15. Fountain Springs Health Care was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K018, K021, K029, K047, K050, K062, K069, K144, and K147 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	K018 1. The north corridor door to the main dining room has been repaired. The door to the locker room has been repaired. All corridor doors have been assessed by maintenance to ensure they close appropriately. 2. Administrator or designee will educate all staff on ensuring corridor doors are in good repair and they close appropriately and that doors cannot be propped open by July 17, 2015. 3. Administrator or designee will audit 4 corridor doors to make sure they are in good repair and close appropriately. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the Administrator for review and recommendations of continuation/discontinuation. <i>* QAPI meets monthly. CKUL5000H1JJ</i> 4. July 17, 2015	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018		<i>* random CKUL5000H1JJ 7/17/15</i>

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

TITLE

(X6) DATE

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

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation, testing, and interview, the provider failed to maintain the twenty minute fire resistive rating for two random doors (main dining room and locker room). One was wedged in the open position, and the other had no bolt mechanism for the door knob. Findings include: 1. Observation at 1:55 p.m. revealed the north corridor door to the main dining room was open. Testing the closure of that door revealed it was extremely hard to pull or push. Closer observation by the maintenance supervisor (MS) at the time of the testing revealed the door had created a groove in the laminate flooring and was stuck in that position. Interview at the time of the observation and testing with the MS revealed he had not realized that door had wedged itself into the laminate. 2. Observation, testing, and interview with the MS at 2:20 p.m. revealed the corridor door to the employee locker room would not latch into the door frame. Closer observation at that time revealed the door knob had no bolt mechanism to latch into the striker plate. The MS revealed he was aware the bolt had been removed from that door knob. He stated the employees had not been able to open the door a couple weeks earlier, and he had removed the bolt from the door knob. He was unaware the bolt mechanism must be in place to hold the door in place to meet the smoke rating of corridor doors.	K 018			
K 021	NFPA 101 LIFE SAFETY CODE STANDARD	K 021			

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K 021 SS=D	<p>Continued From page 2</p> <p>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation, testing, and interview, the provider failed to maintain the ninety minute fire resistive rating for two of six (basement and Garmen wing) door assemblies. One set of cross-corridor doors in the basement had a quarter inch gap between the door leaves. The south door of another set of of ninety minute rated cross-corridor doors in the Garmen wing would not latch into the frame. Findings include:</p> <p>1. Observation and testing at 12:45 p.m. revealed a cross-corridor ninety minute rated door assembly in the basement. Those doors had a quarter inch gap between them when closed. Interview with the maintenance supervisor (MS)</p>	K 021	<p>K021</p> <p>1. The doors in the basement have an astragal plate installed. The South door on Garmen was repaired and will latch. All fire rated doors were assessed by maintenance and close appropriately.</p> <p>2. Administrator or designee will educate all maintenance staff on maintaining fire rated doors in good repair and ensuring they close appropriately by July 17, 2015.</p> <p>3. Administrator or designee will audit 4 fire rated doors to make sure they are in good repair and close/latch appropriately. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the Administrator for review and recommendations of continuation/discontinuation.</p> <p>4. July 17, 2015</p>	<p>* random CKV/500H/15 7/17/15</p>

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K 021	Continued From page 3 at the time of observation confirmed that finding. He stated he was not aware those doors should have had an astragal plate to cover the gap between the doors.	K 021	K029 1. The fire rated door in the laundry room is not being propped open. The fire rated doors to the soiled linen room and the records room on Simpson wing both close appropriately.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation, testing, and interview, the provider failed to maintain proper separation of three randomly observed hazardous areas. The ninety minute rated self-closing west door of the laundry room was held in the open position with a soiled linen barrel. The one hour rated	K 029	2. Administrator or designee will educate all maintenance staff on maintaining one hour rated doors in good repair and ensure they close appropriately by July 17, 2015. 3. Administrator or designee will audit 4A one hour rated doors to make sure they are in good repair and close appropriately and are not propped open. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the Administrator for review and recommendations of continuation/discontinuation. *QAPI meets monthly. CKV/SACOH/JS 4. July 17, 2015	* random CKV/SACOH/JS 7/17/15

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K 029	Continued From page 4 self-closing doors to the soiled linen and record room in the Simpson wing would not latch into the frame. Findings include: 1. Observation at 12:50 p.m. revealed the ninety minute rated self-closing west door of the laundry room was held open with a soiled linen barrel. Interview with the administrator at the time of the observation confirmed that finding. She was aware the laundry room doors could not be propped open. 2. Observation and testing at 1:25 p.m. revealed the one hour rated self-closing doors to the soiled linen room and record room in the Garmen wing would not close and latch into the frame. Interview with the maintenance supervisor at the time of the observation and testing confirmed those findings. He revealed he was not aware those doors were not working correctly.	K 029	K047 1. The exit sign in the basement has been replaced. 2. Administrator or designee will educate all maintenance staff on maintaining exit signs appropriately by July 17, 2015. 3. Administrator or designee will audit 4 ^{*random} exit signs to ensure they are maintained _{ckvls000H/JJ} appropriately and have continuous illumination. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the Administrator for review and recommendations of continuation/discontinuation. ^{* QAPI} _{meets monthly. ckvls000H/JJ} 4. July 17, 2015	7/17/15
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation and interview, the provider failed to provide one of two exit signs in the basement boiler room with continuous illumination. Both lamps were burned out of the southeast exit sign in the basement. Findings include:	K 047		

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K 047	Continued From page 5	K 047		
K 050 SS=C	<p>1. Observation at 2:10 p.m. revealed both lamps were burned out of the southeast exit sign in the basement boiler room. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated he was not aware that exit sign was not illuminated.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Surveyor: 20031 Based on record review and interview, the provider failed to ensure the fire alarm was sounded for the evening shift for the past twelve fire drills (April 2014 through May 2015). The activation of the fire alarm was noted as "simulated." Findings include:</p> <p>1. Fire drill record review from April 2014 through May 2015 revealed the activation of the fire alarm was noted as "simulated" for the second shift from 2:00 p.m. to 10:00 p.m. In addition the night drill from 10:00 p.m. to 6:00 a.m. was also noted as "simulated." Interview with the administrator and maintenance supervisor (MS) at the time of</p>	K 050	<p>K050</p> <p>1. No immediate action could be taken for the past fire drills. Maintenance Director is performing all 2nd shift fire drills by activating the alarm and not using simulation.</p> <p>2. Administrator or designee will educate all maintenance staff on properly performing fire drills by July 17, 2015.</p> <p>3. Administrator or designee will audit all fire drills per month to ensure they are performed correctly, including activation of the alarm on evening shift. This audit will be done monthly for three months. Audit will be brought to QAPI by the Administrator for review and recommendations of continuation/discontinuation. <i>* QAPI meets monthly. CWO/5000H/JS</i></p> <p>4. July 17, 2015</p>	7/17/15

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K 050	Continued From page 6 the record review confirmed that finding. The administrator revealed she was aware only the night time alarm could be simulated for the fire drill for the comfort of the residents. The MS revealed he was not aware only the night time drill could be simulated, and all other fire drills must have the alarm activated.	K 050	K147	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 20031 A. Based on record review, observation, testing, and interview, the provider failed to ensure the automatic sprinkler system was inspected and tested quarterly. Findings include: 1. Review of the provider's automatic sprinkler system inspection reports revealed quarterly flow testing documentation was not available. Interview with the maintenance supervisor (MS) at the time of the record review indicated he was aware of the quarterly flow testing requirements. He had started as the MS about a month ago and would start the flow test on a quarterly basis. Review of the previous survey conducted 4/29/14 revealed that item had been noted. B. Based on observation, measurement, and interview, the provider failed to maintain	K 062	1. The facility has fixed the electrical area noted. The facility is no longer using extension cords and power strips in this area. 2. Administrator or designee will educate all staff on approved use of extension cords and power strips by July 17, 2015. 3. Administrator or designee will audit 4 facility areas for extension cords and power strips. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the Administrator for review and recommendations of continuation/discontinuation. <i>QAPI meets monthly. CKU/5000 HJJ</i> 4. July 17, 2015	7/17/15

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K 069	Continued From page 8 system invoice dated 8/28/14 and 2/27/15 revealed the only information provided was the recharge of the system and extinguishers in the kitchen. An inspection report was not available which indicated what items were inspected or that it was inspected to meet the requirements of NFPA 96. Review of the previous survey conducted 4/29/14 revealed that item had been noted at that time. Interview with the maintenance supervisor (MS) at the time of the record review confirmed that finding. He revealed he had become the MS about a month ago and would need to review the current contractors. An inspection and service of the kitchen hood fire-extinguishment system by properly trained and qualified persons must include (NFPA 96[98], Sec. 8-2): *A check of all activation components, including remote manual pull stations, mechanical or electrical devices, detectors, actuators, and fire-actuated dampers to ensure they were in operable condition (NFPA 96[98], Sec. 8-2.1). *A visual inspection of fire alarm interconnect switches (NFPA 72[99], Table 7-3.1). Fusible links and automatic sprinkler heads are required to be replaced at least annually (NFPA 96[98], Sec. 8-2.2).	K 069	K069 1. The facility has had a range hood inspection completed with an appropriate inspection report completed. 2. Administrator or designee will educate all maintenance staff on proper range hood inspections and documentation by July 17, 2015. 3. Administrator or designee will audit the range hood inspections _____ to ensure that the facility has a proper inspection and proper documentation. This audit will be done _____ by the Administrator for review and recommendations of continuation/discontinuation. _____ meets monthly, _____ 4. July 17, 2015	7/17/15 * Semi-annually CKU/SDOH/JJ
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	<i>yearly for two years. CKU/SDOH/JJ</i> ←	* GAAP

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K 144	Continued From page 9 This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation and interview, the provider could not ensure at least one of the weekly generator run times for the past year from May 2014 through May 2015 had been conducted under load. Findings include: 1. Record review revealed weekly documentation from May 2014 through May 2015 of generator hour meter start and stop times. Interview with the maintenance supervisor (MS) revealed he could not provide clarification to ensure one of the weekly times for each month had been under load for at least thirty minutes. Further interview with the MS revealed the generator started on its own at 1:00 a.m. each Monday. He could not provide further information those run times at night were under load.	K 144	K062 1. The facility has performed a quarterly flow test. Facility has removed the curtain from the shelves in the laundry room and have moved the top shelves so that the sprinklers are not obstructed. 2. Administrator or designee will educate all maintenance staff about quarterly flow test and ensuring that sprinklers are not obstructed by July 17, 2015. 3. Administrator or designee will audit the flow test to to ensure the facility is current and will audit 4 sprinkler areas to ensure that the sprinklers are not obstructed. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the Administrator for review and recommendations of continuation/discontinuation. 4. July 17, 2015	7/17/15
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation and interview, the provider failed to install permanent wiring for the bio-hazard desk in the basement. A power strip and extension cord were used to supply electrical	<i>quarterly for one year</i> CKU/500H/JJ K 147	<i>←</i> * QAPI meets monthly, CKU/500H/JJ	

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K 147	Continued From page 10 power for items on the desk. ([NFPA 70] Article 527 Temporary Installations.) Findings include: 1. Observation at 2:15 p.m. revealed an overhead light fixture plugged into a power strip. The power strip was hanging from the light cord. Additional items for the desk were then plugged into the power strip hanging in the air. The power strip was then plugged into an extension cord that was then plugged into the electrical outlet. Interview with the MS at the time of observation confirmed those conditions. He said the desk was only used once a week. He was not aware the extension cord and power strip could not be used for that type of purpose.	K 147		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10723	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/02/2015
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S 000	Initial Comments Surveyor: 23059 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 5/27/15 through 5/28/15 and on 6/2/15. Fountain Springs Health Care was found not in compliance for the following requirements: S165, S322, S323, and S355.	S 000		
S 165	44:04:02:17 OCCUPANT PROTECTION Each licensed health care facility covered by this article must be constructed, arranged, equipped, maintained, and operated to avoid injury or danger to the occupants. The extent and complexity of occupant protection precautions is determined by the services offered and the physical needs of the... residents admitted to the facility. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 26632 Surveyor: 20031 A. Based on observation and interview, the provider failed to maintain one of two yards for the residents that wanted to and were able to get outside. The front yard had very tall grass, noxious weeds, an old wooden wagon, and an old chicken coop with chicken wire. Findings include: 1. Observation at 7:50 a.m. on 5/27/15 revealed: *The front yard grass had not been mowed. The grass was approximately twelve to eighteen inches tall.	S 165	S165 1. The facility has mowed, trimmed and pulled the weeds in the lawn. The facility has removed all of the rusty and hazardous items in the lawn. The facility has purchased a chair scale to be used when the bath scales are not operable. 2. Administrator or designee will educate all maintenance staff regarding maintaining the lawn appropriately, removing all hazards from the lawn, and maintaining the bath scales so they are operable by July 17, 2015. 3. Administrator or designee will audit the lawn weekly to ensure that it is maintained and that there is no hazardous items in the yard. Administrator or designee will audit the bath scales weekly to ensure they work or that the staff are using a back-up. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the Administrator for review and recommendations of continuation/discontinuation. 4. July 17, 2015	7/17/15

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

TITLE

(X6) DATE

STATE FORM

6899

S8LZ11

Administrator 6/18/15

<p>REC-11</p> <p>JUN 22 2015</p> <p>SD DOH L&C</p>
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If continuation sheet 1 of 8

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10723	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
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NAME OF PROVIDER OR SUPPLIER FOUNTAIN SPRINGS HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 WESLEYAN BLVD RAPID CITY, SD 57702
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S 165	<p>Continued From page 1</p> <p>*Noxious weeds such as milk weed and Canada Thistle had grown near the building and along the sidewalk. Canada Thistle had serrated leaves with barbs that could injure bare skin. *The old wooden wagon had deteriorated and had no paint in some areas. The raw old wood created a splinter hazard to bare skin. *The old chicken coop had no chickens and was surrounded by chicken wire which was sharp to the touch for bare skin. *The back yard appeared to have been mowed once, but it had not been trimmed.</p> <p>Review of the following resident council meeting minutes revealed: *4/28/15: -Would like to have more outdoor time once the weather was nicer. --No response back for the above concern. *5/26/15: -Try to do more outdoor things. --No response back for the above concern.</p> <p>At the resident group meeting at 2:00 p.m. on 5/27/15 with residents 13, 21, 23, 24, and 25 revealed: *They would like to go outside just to take a walk or sit out front. *There had been days when it would have been nice just to be outside. But it appeared the outside was not ready yet as the grass had not been mowed and there were weeds.</p> <p>Interview at 6:15 p.m. on 5/28/15 with the administrator revealed she agreed the front lawn needed to be mowed, trimmed, and weeded. She stated she had talked about the yard work with the new maintenance person when he started about three weeks ago. He stated at that time he would be able to handle the outside work in</p>	S 165		

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S 165	<p>Continued From page 2</p> <p>addition to the maintenance inside the building. She stated it was time to hire a lawn service.</p> <p>B. Based on record review and interview, the provider failed to maintain two of two new scales used to take weekly weights of all residents, and failed to provide a substitute for the scales when they were out of service. Findings include:</p> <p>1. Review of the March, April, and May 2015 bath records for all residents revealed: *The scale for the Watson/Dunn bathing room was noted as "broken" or "not working" on 3/8/15, 3/9/15, and 5/4/15. *The scale for the Simpson/Garmen/Miller bathing room scale was noted as "broken", "not working", or "battery problem" on 3/6, 3/9, 3/17, 3/24, 4/9, 4/10, 4/16, 4/31, 5/5, 5/7, 5/8, 5/16, 5/18, 5/22, 5/25, and 5/26 of 2015.</p> <p>Interview at 7:45 a.m. on 5/28/15 with the certified dietary manager revealed she was not aware the scales were out of service for those above listed days. She stated she was the one responsible to input the weight in the resident's electronic medical record. She stated she relied on those weights to know whether the resident had lost or gained weight. She also revealed she was not aware if the scale was not working the bath aides or certified nurse assistants would leave the weight blank or use the same weight from the previous week.</p> <p>Surveyor: 26632</p> <p>Interview on 5/28/15 at 10:00 a.m. with the maintenance supervisor revealed he was aware the scale for the Simpson/Garmen/Miller bathing room was broken. He had replaced the batteries several times. He had contacted the</p>	S 165		

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S 165	Continued From page 3 manufacturer and was waiting on replacement parts. He thought the scale had been out of commission on and off for three months. Interview on 5/28/15 at 2:05 p.m. with certified nursing assistant's F and H revealed they were aware the scale for the Simpson/Garmen/Miller bathing room was broken. They stated no weights for residents who had received baths in that bathing room had been completed. They had not used the other bathing room scale.	S 165	S322 1. No immediate action could be taken for Resident #16. 2. DON or designee will educate all nurses on obtaining an order to release medications upon discharge if the facility will be sending medications with resident by July 17, 2015.	
S 322	44:04:08:04.01 CONTROL AND ACCOUNTABILITY OF MEDICATIONS Written authorization by the attending physician must be secured for the release of any medication to a...resident upon discharge or transfer. The release of medication must be documented in the...resident's record, indicating quantity, drug name, and strength. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 23059 Based on record review and interview, the provider failed to ensure physician's orders had been obtained for the release of medications upon discharge for one of two sampled residents (16) who had been discharged to another facility. Findings include: 1. Review of resident 16's closed record revealed: *She had been admitted on 10/7/13.	S 322	3. DON or designee will audit all discharges per week to ensure that appropriate order is obtained for medications at time of discharge. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI for review by the DON and recommendations of continuation/discontinuation. 4. July 17, 2015	7/17/15

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S 322	Continued From page 4 *She had been discharged to another nursing facility on 3/14/15. *No physician's order was found to discharge the resident and release her medications. Interview on 5/29/13 at 12:30 p.m. with the interim director of nursing revealed no order could be found for the discharge and release of medications for resident 16.	S 322	S323 1. No immediate action could be taken for Residents #15 and 16.	
S 323	44:04:08:04.02 DOCUMENTATION OF DRUG DISPOSAL If a...nursing facility has a licensed pharmacy, outdated or discontinued medications must be returned to the pharmacy for disposition. In the absence of a licensed pharmacy, the method of disposition of outdated or discontinued medications must be handled and recorded in the resident's medical record as follows: (1) Legend drugs not controlled under SDCL 34-20B must be destroyed by a professional nurse and another witness; (2) Medications controlled under SDCL 34-20B must be destroyed in the facility by a pharmacist and a registered nurse; and (3) Medications, excluding controlled substances listed in SDCL chapter 34-20B, in unit dose packaging which meets packaging standards in chapter 20:51:13:02.01 may be returned to the pharmacy pursuant to chapter 20:51:13:02.01. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 23059 Based on record review, interview, and policy review, the provider failed to ensure drug disposal (medications destroyed) was documented for two	S 323	2. DON or designee will educate all nurses on disposition of medications upon a residents discharge by July 17, 2015. 3. DON or designee will audit all discharges for proper documentation of disposal of medications. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the DON for review and recommendations of continuation/discontinuation. 4. July 17, 2015	7/17/15

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S 323	<p>Continued From page 5</p> <p>of three sampled residents (15 and 16) closed records. Findings include:</p> <ol style="list-style-type: none"> 1. Review of resident 15's closed record revealed she had been admitted on 12/17/09. She had passed away on 4/29/15. Most of her medications had been discontinued prior to her death. She had been on morphine sulfate (a controlled medication for pain) twenty milligrams (mg)/milliliter (ml), five to ten mg every hour as needed for pain. That medication had been ordered on 4/22/15. No documentation was found regarding the disposal or what happened with that medication upon the resident's death. 2. Review of resident 16's closed record revealed she had been admitted on 10/17/13. She had been discharged to another nursing facility on 3/4/15. No documentation of what happened to her medications could be found in her record. 3. Interview on 5/28/15 at 12:35 p.m. with the interim director of nursing revealed she confirmed the documentation of drug disposal was not found for either of the above two records. She contacted the pharmacy, and they provided her with a list of medications that had been returned to the pharmacy. There was no date on those lists when the medications had been returned. The morphine sulfate for resident 15 was not found on that list. She confirmed the documentation of the disposal of that medication should have been kept. <p>Review of the provider's 1/1/13 Disposal/Destruction of Expired or Discontinued Medications policy revealed: *Non-controlled medications should have been destroyed by a registered nurse and witnessed by another staff member.</p>	S 323		
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S 323	Continued From page 6 *The following information should have been documented on the drug destruction form if medications were destroyed: -Resident's name. -Name and strength of medication. -Prescription number. -Amount of medication destroyed. -Date of destruction. -Signature of witnesses. -Method of disposition. *The destruction of controlled substances should have been recorded on the: -Medication Disposition/Destruction form; -Controlled Substance Count form or the Medication Destruction log book.	S 323	S355 1. Social Services Designee had her quarterly Social Worker Consultation completed. 2. Administrator or designee will educate Social Services Designee on ensuring she has her quarterly consultations completed by July 17, 2015.	7/17/15
S 355	44:04:12:05 PROVISION OF SOCIAL SERVICES A nursing facility must provide or make arrangements to provide social services for each resident as needed. A staff social worker or social service designee must be designated as responsible to facilitate the provision of social services. If the staff member is not a social worker, the facility must have a written agreement with a social worker for consultation and assistance to be provided on a regularly scheduled basis but at least quarterly. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 26632 Based on interview and review of the consultant social workers (SW) notes, the provider failed to	S 355	3. Administrator or designee will audit Social Services Designee monthly to ensure that quarterly consultation is completed appropriately. This audit will be done monthly for 6 months. Audit will be brought to QAPI by the Administrator for review and recommendations of continuation/discontinuation. 4. July 17, 2015	

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S 355	<p>Continued From page 7</p> <p>ensure the SW consultant provided consultation and assistance to the social service designee (SSD) at least quarterly. Findings include:</p> <p>1. Review of the SW consultation notes revealed the last consultation she had provided was on 8/25/14.</p> <p>Interview on 5/28/15 at 11:30 a.m. with the SSD confirmed the last time the SW consultant had been to the facility was 8/25/14. She was aware of the quarterly requirement for the SW consultant. She had tried several times to call the SW consultant but had gotten no answer. She had not informed the administrator the SW consultant had not done any consultations as required.</p>	S 355		