

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

ORIGINAL

PRINTED: 07/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - BLACK HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 1620 NORTH 7TH STREET RAPID CITY, SD 57701	
(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	<p><i>Addendums noted with an asterisk per 7/30/15 telephone to facility administrator and Down, KG/SDOAH/JJ</i></p> <p>Surveyor: 28057 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/29/15 through 7/2/15. Golden LivingCenter - Black Hills was found not in compliance with the following requirements: F157, F164, F166, F176, F221, F222, F226, F248, F250, F278, F279, F280, F281, F314, F319, F325, F329, F353, F431, F441, and F514.</p>	F 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or</p>	F 157	<p>F 157D Notify of changes</p> <p>Resident # 2 physician has reviewed current insulin orders, glucose readings and weight loss. <i>*The physician verified the insulin was to be held if the blood glucose was at or below 60 and then be notified for further direction. KG/SDOAH/JJ</i></p> <p>Residents residing in the facility who have a change in condition have the potential to be affected in a similar manner. <i>* 7/31/15 KG/SDOAH/JJ</i></p> <p>Licensed nursing staff have been re-educated on the Golden Living Policy 'Notification of Change in Resident Health Status'</p> <p><i>*All residents will be reviewed within 30 days to ensure any change in condition was reported to the physician. KG/SDOAH/JJ</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Matthew Parson* TITLE *Administrator* (X6) DATE *8/5/15*

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

DEFICIENT
AUG 7 2015
Event ID: QRZK11 Facility ID: 0107
SD DOH L&C

COMPLIANT
JUL 27 2015
If continuation sheet Page 1 of 130
SD DOH L&C

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F 157	<p>Continued From page 1</p> <p>regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure the physician had been notified for one of one sampled resident (2) who had a change of condition. Findings include:</p> <p>1. Review of resident 2's diagnoses included: *Diabetes (abnormal blood sugar control) without complications, Type II. *Depressive disorder. *Congestive heart failure (fluid build up due to poor heart function). *Hypertension (high blood pressure).</p> <p>a. Review of resident 2's weight record revealed: *On 3/5/15 he weighed 157.5 pounds (lb). *On 4/2/15 he weighed 140.5 lb. -That was a 17 lb or 10.7% weight loss in one month.</p> <p>b. Review of resident 2's nurses progress notes revealed: *On 4/20/15 - "BS [blood sugar] low 149 before dinner and held insulin Novolog [medication to control BS for diabetics] until after supper." -There was no documentation the physician had been notified the insulin had been held. *6/12/15 - "Resident BL [blood sugar level]</p>	F 157	<p>Director of Nursing or designee will complete 5 random audits weekly x 4 weeks then monthly x 2 months to ensure physician and responsible party notification has been completed when a resident experienced a condition change. Results will be reviewed at monthly QAPI meetings for further recommendations.</p> <p><i>and report to QAPI. K.G./SDPH/JJ</i></p>	
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F 157	<p>Continued From page 2</p> <p>running low. 125 after hs [hour of sleep] snack. I am holding Lantus [insulin medication to control BS for diabetics] this evening." -There was no documentation the physician had been notified the insulin had been held.</p> <p>Review of resident 2's physician's orders and medication administration record (MAR) revealed: *For the Lantus insulin - "Call MD [medical doctor] if blood sugar is greater than 500." *For the NovoLog insulin - "Call MD if blood sugar is greater than 500." *There were no orders to hold the insulin when the blood sugar level was low.</p> <p>Review of resident 2's nurses progress notes from 3/5/15 through 5/1/15 revealed there had been no documentation the physician had been notified of resident 2's weight loss.</p> <p>c. Interview on 6/30/15 at 11:10 a.m. with the director of nurses regarding resident 2 revealed: *She agreed the MD should have been notified about the resident's significant weight loss. -There was no documentation to support the MD had been notified. *She thought the insulin should have been given if his BS was above 100. -She could not speak for the nurses that had made the decision to hold the insulin without notifying the MD. -Sometimes it was a nurses judgment and that might have been what they had done.</p> <p>Review of the provider's May 2012 Medication Administration - Preparation and General Guidelines policy revealed: **"If a dose seems excessive considering the resident's age and condition, or a medication</p>	F 157		

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F 157	Continued From page 3 order seems to be unrelated to the resident's current diagnoses or condition, the nurse calls the provider pharmacy for clarification prior to the administration of the medication or if necessary contacts the prescriber for clarification." **"If a dose of regularly scheduled medication is withheld, refused, not available or given at a time other than the scheduled time the space provided on the front of the MAR for that dosage administration is initialed and circled. -If two consecutive doses of a vital medication are withheld, refused or not available the physician is notified." Review of the provider's 1/26/15 Weight and Height Measurement policy revealed "Notify the charge nurse or physician of all weight changes of five pounds (5%) or more in a 30-day period or ten percent in a 180-day period per state requirement." Review of the provider's 11/12/14 Notification of Change in Resident Health Status policy revealed "The center will consult the resident's physician, nurse practitioner or physician assistant, and if known notify the resident's legal representative or an interested family when there is: Acute illness or a significant change in the resident's physical, mental, or psychosocial status."	F 157			
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone	F 164	F 164 Personal Privacy/Confidentiality of Records Unable to correct past Personal Privacy/Confidentiality of Records concerns		

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F 164	<p>Continued From page 4</p> <p>communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, resident's bill of rights pamphlet review, and policy review, the provider failed to: *Maintain residents' personal information in a private and secured manner by two of four observed nurses (A and B) during medication administration. *Ensure privacy was maintained for one of two observed residents (4) during a dressing change done by two nurses (B and D). Findings include:</p> <p>1. Observation on 6/30/15 at 11:15 a.m. with</p>	F 164	<p>Nurse's A and B have been reeducated on maintaining Confidentiality of Records *7/31/15 KG/5000H/JJ</p> <p>Nurse's B and D have been reeducated on maintaining privacy of residents during dressing changes.</p> <p>Residents residing in the facility have the potential to be affected in a similar manner</p> <p>*A Staff members have been re-educated on the contents of the Resident's Bill of Rights handbook at a mandatory all staff meeting held on 7/14/15. KG/5000H/JJ</p> <p>Director of Nursing or designee will complete random audits weekly x 4 weeks then monthly x 2 months to ensure resident's privacy is maintained. Results will be reviewed at QAPI monthly meetings for further recommendations.</p> <p>and report to QAPI monthly. KG/5000H/JJ</p> <p>for privacy during dressing changes and resident cares that include resident 4 KG/5000H/JJ</p> <p>* by the multi-sight Clinical Coordinator KG/5000H/JJ</p>	

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F 164	<p>Continued From page 5</p> <p>licensed practical nurse (LPN) B revealed: *She had:</p> <ul style="list-style-type: none"> -Been at the medication cart for the north hallway that was located by resident 18's room. On top of the medication cart had been a computer that contained all of the residents' personal and medical history. -Used that computer to retrieve medication information for resident 18. -Prepared insulin (medication to control blood sugar levels) for administration to resident 18. -Left the medication cart in the hallway unattended and entered resident 18's room. She assisted him with the administration of his insulin. <p>*While she was in resident 18's room she had left the computer screen in the up and open position that revealed:</p> <ul style="list-style-type: none"> -The medication she had administered to him at that time. -Access to his medical history by other residents and visitors that would have been by it. <p>Interview on 6/30/15 at the time of the above observation with LPN B confirmed:</p> <ul style="list-style-type: none"> *She should have locked the computer screen prior to entering resident 18's room. *Leaving the screen unlocked had allowed access for other residents and visitors to view his medical history. *Privacy and confidentiality had not been maintained for resident 18. <p>Observation on 6/30/15 at 11:25 a.m. of registered nurse (RN) A revealed:</p> <ul style="list-style-type: none"> *She had been at the medication cart for the south hallway that was located across from resident 3's room. *On top of the medication cart had been a computer that contained all of the residents' 	F 164		
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F 164	<p>Continued From page 6</p> <p>medical history including medications. She had used that information to assist her with administering medications to the residents.</p> <p>*On the computer she had pulled up medication information on resident 3. From that information she prepared his medications for administration.</p> <p>*She left the medication cart in the hallway unattended, went across the hall, and entered resident 3's room. She had assisted him with those medications.</p> <p>*While she had been in resident 3's room she had left the computer screen in the up and open position that revealed:</p> <p>-All of the medications she had administered to him at that time.</p> <p>-Access to his medical history by other residents and visitors.</p> <p>Interview on 6/30/15 at the time of the above observation with RN A revealed:</p> <p>*She was not aware she had not locked the computer screen prior to entering resident 3's room.</p> <p>*Confirmed privacy and confidentiality had not been maintained for resident 3.</p> <p>Interview on 7/1/15 at 11:15 a.m. with the director of nursing (DON) confirmed the computer screens should have been locked when unattended to ensure privacy and confidentiality were maintained for all of the residents.</p> <p>2. Observation on 7/3/15 at 10:25 a.m. of LPNs B and D with resident 4 revealed:</p> <p>*They had prepared to do two dressing changes for the resident in her room.</p> <p>*Resident 4 had:</p> <p>-Shared a room with another resident. There was a privacy curtain between the two beds.</p>	F 164		

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F 164	Continued From page 7 -Been laying on her bed that was located by a large picture window. The window curtains were open and revealed the back of the building and other parts of the facility. *During the dressing changes to her left foot and right calf both of the LPNs had not closed: -The divider curtain between the two resident's beds to ensure privacy should the room door be opened. -The window curtains. *During the dressing changes an unidentified staff member had entered the room to visit with LPN B. That unidentified staff member had closed the divider curtain. Interview on 7/3/15 at 11:20 a.m. with the DON confirmed the LPNs should have closed the divider curtain and window curtain to ensure privacy for resident 4. 3. Review of the provider's undated Admission Packet revealed a Resident Bill of Rights pamphlet stating: "You have the right to privacy and confidentiality in a long-term care facility." Review of the provider's 6/3/14 Confidential Information policy revealed: *"All employees will maintain the confidentiality of employees, resident, facility, and company information in accord with this policy." *"Description of confidential information: -Resident data, such as diagnosis, treatment condition, progression or regression. -Facility data, such as residents' or employees' names, addresses, telephone numbers, finances, policies, or specific operational issues."	F 164		
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES	F 166		

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F 166	Continued From page 8 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: 26180 Based on observation, record review, interview, and policy review, the provider failed to ensure call light concerns had been resolved for one of one resident group (resident council) and three of four confidential resident interviews. Findings include: 1. Interview of residents on 6/30/15 at 10:00 a.m. during the resident council meeting revealed: *The residents had complained many times about call lights not having been answered in a timely manner. *It was not uncommon for staff to come into their room and shut off their call light. -They would be told the staff would be right back, and they did not come back. -They forgot. *They did not want staff to shut the call light off and leave without helping them. *Sometimes they needed to get another person to help them, if the resident required two people to assist them. -They did not always come back. *At one time they had been told they would schedule more evening activities, so they did not get back to their room after their meals all at the same time and want help. -There was not a lot of evening activities. *They had not felt the resident council was getting	F 166	F 166E Right to prompt efforts by the facility to resolve grievances The facility is unable to correct past call light concerns. Residents residing in the facility have the potential to be affected in a similar manner. Staff members have been re-educated on ensuring call lights are answered promptly. Residents have been re-educated by the social worker by room to room interviews and during resident council meetings related to call light concerns and facility plan to resolve this concern. Resident council meetings will be held twice monthly for three months, *to address call light concerns. Executive Director or designee will complete 5 random resident interview audits of reported call light concerns weekly x 4 weeks then monthly x 2 months to ensure resident's call light concerns have come to resolution. *and report to QAPI monthly. Results will be reviewed at monthly QAPI meetings for further recommendations.	* 7/31/15 KG/5000H/JJ

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F 166	<p>Continued From page 9 the call light issue resolved.</p> <p>Observation of room 5 on 6/30/15 at 8:30 a.m. revealed: *The call light was on for twelve minutes. *Certified nursing assistant (CNA)/medication aide C was outside the room passing medications. -The medication cart was parked outside room 5. -She did not answer the call light.</p> <p>Observation of room 33 on 6/30/15 at 8:30 a.m. revealed: *The call light was on. *Registered nurse (RN) A walked down the hall and obtained her medication cart that was parked outside room 33. *RNA did not enter the room or check on the resident in room 33.</p> <p>Confidential interviews with three residents revealed: *They had to wait many times over one half hour for their call light to be answered. *They did not feel they had enough staff to help everyone. *Their call lights might be answered, but the staff person would not help them saying they would be right back. -They did not come back. *It had not done any good to complain about call lights.</p> <p>Review of Resident Council minutes revealed: *New Business or concern: -January 2015 - "Need more CNAs [certified nursing assistants] call lights need to be answered in a timely manner. Did explain about 'high' call light times (before breakfast, after</p>	F 166	<p>*DON or designee will complete 5 random call light observations X4 weeks then monthly X 2 months until the call light concerns are resolved. The DON will report the results to QAPI monthly. KG/S2004/JJS</p>	

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F 166	<p>Continued From page 10</p> <p>lunch, after supper). We need to implement engaging activities after meals."</p> <p>*February 2015 - "Call lights not answered in a timely manner." Residents very hostile [highly upset and agitated] about food missing and about call lights not being answered in a timely manner (after meals). Activity Director [AD] did state changes in activities, there would be an activity conducted in MDR [main dining room] after supper."</p> <p>*March 2015 - "Call lights not answered in a timely manner (twenty minutes wait). Did talk to residents about call lights not being answered in a timely manner. Residents stated they are sick of CNAs walking in, turning off the call light and stating they will be back in a minute. Stated that if they have the time to walk in, then they have the time to see what they want."</p> <p>*April 2015 - "Call lights. Three residents said the concern had not been resolved to their satisfaction. Director of nursing informed residents they were doing audits of call lights."</p> <p>*June 2015 - "Call lights not answered in a timely manner. Eight of twenty-one residents had this concern."</p> <p>Interview on 7/1/15 at 5:00 p.m. with the activity director revealed:</p> <p>*She was responsible for the resident council meetings.</p> <p>*The complaints about the call lights was an ongoing issue.</p> <p>*They had planned to have activities five nights a week to prevent residents from returning to their room and immediately turning their call lights on. -Their hours had been cut, so now she was unable to have evening activities more than three times per week.</p>	F 166		
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F 166	Continued From page 11 Interview on 6/30/15 at 11:45 a.m. with the executive director revealed: *They were aware how quickly call lights were answered was a frequent concern with residents. *They had done audits on the amount of time it took to answer call lights. *His expectation was that call lights: -Would have been answered by any staff member who walked by the room with the light on. -Should have been answered within five minutes. Review of the provider's 1/26/15 call light policy revealed "Answer ALL call lights promptly whether or not you are assigned to the resident." Review of the provider's 2009 Resident Council Process revealed "The Resident Council is an important part of the QA [Quality Assurance] process. It gives the residents the opportunity to address concerns, and the Living Center the opportunity to fix these concerns. In order for this system to work, once concerns are identified by the Council, they need to be addressed by the appropriate department and then brought back to the Council for the members to decide if the problem has been resolved.	F 166		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Surveyor: 32355	F 176	F176 Self Administration of Medications Resident # 16 Self Administration of Medication Evaluation form unable to be completed as resident has been discharged from the facility.	

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F 176	<p>Continued From page 12</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure one of ten randomly observed residents (16) had been assessed for the capability to self-administer medications after set-up. Findings include:</p> <p>1. Observation on 6/30/15 at 8:20 a.m. in the dining room of resident 16 revealed: *Registered nurse (RN) A took her medication from the medication cart and put it into a medicine cup. *She then walked over to the resident and set the medication cup down in front of her. *She walked away and left the resident to take her medications by herself.</p> <p>Interview on 6/30/15 with RN A at that time revealed: *She had not been educated on what self-medication administration was. *She thought resident 16 had been alert enough to leave the medications with her.</p> <p>Review of resident 16's medical record revealed: *An admission date of 5/26/15. *There had not been a physician's order for medication self-administration. *There was no assessment completed to determine if the resident was capable of self-administration of her medications after set-up.</p> <p>Interview on 7/1/15 at 2:50 p.m. with the Minimum Data Set (MDS) assessment coordinator revealed: *Resident 16 did not have a physician's order to self-administer her medications. *The care team had not done an assessment to</p>	F 176	<p>Residents residing in the facility who self administer medication have the potential to be affected in a similar manner.</p> <p>Residents who choose to Self Administer Medications have had a Self Administration of Medication Evaluation completed.</p> <p><i>*to include RN A</i> Nursing staff have been re-educated on the Golden Living Policy of Self Administration of Medication</p> <p>Director of Nursing or designee will complete 5 random room audits weekly x 4 weeks then monthly x 2 months to ensure compliance to policy. Results will be reviewed at monthly QAPI meetings for further recommendations.</p> <p><i>and report results to QAPI monthly.</i></p>	<p>* 7/31/15 KG/SD00H/JJ</p>
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F 176	Continued From page 13 ensure the resident was safe to self-administer her medications after set-up by the staff. *RNA should not have left the medications for resident 16 to self-administer on her own.	F 176		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, policy review, and interview, the provider failed to ensure one of one sampled resident (14) with a seat belt had been assessed for its use. Findings include: 1. Review of resident 14's closed (no longer in the facility) medical record revealed: *He was admitted on 5/8/15 with a diagnosis of encephalopathy (brain damage) related to a Traumatic Brain Injury (TBI). *A fax was sent to his physician on 5/15/15 stating "Due to resident's impulsiveness and	F 221	F221D The resident has the right to be free from any physical restraints Resident # 14 seatbelt assessment is unable to be completed as resident has been discharged from the facility. Residents residing in the facility utilizing restraints have the potential to be affected in a similar manner. Residents who are utilizing physical restraints have had assessment completed, physician order obtained, consent for restraint signed by power of attorney and care plan has been reviewed and revised.	

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F 221	<p>Continued From page 14</p> <p>frequent falls, nursing feels residents needs a seatbelt. May we have an order for a removable alarmed seatbelt in w/c [wheelchair]? Resident is able to remove belt on his own." -The physician responded with an order for an "Alarmed sb [seatbelt] in w/c only."</p> <p>Interview on 6/1/15 at 2:30 p.m. with the director of nurses regarding resident 2 revealed: *When a restraint was being considered for use on a resident the Pre-Restraint Evaluation was completed by nursing. *That resident was able to release the seat belt.</p> <p>Review of resident 14's 5/8/15 care plan revealed: *Resident at risk for elopement due to his impaired cognition (thought process) *The goal was "Resident will not leave facility without assist [assistance]." *Interventions - Seatbelt to remind resident not to get up without assist. Resident is able to release seat belt. *The care plan related to the fall risk did not address the use of the seat belt.</p> <p>Further review of resident 14's closed medical record revealed there was not a Seatbelt or Pre-Restraint assessment completed to determine his ability to consistently remove the seatbelt.</p> <p>Review of the provider's 1/26/15 Physical Restraint Devices policy revealed the documentation guidelines for the use of the restraint may include: *Methods utilized before restraint device. *Assessment for restraint device use. *Frequency and length of time the restraint device</p>	F 221	<p>Nursing staff have been re-educated on the Golden Living Policy of Pre-restraint evaluation, informed consents for physical restraints and restraint reduction procedures</p> <p>Director of Nursing or designee will complete audits weekly x 4 weeks then monthly x 2 months to ensure restraint reduction evaluations are being completed in conjunction with the MDS schedule. Results will be reviewed at QAPI monthly meetings for further recommendations.</p> <p><i>to include any newly imposed restraints KG/SDDH/JJ</i></p> <p><i>the DON will report the audit results to QAPI monthly. KG/SDDH/JJ</i></p>	* 7/31/15 KG/SDDH/JJ
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F 221	Continued From page 15 was released. *Condition of the resident while restrained. *Care Plan documentation guidelines included a "Goal should lead to removal of restraints or use of less restrictive measures.	F 221		
F 222 SS=G	<p>483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS</p> <p>The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review, policy review, and interview, the provider failed to ensure an as needed (PRN) antipsychotic (mind-altering) medication (Haldol) had not been used for staff convenience and to chemically restrain two of seven sampled residents (10 and 14) with a PRN antipsychotic medication. Findings include:</p> <p>1. Review of resident 10's entire medical record revealed: *She had been admitted on 3/31/15. *She had diagnoses of: chronic airway obstruction (difficult breathing), depression, essential tremor (shaking of hands), urinary tract infection, cataract of the eye, anxiety, hypertension (high blood pressure), esophageal reflux (stomach acid returning to esophagus), and insomnia (trouble sleeping).</p> <p>Review of resident 10's 3/31/15 admission clinical health status assessment revealed she:</p>	F 222	<p>F222G The resident has the right to be free from any chemical restraints</p> <p>Resident #10 and PRN psychoactive medications have been reviewed and PRN medications have been discontinued. Resident #14 has been discharged from the facility so no corrective action could be taken.</p> <p>Residents residing in the facility who receive PRN psychoactive medications have the potential to be affected in a similar manner. Residents who have an active order for PRN psychoactive medications have been reviewed and care plan has been reviewed and revised.</p> <p>Director of Nursing, Consultant Pharmacist and Medical Director have reviewed the Policy of Antipsychotic Medication Review.</p>	<p>* 7/31/15 KG/5000H/JT</p>

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F 222	<p>Continued From page 16</p> <p>*Was alert and her short and long-term memory were good.</p> <p>*Was independent with decision making.</p> <p>*Was able to make her self understood and understood others.</p> <p>*Had no indicators of depression, anxiety (nervousness), sad mood, or adjustment of new conditions.</p> <p>*Had no behavioral symptoms.</p> <p>*Had a risk for elopement (leaving the facility without staff knowing) assessment that had indicated she was physically able to leave the building on her own and was a recent admission. -Those answers had triggered a prevention plan of care for elopement should have been considered.</p> <p>*Smoked and a separate provider assessment had been completed on 3/31/15 indicateing she was able to smoke independently.</p> <p>Review of resident 10's 4/27/15 re-admission clinical health status assessment revealed she:</p> <p>*Was alert and her short-term memory was good.</p> <p>*Had a problem with her long-term memory.</p> <p>*Required assistance with decision making.</p> <p>*Was able to make her self understood and understood others.</p> <p>*Had no indicators of depression, anxiety, sad mood, or adjustment of new conditions.</p> <p>*Had no behavioral symptoms.</p> <p>*Had a risk for elopement assessment that had indicated she was physically able to leave the building on her own and was a recent admission. -Those answers had triggered a prevention plan of care for elopement should have been considered.</p> <p>*Smoked and a separate provider assessment had been completed on 4/27/15 and was unclear on whether she was safe with smoking or not.</p>	F 222	<p>Nursing staff have been re-educated on the Golden Living Policy of Behavior Management guideline, behavior management techniques, targeted behaviors, non pharmacological interventions and the Golden Living Policy of Antipsychotic Medication Review.</p> <p>Director of Nursing or designee will complete audits weekly x 4 weeks then monthly x 2 months to ensure resident's are not receiving unnecessary PRN psychoactive medications. Results will be reviewed at QAPI monthly meetings for further recommendations.</p> <p><i>of all psychoactive medications used KG/SD004/JJ</i></p> <p><i>The DON will report the audit results to QAPI monthly. KG/SD004/JJ</i></p>	
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F 222	<p>Continued From page 17</p> <p>Review of resident 10's interdisciplinary progress notes from 6/7/15 through 7/1/15 revealed: *On 6/7/15 at 6:45 a.m. "Resident is alert with confusion and able to make all needs know to staff using call light." *On 6/14/15 at 6:55 p.m. "Resident is alert and oriented with confusion at times." "Always ask staff to go out and smoke." *On 6/16/15 at 9:16 a.m. "Resident is alert and can be confused at times." "She requires assistance to go out to smoke. She cannot pass the smoking assessment." *On 6/22/15 at 9:39 p.m. the following documentation revealed: -"Situation: At about 1900, [7:00 p.m.] resident was reported to be in the middle of the facility parking lot and stating she was going to leave. Resident hit a parked car of another family member's and scratching it with her WC [wheelchair] and attempting to leave. -Background: History of UTI [urinary tract infection], altered mental status [not thinking clearly], dementia [decreased thought process]. -Assessment: Resident refused any and all cares and vital signs [blood pressure, pulse, and breathing per minute] but is noted to be confused and combative towards staff. Resident trying to stand and get out of chair while WC is being pushed by staff and grabbing staff's hands. -Response: Resident was assisted by staff back onto the sidewalk and back into facility. Resident's sister called as requested. Once sister arrive, resident was assisted down to her room. At 1955 [7:55 p.m.] on call MD [medical doctor] was paged. At 2030 [8:30 p.m.] MD paged again. At 2120, [9:20 p.m.] call from _____ [MDs name] received with orders noted." *On 6/23/15 at 2:54 a.m. "St. [straight] cath</p>	F 222		
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F 222	<p>Continued From page 18</p> <p>[catheterization (tube to drain urine) of urinary bladder] done as ordered. Resident tolerated well. Results pending."</p> <p>*On 6/23/15 at 1:38 p.m. "Received UA [urinalysis] [urine test results] and faxed to _____ [MDs name]."</p> <p>*On 6/23/15 at 8:25 p.m. a note by the social services (SS) worker revealed: "Earlier a mood assessment was completed with resident. She scored 5 for mild depression. She answered yes to thoughts that she would be better off dead and that she has had thoughts in the past of hurting herself but not at the time. As SS was leaving for home this evening found resident in the street trying to leave. Brought her back to facility and she refused to come in. She continued to try to leave and 4 times almost tipped chair over going down the sloping drive and off the curb. She made comments that hurting her self would be ok and being better off dead. These comments were made a few times. She is refusing to come into facility. She states that her behavior is ok and disagrees that being in the road is a safety risk."</p> <p>*On 6/23/15 at 9:00 p.m. the following documentation revealed:</p> <p>- "Situation: At 1900, [7:00 p.m.] facility SS worker found resident in the street trying to leave facility. SS brought her back to facility and resident refused to come in. Resident continue to try and leave 4 times and almost tipped her w/c [wheelchair] over while going down the sloping driveway and off the curb.</p> <p>-Background: Hx [history] of altered mental status, UTI.</p> <p>-Assessment: Resident apparently disoriented and confused. Resident is not thinking clearly and cognitive [thinking; reasoning] status is severely altered. Resident refuses any care from any and all staff.</p>	F 222		
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F 222	<p>Continued From page 19</p> <p>-Response: Resident was brought back several times for safety purposes. One on one and at times two staff to 1 for safety and monitoring. PRN [as needed] medication administration attempted and refused. Call to her niece made. Niece arrived to assist in reassuring resident but resident continued to be agitated and attempt to elope. Call to MD at 2025 [8:25 p.m.] with order to send to _____ [name of hospital] for psych [psychiatric] eval [evaluation] via [by] ambulance. Ambulance on scene and here to transport resident at 2035 [8:35 p.m.]. At 2040, [8:40 p.m.] report called to _____ [name of registered nurse at hospital]. Awaiting update at this time."</p> <p>*On 6/24/15 at 1:44 a.m. "At 2330, [11:30 p.m.] call received from _____ [name of hospital] ER [emergency room] that resident is being sent back to facility. Resident verbalized no intentions to harm self in ER and displayed no behaviors while in the ER. Resident returned at 0030, [12:30 a.m.] with new orders for antibiotics for present UTI as well as progress notes regarding medications administered while in the ER. Resident assisted to bed with no concerns noted at this time. Will continue to monitor."</p> <p>*On 6/24/15 at 6:43 p.m. "Received orders for Ativan [anti-anxiety medication] solution 2 mg [milligram] per ml [milliliter] injection et [and] for a wanderguard [personal alarm device] R/T [related to] recent attempts to leave."</p> <p>*On 6/24/15 at 9:30 p.m. Medication administration of 1 mg of Haldol (antipsychotic medication) intramuscularly (IM). "Resident is exit seeking and combative to staff."</p> <p>*On 6/24/15 at 10: 43 p.m. the following documentation revealed:</p> <p>-Situation: "Resident is repeatedly attempting to elope from facility. Has opened exit doors at least x [times] 3 starting at 1930 [7:30 p.m.] exiting x 2.</p>	F 222		
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F 222	<p>Continued From page 20</p> <p>Resident hitting at staff and grabbing door handles and side rails and attempting to stand when wheel chair is in motion.</p> <p>-Background: Present UTI-currently on antibiotics therapy. Eloping and combative behaviors noted previous two days.</p> <p>-Assessment: Resident is noted to be confused, combative, and danger to self at this time.</p> <p>-Response: Earlier this shift, order was received for IM Ativan. Pharmacy called for medication. Medication unavailable at this time and not in our medication dispensing unit. Pharmacy continued with communications with MD for alternative medication. New order received. During this time, resident was supervised 1 on 1 [one staff person for one resident] at nurse's station by staff to prevent elopement. PRN oral medication administration attempted without success. IM injection of Haldol given as ordered. Family was notified and came to facility to help facilitate ADLs [activities of daily living that includes dressing, toileting, eating and personal care] with success. Family appreciative towards staff. Will continue to monitor and assess."</p> <p>*On 6/25/15 at 4:58 p.m. "Haldol 2 mg IM given. Resident left building three times. On third time, resident became combative with staff, attempting to hit staff, swinging at CNA [certified nursing assistant], nurse, et management. Resident re-directed for brief time et [and] brought into the hallway, where she then pulled the fire-alarm."</p> <p>*On 6/25/15 at 5:19 p.m. "Resident left building three times, stating that she was 'leaving this damn place'. Resident was stopped by nurse et CNA and explained to her why she needs to stay here for her safety. Resident re-directed back into building. A different resident left the building to leave with her son et this resident attempted to leave with the other resident. Nursing was able to</p>	F 222			

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

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F 222	<p>Continued From page 21</p> <p>re-direct resident, but she became combative, swinging to hit staff et kicking at nurse. Resident brought back into building et re-directed for a short time. Resident went down the hallway et pulled the fire-alarm, after being asked not to by nurse. Nurse assigned CNA to do one-on-one with resident; PRN dose of IM Haldol given per MAR [medication administration record]."</p> <p>*On 6/26/15 at 8:44 p.m. a late entry "Resident was trying to get out of the facility, and telling everyone that she will pull the fire alarm. Resident was stopped by nurse et CNA and explained to her why she needs to stay here for her safety. Nursing was able to re-direct but she's trying to hit staff. Given PRN dose of IM Haldol given per eMAR [electronic medication administration record]. She tries to kick staff while given the injection. After that she pours water on the laptop and still mad because she wants to go out."</p> <p>*On 6/28/15 at 8:19 p.m. "Haldol 2 mg IM given. Resident was trying to go out of the facility, and was very agitated."</p> <p>*On 6/28/15 at 9:49 p.m. "Resident was trying to get out the facility again at 2000, [8:00 p.m.] and she want [wanted] to go out and smoke. She was confused, she stated that she want to talk to the doctor on what's going on. Explained to the resident that she's living here and needs to stay here for her safety. Give PRN dose of IM Haldol given per eMAR. Resident is still agitated called her sister and they came to help calm her down. Resident sister help her to bed and finally goes to sleep."</p> <p>*On 6/30/15 at 9:09 p.m. "Haldol 2 mg IM given."</p> <p>*On 6/30/15 at 10:03 p.m. "Resident with increased agitation, admin [administered] one IM shot of Haldol and called family to come up to see res.[resident] Res. then called 911 and police officer showed up, explained situation to police</p>	F 222		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - BLACK HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 NORTH 7TH STREET RAPID CITY, SD 57701
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F 222	<p>Continued From page 22</p> <p>without any issues. res is resting in bed at this time, family just left. will cont [continue] to monitor."</p> <p>*On 7/1/15 at 12:43 p.m. a note by the SS worker. "Faxed _____ [MD] regarding resident behaviors. Family member is concerned about the behavior and said they have a Dr appt [appointment] schedule with _____ [MD] on 7/10/15. Discussed that we have request bed on 2nd fl [floor] _____ [another facility] for her safety."</p> <p>Review of a 7/1/15 facsimile note sent to resident 10's primary physician by the SS worker included: **"Resident begins behaviors around 2:30 - 3:30 [p.m.]. *She is agitated not easily redirected, combative, verbally abusive. *Calls the police and pulls the fire alarm, dumped water on computer. *See notes and med [medication] list. *Please review and provide direction."</p> <p>Surveyor: 26180 Observation and interview on 7/2/15 at 10:00 a.m. with resident 10 revealed: **"Everything had gone pretty good here until recently. She got mad a little while back and was upset, because her brother-in-law had died. So you know how that can stress you out?" *She used to be able to go outside and have a cigarette. Now she needed a supervisor with her if she wanted to go out and have a cigarette. That was new. *She just wanted to go out and talk with people the way she used to. *She was stressed and could not get a supervisor to go out with her. She got angry. "Talk about acting like a 10 year old. I was real angry."</p>	F 222		
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F 222	<p>Continued From page 23</p> <p>-So she went out and was in the parking lot, then when she had to come back in, she got so mad she pulled the fire alarm.</p> <p>*"That was when they stuck me. They gave me a shot and told me it was to make me sleep. I don't take meds [medications] that I don't know what they are for.</p> <p>-They did that to me four or five times. It didn't make me sleep. It made me angry.</p> <p>-"They should put a picture of a dog on my door that said Beware of Dog. That is how I feel."</p> <p>*She thought a couple of the nurses are bull dogs. They were the ones that gave her the shots. They said I was combative. I was not combative."</p> <p>*Now they wanted her to move to another facility "because I am combative."</p> <p>*She relayed that one certified nursing assistant (CNA) who was holding her when they gave her the shot, the resident used her long fingernails to get the CNA and pointed to her neck were she had "gotten" the CNA.</p> <p>*A new resident had come in on 7/1/15, and that resident also smoked. When the staff saw her warning this new resident about not being able to smoke they moved resident 10 to a different table away from the new resident.</p> <p>Surveyor: 26632 Review of a 5/4/15 psychosocial history and assessment for resident 10 by the social services (SS) worker revealed: *A history of depression and anxiety. *An active smoker and required supervision to smoke for safety as she had failed the smoking assessment. Due to her history of falls she required supervision. *Was alert and oriented to person, place, time, and self. She was limited regarding safety</p>	F 222		

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F 222	<p>Continued From page 24</p> <p>awareness.</p> <p>*Was able to make herself known and was able to understand others well.</p> <p>**"Was pretty upbeat and usually did not trigger for any mood indicators."</p> <p>*Would have rather lived on her own but understood she was not able to do that due to her medical limitations.</p> <p>Review of resident 10's physician's orders from 6/23/15 through 6/29/15 revealed:</p> <p>*A 6/23/15 1:40 p.m. order to await a culture from her urinalysis results.</p> <p>*A 6/24/15 1:00 a.m. order from the ER physician for Keflex 250 mg for her UTI.</p> <p>*A 6/24/15 untimed order for Ativan one mg for one time and for a Wanderguard due to her elopement risk.</p> <p>*A 6/24/15 at 12:08 p.m. order for Haldol 1 mg IM every six hours as needed for combativeness and anxiety related to UTI and anxiety.</p> <p>*A 6/24/15 at 9:15 p.m. order for Haldol one to two mg IM every six hours as needed.</p> <p>*A 6/29/15 untimed order for a urinalysis and to make an appointment with her primary physician.</p> <p>Review of resident 10's 5/6/15 alterations in ADLs related to a recent hospitalization included an intervention that had been initiated on 4/27/15. Those interventions included:</p> <p>**"Resident will be safe when smoking and staff to assist with removing O2 [oxygen] prior to going outside to smoke. Resident will follow smoking policy and pass smoking assessment. She is to wear smoking apron."</p> <p>*Handwritten addendums (additions) on 6/22/15 were supervised smoking and cigarettes kept at nurses station/medication room.</p>	F 222		

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F 222	<p>Continued From page 25</p> <p>An immediate plan of care for the risk of elopement was initiated on 6/25/15. That plan included:</p> <ul style="list-style-type: none"> *Problems of resident stated "I'm leaving" and active exit seeking. *Interventions included: <ul style="list-style-type: none"> -Evaluate need for wandering management program. -Check resident every two hours and as needed. -Involve resident in activities of her liking. -Accutech bracelet (personal alarm). -Communicate with resident to determine reason for the behavior. -Involve the resident in decision making regarding daily choices. <p>Surveyor: 26180</p> <p>2. Review of resident 14's 5/8/15 physician's orders revealed:</p> <ul style="list-style-type: none"> *He was admitted on 5/8/15 and discharged on 6/18/15. *His diagnoses included: <ul style="list-style-type: none"> -A traumatic brain injury (TBI). -Mild cognitive impairment. *The following psychotropic (medications effecting mood and behavior) had been ordered: <ul style="list-style-type: none"> -Haldol (treatment for psychosis/severe mental disorder) inject 2 milligram (mg) intramuscularly (IM) PRN (as needed) every eight hours for severe agitation. Start date 5/10/15. There was no time limit on the use of that medication. -Risperidone (treatment for psychosis/severe mental disorder) tablet - 0.25 mg per PEG Tube (tube placed into the stomach for nutrition and medication) three times a day related to mild cognitive impairment. Start date 5/14/15. -Seroquel (for psychosis) tablet 25 mg per PEG tube every four hours as needed for severe agitation. 	F 222		

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F 222	<p>Continued From page 26</p> <ul style="list-style-type: none"> -Trazodone (depression) HCL (hydrochloride) tablet 25 mg every six hours as needed for ABS (agitated behavior scale) greater than 27. Start date 5/8/15. -Trazodone HCL tablet 50 mg every 6 hours as needed for ABS greater than 27. Start date 5/8/15. <p>Review of resident 14's 6/1/15 physician's orders revealed:</p> <ul style="list-style-type: none"> *His diagnoses remained unchanged from 5/8/15. *The following psychotropic had been ordered: <ul style="list-style-type: none"> -Haldol inject 2 milligram (mg) intramuscularly every eight hours for severe agitation. Start date 5/10/15. -Risperidone - 0.25 mg by mouth three times a day related to mild cognitive impairment. Start date 5/14/15 -Seroquel tablet 25 mg by mouth every four hours as needed for severe agitation. -Trazodone HCL 25 mg every six hours as needed for ABS greater than 27. Start date 5/8/15. -Trazodone HCL 50 mg every six hours as needed for ABS greater than 27. Start date 5/8/15. <p>Review of nurses progress notes and the Medication Administration Records for May and June 2015 revealed:</p> <ul style="list-style-type: none"> *He received the Haldol 2 mg IM 5/20/15 for severe agitation. *He received the Seroquel 25 mg on 6/10/15 for severe agitation. *The nurses had documented he had: <ul style="list-style-type: none"> -Attempted to leave the building. -Fallen. -Attempted to stand up and required assistance. -Become agitated. 	F 222		

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F 222	<p>Continued From page 27</p> <ul style="list-style-type: none"> -A Wanderguard on. -A fall mat by his bed (to prevent injury if he fell). <p>Review of resident 14's 5/18/15 care plan revealed there were no resident specific interventions to reduce agitation other than medications.</p> <p>Review of resident 14's behavior log revealed:</p> <ul style="list-style-type: none"> *From 5/8/15 through 6/18/15 he exhibited behaviors thirteen times. *Those behaviors included: <ul style="list-style-type: none"> -Rejecting care four times. -Wandering four times, -Verbal behavior twice. -Physical behavior twice. -Other behavior once. *On 5/20/15 he exhibited verbal behavior one time. *On 6/10/15 he wandered one time. <p>Interview on 7/2/15 at 10:40 a.m. with the director of nurses regarding resident 14 revealed:</p> <ul style="list-style-type: none"> *He was very confused and restless. *He was assigned a one-on-one staffing ratio to monitor him when he first came in, because he was constantly trying to leave the building and was a fall risk. *The ABS scale was a scale the TBI unit used that he came from. -They did not have a copy of that scale and had not used it. -The nurses should have addressed that when they got the order for using a medication based on an assessment (scale) they did not have. *She agreed the diagnoses of mild cognitive impairment and severe agitation were not appropriate indicators for the use of an antipsychotic. 	F 222		
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F 222	<p>Continued From page 28</p> <p>-Those were diagnoses he was admitted with.</p> <p>*She acknowledged the behavior documentation had not reflected the extent of his behaviors.</p> <p>*She confirmed the nurses should have addressed those diagnoses with the admitting physician.</p> <p>Review of the provider's 1/29/14 antipsychotic medication review policy revealed:</p> <p>*The Procedure was to "Ensure that the Medical Record of any Resident who receives antipsychotic medication contains documentation supporting the appropriateness and necessity for the use of the drug.</p> <p>*Antipsychotics are a class of psychiatric medication primarily used to manage psychosis (including delusions, hallucinations, or disordered thought) particularly in schizophrenia and bipolar disorder, and is increasingly being used in the management of non-psychotic disorders."</p> <p>*The Assessment of Psychotropic medications was a part of the policy.</p> <p>Review of the provider's 2/12/15 Behavior Management Guideline policy revealed:</p> <p>*The use of any medication to control behaviors should always have been considered a last resort to assist with managing a patient's/resident's behavior.</p> <p>*Antipsychotic drugs would not be used unless the clinical record documented the patient/resident has one or more of the following specific conditions as dictated and documented by the physician:</p> <p>*A. Conditions other than Dementia included a list of twelve diagnoses and had not included:</p> <p>-Mild cognitive impairment.</p> <p>-Severe agitation.</p> <p>*Criteria: "All of the above highlight</p>	F 222		
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F 222	Continued From page 29 conditions/diagnosis where antipsychotic medications may possible be appropriate, but diagnosis alone do not warrant the use of an antipsychotic unless the following criteria are also met: -The behavioral symptoms present a danger to the patient/resident or others AND one or both of the following: -The symptoms are identified as being due to mania (hyperactive thinking) or psychosis (such as auditory, visual or other hallucinations; delusions, paranoia, or grandiosity); OR -Behavioral interventions have been attempted and included in the plan of care, except in an emergency."	F 222	→ F226: Resident 10 now has a bracelet in place to sound the alarm if she exits unattended. Her care plan was reviewed and revised for interventions when she is exit seeking or requests to be outside. Resident 2's care plan was revised to alert staff to check the residents pockets before sending clothing to laundry and to also alert the charge nurse if money is found in his room. KG/SDMH/JJ	
F 226 SS=D	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: 32355 Surveyor: 26632 Based on record review, interview, and policy review, the provider failed to thoroughly investigate one of one sampled resident (10) who had eloped (left the facility without staff knowledge) and one of one sampled resident (2) who had an incident involving missing property. Those incidents had also not been reported to the South Dakota Department of Health (SD DOH).	F 226	F226D Develop/Implement abuse neglect policies Unable to correct past investigation for resident #10 and #2 * Resident's residing in the facility have the potential to be affected in a similar manner. Staff has been re-educated to the abuse and neglect policy including the investigative and reporting protocols. ED and/or DNS will contact Field Service Clinical Director and/or Area Vice President to advise of any potential abuse/neglect allegations and send reports for further guidance.	* 7/31/15 KG/SDMH/JJ

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F 226	Continued From page 30 Findings include: 1. Review of resident 10's interdisciplinary progress notes from 6/22/15 through 6/23/15 revealed: *On 6/22/15 at 9:39 p.m. the following documentation revealed: -"Situation: At about 1900, [7:00 p.m.] resident was reported to be in the middle of the facility parking lot and stating she was going to leave. Resident hit a parked car of another family member's and scratching it with her WC [wheelchair] and attempting to leave. -Background: History of UTI [urinary tract infection], altered mental status [not thinking clearly], dementia [decreased thought process]. -Assessment: Resident refused any and all cares and vital signs [blood pressure, pulse, and breathing per minute] but is noted to be confused and combative towards staff. Resident trying to stand and get out of chair while WC is being pushed by staff and grabbing staff's hands. -Response: Resident was assisted by staff back onto the sidewalk and back into facility. Resident's sister called as requested. Once sister arrive, resident was assisted down to her room. At 1955 [7:55 p.m.] on call MD [medical doctor] was paged. At 2030 [8:30 p.m.] MD paged again. At 2120, [9:20 p.m.] call from _____ [MDs name] received with orders noted." *On 6/23/15 at 8:25 p.m. a note by the social services (SS) worker revealed: "Earlier a mood assessment was completed with resident. She scored 5 for mild depression. She answered yes to thoughts that she would be better off dead and that she has had thoughts in the past of hurting herself but not at the time. As SS was leaving for home this evening found resident in the street trying to leave. Brought her back to facility and	F 226	Field Service Clinical Director and/or Area Vice President will review abuse/neglect allegations and provide guidance for development of process improvement plan if indicated at the monthly QAPI meetings x 3 months. <i>* The Social Service Designee will audit weekly x 4 weeks then monthly x 2 months to ensure all reports of elopements and missing property are reported and investigated properly. The Social Service Designee will report the results of these audits to QAPI monthly for further recommendations.</i> <i>KELSDPH/JT</i>		

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F 226	Continued From page 31 she refused to come in. She continued to try to leave and 4 times almost tipped chair over going down the sloping drive and off the curb. She made comments that hurting her self would be ok and being better off dead. These comments were made a few times. She is refusing to come into facility. She states that her behavior is ok and disagrees that being in the road is a safety risk." *On 6/23/15 at 9:00 p.m. the following documentation revealed: -"Situation: At 1900, [7:00 p.m.] facility SS worker found resident in the street trying to leave facility. SS brought her back to facility and resident refused to come in. Resident continue to try and leave 4 times and almost tipped her w/c [wheelchair] over while going down the sloping driveway and off the curb. -Background: Hx [history] of altered mental status, UTI. -Assessment: Resident apparently disoriented and confused. Resident is not thinking clearly and cognitive [thinking; reasoning] status is severely altered. Resident refuses any care from any and all staff. -Response: Resident was brought back several times for safety purposes. One on one and at times two staff to 1 for safety and monitoring. PRN [as needed] medication administration attempted and refused. Call to her niece made. Niece arrived to assist in reassuring resident but resident continued to be agitated and attempt to elope. Call to MD at 2025 [8:25 p.m.] with order to send to _____ [name of hospital] for psych [psychiatric] eval [evaluation] via [by] ambulance. Ambulance on scene and here to transport resident at 2035 [8:35 p.m.]. At 2040, [8:40 p.m.] report called to _____ [name of registered nurse at hospital]. Awaiting update at this time."	F 226			

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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
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F 226	<p>Continued From page 32</p> <p>Interview on 7/1/15 at 10:30 p.m. with the administrator revealed the above elopements for resident 10 had not been reported to the SD DOH. He stated since resident 10 had not left the facility property it was not considered an elopement.</p> <p>Review of the provider's undated Elopement Guideline policy revealed: *Elopement was defined as a situation where a resident with impaired decision-making ability had left the facility without staff knowledge. *The executive director (administrator) would notify the state agency as necessary by state requirement.</p> <p>Surveyor: 32355 Interview on 7/1/15 at 5:30 p.m. with the social services designee regarding resident 10 revealed: *She had been aware of the resident's two elopements from the facility on 6/23/15 and 6/24/15. *She was aware no incident reports had been completed on both of those elopements. *She could not give a reason why there were no incident reports completed. *She stated "I reported them to my supervisor." *She confirmed her supervisor had been the administrator.</p> <p>Surveyor: 26180 2. Review of resident 2's 11/17/14 progress notes revealed: "Residents daughter brought in resident's wallet. Said charge nurse called her last evening at resident's request to let her know the wallet was found. She wanted us to know it appeared to</p>	F 226		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2015
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F 226	<p>Continued From page 33</p> <p>have gone through the laundry. Told her the last time it was lost it had gone through laundry. Resident's daughter said the wallet was lost last week, and the resident told her there was about thirty dollars in it. Today she told the business office there was one-hundred-fifty dollars in the wallet. She opened an account with the business office today, as staff had continued to tell her residents were discouraged from having more than five dollars on them."</p> <p>Interview on 7/1/15 at 11:50 a.m. with resident 2's daughter revealed: *He had recently misplaced his wallet. *The wallet had been found by the staff, and all the cards were still in it. -It looked like it had gone through the laundry. -There was no money in the wallet when it was found. *She thought there had been about one-hundred-thirty dollars in it. *The staff had been made aware of the missing money, but nothing more had been done about it. *they had started an account that he could keep money in and have access to it. *He also got travel money from the Veteran's Administration when he went to see his doctor, but she let him keep that money. -She did not know what he did with the travel money or how much he got when he received it.</p> <p>Interview on 7/1/15 at 2:00 p.m. and review of the provider's Verification of Investigation (VOI) report the executive director (ED) regarding resident 2's missing money revealed: *The VOI: -Was undated and "approx [approximately] Mid November" was written in the Date/Time of occurrence box on the form.</p>	F 226		
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F 226	<p>Continued From page 34</p> <ul style="list-style-type: none"> -The detailed description of event/allegation read: "Resident family member reports missing money, varying amounts, after wallet went through laundry services. Resident states he lost \$150." -It had not identified who had reported the money missing. -There was not an investigation completed or documented. *The ED: <ul style="list-style-type: none"> -Had spoken to the resident's daughter about the missing wallet and money. -Could not say the name of the person (daughter) he had spoken to, but knew what she looked like. -He was unsure if it was the resident's daughter or the daughter-in-law. -Reported the daughter's store kept changing about how much money was in the wallet. -He did not think the report was valid, because the amount of money kept changing, so he did not report it to the state agency (South Dakota Department of Health) (SD DOH). -He understood reports of missing money would have been reported to law enforcement and the SD DOH. -He again confirmed he did not report it to the SD DOH because the amount of money that had been reported missing, kept changing. -Confirmed the VOI had not been completed at the time of the incident. It had just been completed when this surveyor requested it. <p>3. Review of the provider's 1/15/15 Reporting Alleged Abuse Violation policy revealed: *The ED or DNS [director of nursing services] conducts all investigation, in the event an alleged violation occurs when neither of these people are in the center, the charge nurse is responsible for initiating the investigation procedure. *The investigation includes interviews, of</p>	F 226		
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F 226	Continued From page 35 employees, visitors or residents who may have knowledge of the alleged incident. Only factual information is documented - not assumptions or speculation. *Federal law requires the center to have evidence of investigations of alleged violations. *The attached VOI form is completed after the investigation is complete and provided to survey agencies when requested or required by state or federal law. *Any employee who suspects an alleged violation immediately notified the ED or designee. The ED notifies the appropriate state agency in accordance with state law and the regional vice president."	F 226		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, interview, and record review, the provider failed to ensure 1 of 13 sampled residents (2) received activities based on their assessed interests and needs. Findings include: 1. Random observation and interview of resident 2 from 6/29/15 in the afternoon through 7/2/15 in the morning revealed: *He came out to the dining room for most meals.	F 248	F248 F Activities Meet Interests/Needs of each Resident Resident # 2 activity evaluation has been reviewed and revised. <i>* All other residents activities evaluations will be reviewed within 30 days. KG/SDDH/JJ</i> Residents residing in the facility have the potential to be affected in a similar manner. <i>* Continue to</i> Resident's activity evaluations will be reviewed and care plans revised as indicated with next MDS to ensure resident's activity needs are being met. <i>KG/SDDH/JJ</i> Activity Director has been reeducated on the CMS regulation Activities Meet Interests/Needs of each Resident <i>* 7/31/15 KG/SDDH/JJ</i>	

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F 248	<p>Continued From page 36</p> <p>*After meals he returned to his room and laid down on his bed.</p> <p>*He would appear to be asleep but would wake up when you said his name.</p> <p>*He enjoyed talking about being in the military.</p> <p>Review of resident 2's 5/18/15 care plan revealed activity interventions included:</p> <p>*Invite to food related activities.</p> <p>**I will agree to brief check-in visit several times a week to see if I've had a change of heart or if there is any supplies I many need."</p> <p>**When available invite Veterans groups to visit with me, encouraging discussion about my military experiences."</p> <p>Review of the June 2015 activity participation record and interview with the activity director on 7/1/15 at 5:00 p.m. regarding resident 2 revealed:</p> <p>*He was a very quiet man who spent most of his time in his room.</p> <p>*He refused to come out to activities.</p> <p>-They had not documented those when he refused.</p> <p>*His family visited often.</p> <p>-They had not documented family visits.</p> <p>*He slept a lot.</p> <p>-His activity was self-directed.</p> <p>*There were at least eighteen food related activities that had been scheduled during June.</p> <p>-There was no documentation he had been invited to any of them.</p> <p>*There was no documentation they had encouraged his participation in any other activity or had done the weekly visits.</p> <p>*There had not been any Veterans groups that had come out to visit with him.</p> <p>Review of the provider's 2009 recreation services</p>	F 248	<p>Executive Director or designee will complete random resident interview audits of satisfaction of activities weekly x 4 weeks then monthly x 2 months to ensure resident's satisfaction with activities. Results will be reviewed at QAPI meetings monthly for further recommendations.</p> <p>activity log audits, observation of activities, review of the activity calendar, and KG/5000H/JJ</p> <p>The Executive Director will report the audit results to QAPI monthly. KG/5000H/JJ</p>		

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F 250	<p>Continued From page 38</p> <p>-Changes in sleeping such as sleeping too much or sleeping too little.</p> <p>Random observation of resident 2 from 6/29/15 in the afternoon through 7/2/15 in the morning revealed:</p> <ul style="list-style-type: none"> *He remained in bed most of the day and appeared to be sleeping with his blanket pulled up around his face. *He attended no activities and participated in no in-room activity. *He came out to the dining room for most meals. *He ate a very small amount of food - stating he had no appetite. *After meals he returned to his room and went right to bed. *He had not visited with other residents in the dining room. *He had no interest in any activity. *His clothes oftentimes were soiled with food spills, and he showed no interest in changing them before he came out of the room for a meal. <p>Interview on 7/1/15 at 11:50 a.m. with resident 2's daughter revealed he:</p> <ul style="list-style-type: none"> *Needed more help than he had received with grooming and making sure he got to the toilet. *She had told the staff awhile back he might be more cooperative with bathing if he had a male caregiver. -Had a urine odor in his room at times. *Had recently been to the dentist and needed to have a lot of dental work done. *Had always been very difficult to talk to; he was a very quiet man. -Sometimes when she came he would not talk to her and he would appear to be sleeping. *There had been some issues regarding a relationship her dad was in, and that had been 	F 250	<p>Executive Director or designee will complete random audits weekly x 4 weeks then monthly x 2 months to ensure resident's medically social service needs have been met. Results will be reviewed at QAPI meetings monthly for further recommendations.</p> <p><i>and report the results to QAPI monthly. KG/SDD/H/JJ</i></p>	
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F 250	<p>Continued From page 39</p> <p>very difficult for the daughter to deal with.</p> <p>*His wife had died only two years ago.</p> <p>*She had concerns that person might have taken some money from her dad.</p> <p>*Had recently lost his billfold and when it returned all the money was missing.</p> <p>-They had reported that to the facility staff.</p> <p>Review of resident 2's weight record revealed:</p> <p>*On 3/5/15 he weighed 157.5 pounds (lb).</p> <p>*On 4/2/15 he weighed 140.5 lb.</p> <p>-That was a 17 lb or 10.7% weight loss in one month.</p> <p>Interview on 6/30/15 at 3:10 p.m. with the social services designee (SSD) regarding resident 2 revealed he:</p> <p>*Was very quiet , a loner.</p> <p>*Had denied he was depressed.</p> <p>*Slept a lot.</p> <p>*Had lost weight, but his daughter thought that was because someone had told him he had "chunked up a bit."</p> <p>-He had a history of cutting back on eating if anyone ever commented on his weight. She felt that was what had happened.</p> <p>*Had not addressed that he slept most of the day, had lost his appetite, had decreased energy, and had lost interest in normal activity.</p> <p>*Had not brought to their attention until today that he might prefer a male caregiver when he had a bath.</p> <p>*Had not shown an interest in his hygiene; that had been a concern.</p> <p>She further stated that as a social services designee her focus had been on admissions and discharges as they had so many. It was hard for her to get her other documentation completed.</p>	F 250		

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F 250	Continued From page 40 Review of resident 2's social services progress notes revealed: *11/11/14 - "Resident scored 3 minimal depression on the mood assessment. Called daughter ___[name] let her know. ___[name] said she has noticed that he seems depressed. ___[name] said tomorrow is the 1 year anniversary date that his wife passed away. Relaid information to charge nurse to inform staff." -There was no further documented follow-up with the resident regarding the loss of his wife. *11/17/14 - Resident's wallet was lost. When it was found the money that reportedly was in it was gone. -There was no further follow-up on securing the resident's property. *11/20/14 - "Care conference held with resident's family." -"Questions if he has a UTI [urinary tract infection] and concern about his being wet and smelling of urine." -No further follow-up on family concerns regarding the urine odor. *5/29/15 - "Resident usually does not have moods or behaviors. This month he had 2 verbal and 1 physical behavior. Will monitor for next month and see if there is a pattern." *From 11/14/14 through 7/2/15 there was nothing addressed regarding the signs of depression he exhibited including: change of appetite, excess sleeping, loss of interest in normal routine, and decreased energy. -There was also nothing documented regarding dental issues. Review of the social services specialist facility visit (social work consultant) summary report	F 250		

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F 250	<p>Continued From page 41 revealed:</p> <p>*Consultations were completed on 10/27/14, 1/26/15, and 4/29/15.</p> <p>*Each visit recommendations were made regarding completing the psychosocial assessment, addressing the moods and behaviors as part of the care plan, and making referrals to mental health agencies for counseling if warranted.</p> <p>Review of the provider's August 2011 social services coordinator job description revealed: "General Purpose: Identify and provide for each residents social, emotional and psychological needs, and the continuing development of the resident's full potential during his/her stay at the facility and to assist in the planning of his/her discharge."</p> <p>Surveyor: 26632</p> <p>2. Review of resident 9's medical record revealed:</p> <p>*Her family had called her attending physician and asked for discharge orders on 5/22/15.</p> <p>*The physician had not agreed to the request and stated if they wanted to discharge it would have been considered against medical advice (AMA).</p> <p>*The physician stated "If they do not want to follow medical advice I suggest they seek a new physician and if they take her out of her SNF [skilled nursing facility] AMA please send a 30 day notice that will see her for emergency only until they can establish with another PCP [primary care physician]."</p> <p>*A facsimile on 6/25/15 from the above physician in regards to a laboratory test result revealed the physician stated "I have been fired as her physician ~ [about] 2 wks [weeks] ago. I was told they were leaving AMA 2 wks ago. Confused to</p>	F 250		

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IDENTIFICATION NUMBER:

435064

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

07/02/2015

NAME OF PROVIDER OR SUPPLIER

GOLDEN LIVINGCENTER - BLACK HILLS

STREET ADDRESS, CITY, STATE, ZIP CODE

1620 NORTH 7TH STREET
RAPID CITY, SD 57701

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(X5)
COMPLETION
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Continued From page 42
why they didn't leave & [and] who is her new
physician."
*A facsimile on 6/15/15 to the above physician
from the SSD revealed:
-"The _____ [family's name] would like to take
_____ [resident 9] home on 6/18/15. I have
attempted to visit with her cancer doctors but
have not been successful. They have prepared
their home for her return. Therapy will complete a
home visit."
-The physician replied "The _____ [family's name]
have fired me, didn't you get the note I sent last
week?" "I was told I'm no longer her Doctor by
her son."

Interview on 7/1/15 at 8:20 a.m. with the SSD
revealed:
*The 5/22/15 physician's note had not been
received until 6/25/15.
*She had sent the 6/15/15 note before she had
received those 5/22/15 notes.
*She had been working very hard on finding
resident 9 a new physician.
*She agreed there was no further documentation
that she had contacted other physicians.

3. Review of resident 1's medical record
revealed:
*A note from her admitting physician of his
retirement on 6/19/15.
*There was no documentation a new physician
had been contacted to have taken over her care.

Interview on 7/2/15 at 8:00 a.m. with the SSD
revealed:
*Resident 1 had a new attending physician.
*She had not updated her chart including the face
sheet.
*She agreed staff would not have known which

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F 250	<p>Continued From page 43 physician to contact.</p> <p>Surveyor: 26180 4. Interview on 7/2/15 at 10:00 a.m. of resident 10 revealed: *Everything had gone pretty good here until recently." She got "mad" a little while back and was upset because her brother-in-law had died. "So you know how that can stress you out?" *She used to be able to go outside and have a cigarette. Now she needed a supervisor with her if she wanted to go out and have a cigarette. That was new. -She just wanted to go out and talk with people the way she used to. *She was stressed and could not get a supervisor to go out with her. She got angry. "Talk about acting like a 10 year old. I was real angry." -So she went out and was in the parking lot, then when she had to come back in, she got so "mad" she pulled the fire alarm. "That was when they stuck me. They gave me a shot and told me it was to make me sleep. I don't take meds [medications] that I don't know what they are for. They did that to me four or five times. It didn't make me sleep. It made me angry. They should put a picture of a dog on my door that says "Beware of Dog." "That is how I feel." *She thought a couple of the nurses are bull dogs. They were the ones that gave her the shots. They said I was combative. I was not combative." *Now they wanted her to move to another facility "because I am combative." *She relayed that one certified nursing assistant who was holding her when they gave her the shot, the resident used her long fingernails to get the CNA and pointed to her neck. *A new resident had come in on 7/1/15, and that</p>	F 250		
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F 250	<p>Continued From page 44</p> <p>resident also smoked. When the staff saw her warning that new resident about not being able to smoke they moved her (resident 10) to a different table away from the new resident.</p> <p>Surveyor: 26632</p> <p>Review of a 5/4/15 psychosocial history and assessment for resident 10 by the SSW revealed:</p> <ul style="list-style-type: none"> *A history of depression and anxiety. *An active smoker and required supervision to smoke for safety as she had failed the smoking assessment. Due to her history of falls she required supervision. *Was alert and oriented to person, place, time, and self. She was limited regarding safety awareness. *Was able to make herself known and was able to understand others well. *Was pretty "upbeat" and usually did not trigger for any mood indicators. *Would have rather lived on her own but understood she was not able to do that due to her medical limitations. <p>Review of the provider's 12/1/14 Admission Guidelines for Smoking revealed:</p> <ul style="list-style-type: none"> *Should the resident choose to smoke they would have to be assessed for safety. *If they were deemed (decided) independent to smoke they could do so outside. *If they did not pass the assessment then arrangements could be made with family to come up and assist the resident. <p>Interview on 7/1/15 at 4:30 p.m. with the SSD revealed resident 10 had not passed the smoking assessment to have been able to smoke unsupervised. She agreed staff had been supervising resident 10 when she smoked. She</p>	F 250		
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - BLACK HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 1620 NORTH 7TH STREET RAPID CITY, SD 57701	
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F 250	Continued From page 45 had not thought resident 10's behaviors had been related to her not being able to smoke.	F 250		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on interview, record review, and policy	F 278	F278D Accuracy of Assessment Resident #8 MDS has been reviewed and revised. Residents residing in the facility who have skin concerns have the potential to be affected in a similar manner. The Clinical Assessment Reimbursement Specialist will complete a coding audit of residents currently residing in the facility with skin concerns to ensure accurate coding MDS Coordinator has been reeducated on the RAI coding guidelines for section M of the MDS Clinical Assessment Reimbursement Specialist or designee will complete 5 audits weekly x 4 weeks then monthly x 2 months to ensure section M of the MDS is coded accurately. This will be completed in conjunction with the MDS schedule. Results will be reviewed at QAPI monthly meetings for further recommendations. <i>and report results to QAPI monthly. KG/5000H/JJ</i>	<i>#7/31/15 KG/5000H/JJ</i>

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F 278	<p>Continued From page 46</p> <p>review, the provider failed to ensure the Minimum Data Set (MDS) assessments had been completed accurately for 1 of 15 sampled residents (8). Findings include:</p> <p>1. Review of resident 8's 6/23/15 MDS assessment revealed: *He had one stage 2 pressure ulcer (open area with skin missing). *It had slough (dead off colored skin) present in the wound bed.</p> <p>Review of the resident's progress notes from 4/13/15 through 6/30/15 revealed he had slough present in the wound bed.</p> <p>Review of the provider's 2007 Pressure Ulcer Staging Guide revealed that the resident's pressure ulcer had been unstageable when slough had been present.</p>	F 278		
F 279 SS=D	<p>Refer to F314, finding 1.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's</p>	F 279	<p>F 279 D Develop Comprehensive Care Plans</p> <p>Resident #18 has been discharged from the facility so no corrective action could be taken.</p> <p>Residents residing in the facility have the potential to be affected in a similar manner. Care plans will be reviewed and revised in conjunction with next MDS to ensure current resident needs are reflected on the care plan</p>	<p>*7/31/15 K6/SQA/H/JJ</p>

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F 279	<p>Continued From page 47</p> <p>highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on interview and record review, the provider failed to develop a thorough temporary care plan regarding infection control for one of one sampled resident (18) with methicillin resistant staphylococcus aureus (MRSA, type of infectious germ) and continued diarrhea. Findings include:</p> <p>1. Review of resident 18's immediate plan of care initiated on 6/25/15 included: *Risk for falls related to diagnosis of muscle weakness and narcotic use. *Risk for urinary tract infection related to Foley catheter (type of catheter used to drain urine from the bladder) use.</p> <p>Review of resident 18's admission face sheet revealed: *He had been admitted on 6/25/15 from another skilled nursing facility. *He had diagnoses that included MRSA in his urine.</p> <p>Review of resident 18's history and physical completed on 7/1/15 by his primary physician revealed: *He had been hospitalized for MRSA with</p>	F 279	<p>Nursing staff, MDS Coordinator and Interdisciplinary team has been reeducated on the RAI care plan guidelines</p> <p><i>of resident care plans KG/SDPH/JJ</i></p> <p>Director of Nursing or designee will complete 5 audits [*]weekly x 4 weeks then monthly x 2 months to ensure care plans are accurately reflective of residents needs. [*]This will be completed in conjunction with the MDS schedule. Results will be reviewed at QAPI monthly meetings for further recommendations.</p> <p><i>the DON will report the results of the audits to QAPI monthly. KG/SDPH/JJ</i></p> <p><i>* All new admissions since 7/3/15 will be reviewed and revised to ensure care plans adequately address those residents needs. KG/SDPH/JJ</i></p>	

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F 279	<p>Continued From page 48</p> <p>urosepsis (severe, life threatening infection of the urinary tract) and treated with intravenous (medication into a vein) antibiotics at the other skilled nursing facility.</p> <p>*He had chronic loose stools (bowel movement).</p> <p>*Resident had stated to the physician he had "Between 5 to 15 loose watery stools per day."</p> <p>*He had problems with urinary retention (could not empty bladder) and had a urinary catheter in place.</p> <p>*Discussion notes by the physician included: -Chronic diarrhea, history of microscopic colitis (inflammation of the colon). -Would plan for test of his stool for clostridium difficile (contagious infection of the intestine) due to his recent antibiotic therapy.</p> <p>Review of resident 18's nurses' notes revealed: *On 6/15/15 at 5:58 p.m. an admission note that had not mentioned his previous MRSA infection diagnosis in his urine. *On 7/1/15 at 10:36 p.m. Resident went to physician appointment at 3:00 p.m. and was back at 5:02 p.m. *Has a diagnosis of diarrhea. Has new orders that included to get a stool sample for C. difficile (clostridium difficile).</p> <p>Interview on 7/2/15 at 9:55 a.m. with licensed practical nurse N and registered nurse O revealed: *They had not been aware resident 18 had a previous diagnosis of MRSA in his urine. *They confirmed his immediate plan of care did not include his previous MRSA or his ongoing diarrhea. *The director of nursing reviewed all new admission history and physicals and if she was not there the SSW or the Minimum Data Set</p>	F 279		

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F 279	Continued From page 49 assessment nurse and the infection control nurse had that responsibility.	F 279		
F 280 SS=F	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in 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: 26180 Based on observation, record review, interview, professional standard, job description, and professional standard review, the provider failed to ensure 9 of 13 sampled residents (1, 2, 3, 4, 5, 8, 9, 10, and 11) care plans had been reviewed and revised as resident care needs had changed. Findings include:	F 280	F 280F Right to participate in Care plans/revise care plans Resident # 1, 2, 3, 4, 5, 8, 10 and 11 have had care plans reviewed and revised to reflect current needs. Resident #9 has been discharged from the facility so no corrective action could be taken. Residents residing in the facility have the potential to be affected in a similar manner. Care plans will be reviewed and revised in conjunction with next MDS to ensure current resident needs are reflected on the care plan <i>* See F279 for other audits. KG/SDM/HJT</i> The Dietary Manager, Registered Dietician, Director of Nursing and Interdisciplinary team have reviewed the Golden Living Weight Monitoring and Nutrition Risk Meeting policy. The Director of Nursing, Medical Director and Interdisciplinary team have reviewed the Golden Living Skin Integrity policy. MDS Coordinator and Interdisciplinary team has been reeducated on the RAI care plan guidelines.	<i>* 7/31/15 KG/SDM/HJT</i>

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F 280	<p>Continued From page 50</p> <p>1. Random observation of resident 2 from 6/29/15 in the afternoon through 7/2/15 in the morning revealed:</p> <ul style="list-style-type: none"> *He came out to the dining room for most meals. *After meals he returned to his room and laid down on his bed. *He remained in bed most of the day and was quiet. *He enjoyed talking about being in the military. *He did not visit with other residents in the dining room. *His clothes oftentimes were soiled with food spills. *His room at times had a urine odor. <p>Interview on 6/1/15 at 11:50 a.m. with resident 2's daughter revealed he:</p> <ul style="list-style-type: none"> *He liked his ethnic food as that was part of his culture and background *He needed more help with grooming and making sure he got to the toilet. -She had told the staff he might be more cooperative with bathing if he had a male caregiver. *His room sometimes had a urine odor in it. *He had recently been to the dentist and needed to have a lot of dental work done. -She was going to take him to those appointments. *He had always been very difficult to talk to; a very quiet man. -Liked to talk about his time in the military and being on a ship. <p>Review of resident 2's weight record revealed:</p> <ul style="list-style-type: none"> *On 3/5/15 he weighed 157.5 pounds (lb). *On 4/2/15 he weighed 140.5 lb. -That was a 17 lb or 10.7% weight loss in one month. 	F 280	<p>Nursing staff has been reeducated on following individualized care plans for residents.</p> <p>Director of Nursing or designee will complete 5 audits weekly x 4 weeks then monthly x 2 months to ensure care plans are accurately reflective of residents needs. This will be completed in conjunction with the MDS schedule. Results will be reviewed at QAPI monthly meetings for further recommendations.</p> <p><i>and will report the results to QAPI monthly, KG/south/JJ</i></p>	

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F 280	<p>Continued From page 51</p> <p>Review of resident 2's June 2015 blood sugar (BS) record revealed: *His BS was below 100 three times. *His BS was between 101-199 thirty-one times. *His BS was between 200-299 forty-one times. *His BS was between 300-399 thirty-four times. *His BS was over 400 six times. *Normal levels from that were 70 to 100.</p> <p>Interview on 6/30/15 at 11:20 a.m. with the dietary services manager (DSM) revealed: *He had a significant weight loss. *They had reviewed him at their monthly weight meeting for a month. -His weight had stabilized now. *They encouraged his family to bring ethnic food for him because he liked that kind of food. *He came out to the dining room very early in the morning and always ate two packets of peanut butter and a cup of hot chocolate. -He then returned to his room. -It was sometimes difficult to get him to come back out. *When he selected his own meals he circled everything on the menu. -When the food came he had four or five glasses of juice and milk plus all the food. -He would not eat very much of any of it. -Their plan was to assist him in ordering a more reasonable meal, so he might eat more. *They had also started him on a daily nutritional supplement drink.</p> <p>Telephone interview with the registered dietitian on 6/30/15 at 4:30 p.m. revealed he confirmed the above interview with the DSM.</p> <p>Review of the nutrition care team meeting</p>	F 280		

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

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F 280	<p>Continued From page 52</p> <p>minutes revealed resident 2's weekly meal intake from 4/20/15 through 5/12/15 was 40% or less.</p> <p>Interview on 6/30/15 at 2:00 p.m. with certified nursing assistant G regarding resident 2 revealed he:</p> <ul style="list-style-type: none"> *Got up at 5:30 a.m. every day and went to the bathroom *Always wore one piece jumpsuits and he had about twenty of them. *Frequently missed the toilet when he went to the bathroom. *Refused to sit down when he went to the toilet, because he did not want to remove the jumpsuit. *If he used the urinal he sometimes spilled it. -That contributed to the urine odor in his room and his falls. *Wanted to be very independent and would not let staff help him. *Loved peanut butter and hot chocolate, and his ethnic food. *Lost his wallet a lot. <p>Review of resident 2's 5/18/15 care plan revealed:</p> <ul style="list-style-type: none"> *It had not addressed: <ul style="list-style-type: none"> -His significant weight loss. -How they ensured a staff person sat with him to select his meals. -The nutritional supplement. -How the provider accommodated his preference for food. -How they assisted him with using the urinal without spilling it. -How they assisted him with toileting. -His high BS. -The preference for a male caregiver. -Any dental concerns. 	F 280		
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F 280	<p>Continued From page 53</p> <p>Surveyor: 26632</p> <p>2. Review of the physician's ordered outpatient wound care therapy orders regarding resident 1 revealed:</p> <p>*On 3/3/15 "Bedrest with no backlying. Pt. [patient] to reposition from side to side in bed Q [every] 1 hr [hour] offloading {taking pressure off} all bony prominences, meals in bed with HOB [head of bed] elevated. HOB to be lowered after meals are finished with placing pt. back on side."</p> <p>*On 5/20/15 "Geomatt {special chair cushion} chair cushion provided 4/22 [4/22/15]. Pt to be laying on her L [left] side with R [right] leg positioned over L; lift R buttock [bottom] for wound visualization/consistency with measurements. Pt. to use Geomatt chair cushion when sitting in w/c [wheelchair] to attend appts [appointments]."</p> <p>*On 5/27/15 "Reposition from side to side every 1-2 hours, NO LAYING ON BACK. Recommend use of elbow protectors bilaterally to maintain skin integrity {no open areas}."</p> <p>*On 6/4/15 the wound vac [vacuum; device for draining a wound] was ordered to be held and wet-to-dry dressings applied daily.</p> <p>Review of resident 1's revised 6/2/15 care plan revealed the following interventions implemented:</p> <p>*3/6/15, She was only to have been positioned on her back for meals then onto her left side. Turn every one and one-half to two hours to her sides only.</p> <p>*3/19/15, Wound vac applied with changes on Monday, Wednesday, and Friday.</p> <p>*4/1/15, Meals in bed with head of bed raised and staff assistance.</p> <p>*Those interventions were related to her stage IV (four) (full thickness tissue loss exposing bone,</p>	F 280		

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F 280	<p>Continued From page 54 tendon, or muscle) sacrum (tailbone area) pressure ulcer.</p> <p>3. Review of resident 9's medical record revealed an undated chemotherapy list for safety precautions during and after chemotherapy. Resident 9 was currently receiving intravenous (through a vein) chemotherapy (cancer medication) daily. She received the chemotherapy through an implanted port (access to a large vein) to her left upper chest.</p> <p>Review of resident 9's 5/20/15 care plan revealed no focus, goals, or interventions related to her chemotherapy, chemotherapy precautions, or the implanted port.</p> <p>4. Review of resident 10's 5/6/15 care plan revealed: *A focus area that she wished to smoke, a goal she would follow the smoking policy, and interventions she would have been safe to smoke. *An undated handwritten addendum to the interventions of "supervised smoking." *A 6/22/15 handwritten addendum "Cigarettes kept @ [at] nurses station/med [medication] room."</p> <p>Review of a 5/4/15 psychosocial history and assessment for resident 10 by the social services designee worker included: *An active smoker and required supervision to smoke for safety as she had failed the smoking assessment. *Due to her history of falls she was deemed (decided) to require supervision.</p> <p>Interview on 7/2/15 at 8:00 a.m. with the</p>	F 280		

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F 280	<p>Continued From page 55</p> <p>registered nurse/Minimum Data Set (MDS) assessment coordinator revealed: *She was aware she had not kept all residents' care plans updated to their current status. *She did not have enough time to keep them all updated and keep up with all of the MDS assessments that were due.</p> <p>Surveyor: 28057 5. Review of resident 8's care plan in use until 6/30/15 and his revised 6/30/15 care plan revealed: *It failed to adequately address his pressure ulcers to prevent further breakdown and worsening of the pressure ulcer on his ischium (area on the bottom where all the weight is when sitting). *It had failed to prevent breakdown to his heels. *Staff had not followed the care plan adequately to ensure breakdown had not occurred or worsened in those areas. Refer to F314, finding 1.</p> <p>Surveyor: 32355 6. Review of resident 3's medical record revealed: *An admission date of 10/31/14. *Diagnoses of total right knee replacement with a history of infection, congestive heart failure (poor heart functioning), pain, dementia (forgetfulness), anxiety (anxiousness), and depression (sadness). *Upon admission he had required extensive to limited assistance of one staff member with transfers, dressing, personal hygiene, eating, and toileting. *He had been at risk for falls.</p>	F 280			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - BLACK HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 NORTH 7TH STREET RAPID CITY, SD 57701
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F 280	<p>Continued From page 56</p> <p>Review of resident 3's 5/13/15 quarterly Minimum Data Set (MDS) assessment revealed: *He had improved and was currently independent with transfers, personal hygiene, eating, and toileting. *He remained at risk for falls.</p> <p>Random observations from 6/29/15 through 7/1/15 of resident 3 revealed: *He had: -Been eating independently after set-up. -Transferred independently from his bed to his wheelchair (w/c) multiple times. -Toileted himself without staff assistance. -Dressed himself without staff assistance. -A scoop mattress on his bed to help prevent falls. *His bed had never been lowered to the floor when he was resting in bed.</p> <p>Interview on 6/30/15 at 2:45 p.m. with resident 3 revealed: *He had rarely asked the staff to assist him with any activities of daily (ADL) tasks. *He had used the scoop mattress since admission to the facility. *He could not recall his bed being lowered to the floor while he had been resting in it.</p> <p>Review of resident 3's undated MDS Kardex report revealed: *It had failed to identify: -The amount of staff support he required to successfully complete his ADL tasks. -The interventions put in place to prevent falls.</p> <p>Review of resident 3's undated care sheet revealed: *He had required one staff member to assist him</p>	F 280		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2015
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F 280	<p>Continued From page 57 with transfers.</p> <p>*For safety: -His bed was to have been lowered to the floor. -Failed to identify the use of a scoop mattress.</p> <p>Review of resident 3's revised care plan of 5/19/15 revealed: *It had failed to identify his independence with transfers, personal hygiene, eating, and toileting. *Failed to adequately support: -The use of a scoop mattress for a fall prevention measure. -His bed was to have been lowered to the floor when he was resting in it.</p> <p>7. Review of resident 4's medical record revealed: *An admission date of 12/7/11. *Diagnoses of Type II diabetes (uncontrollable blood sugar levels), pain, depression, and diabetic ulcers (wounds) to her legs due to poor circulation (blood supply). *Currently had three diabetic ulcers with one on her right calf, one on left great toe, and one on the left heel. *She had been on comfort measures and under the support of hospice care since 3/4/15. *The diabetic ulcer on her left heel had tested positive for methicillin resistant staphylococcus aureus (MRSA) (bacterial infection that is resistant to many antibiotics and highly contagious (easily spread to others) in February 2015. *She had required staff support with transfers, dressing, personal hygiene, and toileting. *She had been at risk for: -Skin breakdown and required the use of prevalon boots (type of pressure relieving) for her legs and feet.</p>	F 280		

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F 280	<p>Continued From page 58</p> <p>-Falls.</p> <p>Random observations from 6/29/15 through 7/2/15 of resident 4 revealed:</p> <ul style="list-style-type: none"> *She had a scoop mattress on her bed. *The bed had not been in the low position when she was resting in it. *She had worn the prevalon boots at all times. *No identifiable precautionary directions for the MRSA infection had been posted on her door or in her room for visitors or staff to follow. <p>Review of resident 4's undated MDS Kardex report revealed:</p> <ul style="list-style-type: none"> *She had skin and ulcer treatments with a "dressing to her feet." *It had failed to identify: <ul style="list-style-type: none"> -How many diabetic ulcers she had and the locations. -Her comfort measures with hospice support and interventions. -The MRSA infection to her left heel and any precautionary interventions that should have been used by the staff when assisting her with dressing changes and ADLs. -Her risk for skin breakdown and the use of the prevalon boots. -The use of a scoop mattress for a preventative fall intervention. <p>Review of resident 4's undated resident care sheet revealed:</p> <ul style="list-style-type: none"> *For safety measures and fall interventions her bed was to have been in the low position. *She was not to have worn the prevalon boots while she was resting in bed. *It had failed to identify: <ul style="list-style-type: none"> -The diabetic ulcers to her left foot and right calf. -The MRSA infection to her left heel and any 	F 280		

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F 280	<p>Continued From page 59 precautionary interventions that should have been used by the staff assisting her. -Her comfort measures with hospice support and interventions for staff to follow. -The use of a scoop mattress as a preventative fall intervention.</p> <p>Review of the provider's 6/29/15 daily stand-up information revealed it had not identified resident 4's MRSA infection to her left heel. And it did not identify any precautionary interventions that should have been followed by the staff.</p> <p>Review of resident 4's revised 6/16/15 care plan revealed: *Failed to adequately support: -The use of a scoop mattress for a fall prevention measure. -That her bed was to have been lowered to the floor when she was resting in it or not. *Failed to identify: -The diabetic ulcers to her left great toe and the right calf. -The MRSA infection in her left heel until 6/23/15. No precautionary interventions had been in place for the staff to follow when assisting her with ADLs or dressing changes. *She was to have worn her prevalon boots at all times. That had been a conflict from the directions provided on the resident care sheet.</p> <p>8. Review of resident 5's medical record revealed: *An admission date of 2/18/13. *Diagnoses of dementia (forgetfulness), seizures (uncontrollable body movements), depression, congestive heart failure (poor heart function), and Type II diabetes. *She had recently been hospitalized on 6/4/15 for</p>	F 280		

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F 280	<p>Continued From page 60</p> <p>fluid overload (retaining of fluid in the body). *When she had returned from the hospital on 6/5/15 she had been placed on a 1200 cubic centimeter (cc; type of measurement) fluid restriction per day.</p> <p>Random observations from 6/29/15 through 7/1/15 of resident 5 revealed: *She had been provided with three 6 ounce (oz) glasses of fluids to drink at all meals. *She had an 8 oz glass of fluid in her room to drink at all times.</p> <p>Interview on 6/30/15 at 3:45 p.m. with the dietary manager regarding resident 5 revealed: *She had confirmed the resident had been on a 1200 cc fluid restriction per day. *She should have had one 8 oz glass of fluid for all meals. *They would have given her more than 8 oz of fluid with a meal if she had requested more. *When residents were on a fluid restriction she would have provided the staff with the amount they were to have at meals only. *The nursing staff were to have determined and recorded the amount of fluids the resident should have in their rooms and with medication administration. *She would not have monitored the daily intake of fluids for any resident on a fluid restriction.</p> <p>Review of resident 5's undated MDS Kardex report revealed: *Under fluid management it had failed to identify: -That she had a fluid restriction of 1200 cc per day. -The breakdown on the amount of fluids she was to have received for meals, in her room, and during medication administration.</p>	F 280			

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F 280	<p>Continued From page 61</p> <p>Review of resident 5's undated resident care sheet revealed: *Under nutritional needs it had failed to identify: -That she had a fluid restriction of 1200 cc per day. -The breakdown on the amount of fluids she was to have received for meals, in her room, and during medication administration.</p> <p>Review of the provider's 6/29/15 daily stand-up information regarding resident 5 revealed: *She had a fluid restriction of 1200 cc per day. *The fluid restriction had failed to identify the breakdown on the amount of fluids she was to have received for meals, in her room, and during medication administration.</p> <p>Review of resident 5's revised care plan of 6/5/15 revealed: *She had a fluid restriction of 1200 cc per day. *It had not identified the amount of fluids she was to have received for meals, in her room, and during medication administration.</p> <p>Interview on 6/30/15 at 4:00 p.m. with the DON revealed: *She had confirmed resident 5 had been on a fluid 1200 cc fluid restriction per day. *The nursing staff would have informed the dietary department when a resident had physician's orders for a fluid restriction. *The nursing staff would have followed the fluid breakdown for meals and medication pass provided by the dietary department. *There should not have been any fluids provided in the resident's room when on a fluid restriction. *Each nursing staff member was to have recorded the amount of fluids she had consumed</p>	F 280		

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F 280	<p>Continued From page 62 during their shift.</p> <p>*She had not been aware the fluid restriction breakdown for resident 5 during meals, in her room, and medication pass had not been provided for the staff to follow.</p> <p>*All of the documents reviewed above should have provided the necessary daily fluid breakdown for all of the residents on a fluid restriction.</p> <p>Review of the provider's undated Fluid Restriction policy revealed:</p> <p>**All fluid restrictions are ordered by the physician."</p> <p>**Responsibility for fluid allotment is divided between the dining services and nursing departments."</p> <p>*There was an example for specific breakdown and designation:</p> <p>-"Physician's order."</p> <p>-"Nursing medication pass."</p> <p>-"Breakfast."</p> <p>-"Lunch."</p> <p>-"Supper."</p> <p>*Documentation "Total cc designations, as ordered by the physician and amount supplied by the dining services department, should be clearly documented on the patient's tray card, and the dining services progress notes in the patient's chart, as well as in the interdisciplinary care plan."</p> <p>9. Review of resident 11's medical record revealed:</p> <p>*An admission date of 10/22/14.</p> <p>*Diagnoses of Type II diabetes, chronic kidney disease with dialysis (removal of wastes in the blood and the extra fluid retained by the body) three times a week, and depression.</p> <p>*She had been placed on a 1800 cc fluid</p>	F 280		

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F 280	<p>Continued From page 63 restriction per day.</p> <p>Random observations on 7/1/15 and 7/2/15 of resident 11 revealed: *She had been in her room. *On her bedside table there had been a mug of water. The mug had marks on it indicating there was approximately 400 cc of fluids in the mug.</p> <p>Interview on 7/1/15 at 3:15 p.m. with resident 11 revealed: *She had been aware of her 1800 cc fluid restriction. *She would have received two mugs of water everyday.</p> <p>Observation and interview on 7/1/15 at 3:20 p.m. with certified nursing assistant (CNA) I revealed: *She had been: -Passing fresh water to all of the residents' rooms. -Able to identify that residents 5 and 11 had been on a fluid restriction. -Unsure how much fluid the two residents should have received in their room. *The CNAs had documented the residents' fluid intake for meals. *She was unsure who documented the amount of fluid the residents would have consumed in their rooms.</p> <p>*Review of resident 11's undated resident care sheet revealed: *Under nutritional needs it had failed to identify: -That she had a fluid restriction of 1800 cc per day. -The breakdown on the amount of fluids she was to have received for meals, in her room, and during medication administration.</p>	F 280		

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F 280	Continued From page 64 Review of the provider's 6/29/15 daily stand-up information revealed: *She had a fluid restriction of 1800 cc per day. *The fluid restriction had failed to identify the breakdown on the amount of fluids she was to have received for meals, in her room, and during medication administration. Review of resident 11's 5/6/15 revised care plan revealed: *The staff were to have followed her diet and fluid restrictions as ordered. *It had not identified: -The total amount of fluids she was to have received per day. -The amount and breakdown of fluids she was to have received for meals, in her room, and during medication administration. 10. Interview on 6/30/15 at 5:10 p.m. with the MDS coordinator and the infection control nurse revealed: *They confirmed there had been several sheets and forms for the staff to review, use, and guide them when taking care of the residents. *The MDS Kardex would have been filled out upon admission of the resident. It would not have been updated thereafter. The staff were to have used it for a quick reference guide. *The care sheets were used by the staff daily to guide them with the care they provided for the residents. Their goal was to update them every two weeks, but that had not always occurred. There had not been any specific staff assigned for the updating of those sheets. *The daily stand-up form was used by the staff. *All of the staff had been responsible for the updating and revising of the care plans. There	F 280			

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F 280	<p>Continued From page 65</p> <p>had not been a person assigned to oversee that process. They had been reviewed and revised every quarter and as needed with the resident's care conference.</p> <p>*They had agreed:</p> <ul style="list-style-type: none"> -Not all of the above information reviewed for the above residents had been revised and updated appropriately and accurately. -Their process for providing information to the staff on the necessary care for all the residents should be re-assessed. <p>Interview on 6/30/15 at 5:30 p.m. with the DON revealed:</p> <ul style="list-style-type: none"> *She confirmed there had been too many forms and sheets for the staff to help guide them with resident care. *She agreed there were many conflicts and discrepancies with all of the above forms and sheets reviewed for each resident. *She agreed their process for guiding the staff with the appropriate care they needed to provide for the residents had been confusing and required a change. *It had been a part of the MDS coordinator's job to ensure the care plans had been accurate, reviewed, and revised by all the departments. <p>Review of the provider's unsigned and undated RN Assessment Coordinator job description revealed:</p> <ul style="list-style-type: none"> **"Accurate and thorough completion of the MDS, care area assessments, and care plans, in accordance with current federal and state regulations and guidelines that govern the process." **"Acts as an in-house case manager demonstrating detailed knowledge of residents health status, critical thinking skills to develop an 	F 280		

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F 280	Continued From page 66 appropriate care pathway and timely communication of needed information to the resident, family, other health care professionals and third party payers." Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, p. 257, revealed "After reassessing a patient, review the care plan and compare assessment date to validate the nursing diagnoses and determine whether the nursing interventions remain the most appropriate for the clinical situation. If a patient's status has changed and the nursing diagnosis and related nursing interventions are no longer appropriate, modify the nursing care plan. An out-of-date or incorrect care plan compromises the quality of nursing care."	F 280			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, professional standard review, and policy review, the provider failed to ensure physician orders for notification of physician for: *Withholding of insulin for one of one sampled resident (2) without a physician order. *Wound care for one of two sampled residents (1) with a pressure ulcer. Findings include: 1. Review of resident 2's nurses progress notes	F 281	F281D Meet professional standards of quality Resident # 2 physician has reviewed current insulin orders and glucose readings. *Refer to F157. *7/31/15 KG/500MH/JJ KG/500MH/JJ Resident #1 physician has reviewed current orders related to skin integrity Residents residing in the facility have the potential to be affected in a similar manner.		

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F 281	<p>Continued From page 67</p> <p>revealed: *On 4/20/15, "BS [blood sugar] low 149 before dinner and held insulin Novolog [medication to control BS for diabetics] until after supper." -There was no documentation the physician had been notified. *6/12/15, "Resident BL [blood sugar level] running low. 125 after hs [hour of sleep] snack. I am holding Lantus [a medication to control BS for diabetics] this evening." -There was no documentation the physician had been notified.</p> <p>Review of resident 2's physician's orders and Medication Administration Record (MAR) revealed: *For the Lantus insulin, "Call MD [medical doctor] if blood sugar is greater than 500." *For the NovoLog insulin, "Call MD if blood sugar is greater than 500." *There were no orders to hold the insulin when it was low.</p> <p>Interview on 6/30/15 at 11:10 a.m. with the director of nurses (DON) regarding resident 2 revealed: *Based on professional standards she thought the insulin should have been given if his BS was above 100. *She was unsure why a nurse would hold the insulin when the resident's BS was 149. -She could not speak for the nurses that had made the decision to hold the insulin without notifying the MD. -Sometimes it was a nurse's judgment and that might have been why the nurse had withheld it.</p> <p>Review of the provider's May 2012 Medication Administration - Preparation and General</p>	F 281	<p>Licensed nursing staff have been re-educated on the Golden Living Policy 'Notification of Change in Resident Health Status' and following physician orders</p> <p>Director of Nursing or designee will complete 5 random audits weekly x 4 weeks then monthly x 2 months to ensure physician and responsible party notification has been completed when a resident experienced a condition change. Results will be reviewed at monthly QAPI meetings for further recommendations.</p> <p><i>and/or skin breakdown. KG/SPDH/JT</i></p>	

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F 281	<p>Continued From page 68</p> <p>Guidelines policy revealed: *"If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnoses or condition, the nurse calls the provider pharmacy for clarification prior to the administration of the medication or if necessary contacts the prescriber for clarification." *"If a dose of regularly scheduled medication is withheld, refused, not available or given at a time other than the scheduled time the space provided on the front of the MAR for that dosage administration is initialed and circled. -If two consecutive doses of a vital medication are withheld, refused or not available the physician is notified."</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, p. 306, revealed "Nurses follow health care provider's orders unless they believe the orders are in error or harm patients."</p> <p>Surveyor: 26632 2. Review of the physician's ordered outpatient wound care therapy orders regarding resident 1 revealed: *On 3/3/15 "Bedrest with no backlying. Pt. [patient] to reposition from side to side in bed Q [every] 1 hr [hour] offloading {taking pressure off} all bony prominences, meals in bed with HOB [head of bed] elevated. HOB to be lowered after meals are finished with placing pt. back on side." *On 5/20/15 "Geomatt {special chair cushion} chair cushion provided 4/22 [4/22/15]. Pt to be laying on her L [left] side with R [right] leg positioned over L; lift R buttock [bottom] for wound visualization/consistency with</p>	F 281			

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F 281	Continued From page 69 measurements. Pt. to use Geomatt chair cushion when sitting in w/c [wheelchair] to attend appts [appointments]." *On 5/27/15 "Reposition from side to side every 1-2 hours, NO LAYING ON BACK. Recommend use of elbow protectors bilaterally to maintain skin integrity {no open areas}." *On 6/4/15 the wound vac [vacuum; device for draining a wound} was ordered to be held and wet-to-dry dressings applied daily. Review of resident 1's revised 6/2/15 care plan revealed interventions implemented on: *3/6/15. She was only to have been positioned on her back for meals then left side. Turn every one and one-half to two hours to her sides only. *3/19/15. Wound vac applied with changes on Monday, Wednesday, and Friday. *4/1/15. Meals in bed with head of bed raised and staff assistance. *These interventions were related to her stage four (full thickness tissue loss with exposed bone, tendon, or muscle) sacrum pressure ulcer. Interview on 6/30/15 at 10:45 a.m. with licensed practical nurse and wound care nurse P revealed: *She was not aware of the positioning for resident 1 during dressing changes. *She was not aware of using a Geomatt cushion in her wheelchair. Resident 1 had a gel cushion that was used. Interview on 7/2/15 at 7:45 a.m. with the DON confirmed the above orders had not been followed.	F 281		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		

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F 314	<p>Continued From page 70</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on record review, interview, and policy review, the provider failed to ensure two of three residents (1 and 8) with pressure ulcers (injury to skin usually from pressure and frequently over a boney area) had received effective preventative care to ensure pressure ulcers had not occurred and/or worsened while a resident in the facility. Findings include:</p> <p>1. Review of resident 8's June 2015 treatment administration record (TAR) revealed: *A right ischial (area on the bottom where all the weight is when sitting) wound that was to have been cleansed, ointment applied, and a dressing applied every day and evening. *It had not been described as a pressure ulcer. *Prevalon (special padded boots) boots were to have been on when the resident was in bed every shift. *It had not stated why the boots were to have been worn.</p> <p>Review of resident 8's nursing progress notes from 12/22/15 through 6/30/15 revealed: *On 12/1/14 in the weekly wound documentation</p>	F 314	<p>F 314G Treatment/Services to prevent/heal pressure sores</p> <p>Resident #1 and #8 have had a comprehensive skin assessment completed to identify any skin concerns. Physician and responsible parties have been notified of any skin concerns identified. Physician orders have been obtained and are being followed. Care plan has been reviewed and revised to reflect resident's current status.</p> <p>Residents residing in the facility at high risk for pressure ulcers have the potential to be affected in a similar manner.</p> <p>Residents residing in the facility at high risk for pressure ulcers have had a comprehensive skin assessment completed to identify any skin concerns. Physician and responsible parties have been notified of any skin concerns identified. Physician orders have been obtained and are being followed. GLC – Black Hills skin integrity guidelines are in place.</p> <p>The Director of Nursing, Medical Director and Interdisciplinary team has reviewed the Golden Living Center Skin integrity guideline.</p> <p><i>* 7/31/15 KG/SOAH/JSS</i></p>	

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F 314	<p>Continued From page 71</p> <p>the resident had:</p> <ul style="list-style-type: none"> -A wound on his right ischial that measured 1.0 centimeters (cm) by 1.0 cm by less than 0.1 cm. -No drainage, odor, pain, or signs of infection were noted. -The tissue was described as epithelial tissue (tissue that covers an area) . -The wound bed had been dry and pink. -A deep tissue injury identified to his right outer heel. -An area on his left heel was measured and described as "the appearance of a donut with a dry pink to white center and 50% of dark smooth coloration to the skin tissue." -Both heels had no drainage, odor, pain, or signs of infection noted. *On 12/22/15 the wound care nurse documented the right ischial wound was healed. *On 1/2/15 in the Minimum Data Set (MDS) assessment for 12/31/14 revealed the resident had deep tissue injuries to both of his heels. -It had not addressed how it had occurred. -It had not addressed any concerns with his ischial area. -Interventions listed were a redistribution mattress for the resident's bed and a cushion in his wheelchair. -Heel protectors were to be used while he had been in bed. *On 1/5/15 the wound care nurse documented there were no concerns with the resident's right heel. -The left heel deep tissue injury had been intact (no open area) and dark in color. *On 1/19/15 the wound care nurse documented the left heel deep tissue injury was clear from signs of breakdown or irritation. -The resident was to have worn Prevalon heel boots when in bed. 	F 314	<p>Nursing staff have been reeducated on the Skin integrity guideline.</p> <p>Director of Nursing or designee will complete 5 random audits weekly x 4 weeks then monthly x 2 months to ensure compliance the skin integrity guideline. Results will be reviewed at QAPI meetings monthly for further recommendations.</p> <p><i>including observations that interventions are instituted and followed as care planned to prevent breakdown and promote healing. Residents 1 and 8 will be included in those audits. KG/SOD/H/JJ</i></p> <p><i>The DON will report the audit results to QAPI monthly. KG/SOD/H/JJ</i></p>	

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F 314	<p>Continued From page 72</p> <p>*On 1/26/15 the wound care nurse documented the resident had a "stage 2 (partial loss of the top skin layers without slough [dead, off-colored skin] or a serum filled blister) on residents right ischial." -(This would be a re-occurrence of the one healed on 12/22/15, the previous month) -It had measured 3.0 [no unit of measurement noted] by 1.6 by less than 0.1 cm. -The wound was red and moist. -A dressing was applied to the area. -The resident was positioned on his right side between meals. -He had a cushion [not specified what kind] in his wheelchair.</p> <p>*On 2/16/15 the wound care nurse documented the resident continued to have a "stage two on resident right ischial". -It had measured 1.0 cm by 0.5 cm by less than 0.1 cm. -He had a cushion [not specified what kind] in his wheelchair. -Wore Prevalon boots when in bed.</p> <p>*On 3/16/15 the wound care nurse documented the stage two on his right ischial had measured 0.4 cm by 0.7 cm by 0.1 cm. -The wound bed had been red and moist.</p> <p>*On 3/23/15 the wound care nurse had documented the stage 2 on his right ischial had measured 1.7 by 0.8 by less than 0.1 cm. (This was larger than on 2/16/15.)</p> <p>*On 4/13/15 the wound care nurse documented the resident had an unstageable (unable to determine how deep the open area was) area on his right ischial area. -It had measured 0.5 cm by 0.4 cm by 0.1 cm. -It had been 90 percent dark smooth tissue.</p> <p>*On 4/20/15 the wound care nurse had documented the resident's area on his right ischial had gotten larger.</p>	F 314		
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F 314	<p>Continued From page 73</p> <p>-It had measured 1.4 cm by 1.2 cm by 0.1 cm. -Ten percent of the wound had been slough. -The previous red area had broken down and had added to the size of the wound. *On 4/27/15 the area on his right ischial had improved from last week. -It then measured 0.8 cm by 0.5 cm by less than 0.1 cm. *On 6/2/15 the wound care nurse documented the ischial area was a stage 2 and measured 0.6 cm by 0.5 cm by 0.1 cm. -The wound bed had been 40 percent yellow slough. *On 6/16/15 the weekly wound assessment measurements for the right ischial had been 0.3 cm by 0.5 cm by 0.1 cm. -The wound bed was 100 percent slough. *On 6/23/15 the wound care nurse documented the resident had a stage 2 on his ischial area. -It had measured 0.7 by 0.5 by 0.1 cm (an increase from the week before). -The wound bed had been 80 percent yellow slough. *On 6/25/15 the MDS assessment for the 6/23/15 time period revealed a stage 2 pressure ulcer on his right ischium. *On 6/30/15 the wound care nurse documented the resident had a stage 2 pressure ulcer to his right ischium. -It had measured 1.1 cm by 0.7 cm by 0.1 cm. (an increase from the week before). -It had 40 percent white to light yellow slough present. -He was to have a pressure relieving cushion in his wheelchair. *He was to have worn Prevalon boots at all times.</p> <p>Review of the resident's care plan that was in use from 7/2/14 until 6/30/15 revealed:</p>	F 314			

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F 314	<p>Continued From page 74</p> <p>*He had a focus of "At risk for skin breakdown related to mobility deficit [difficulty moving] and incontinence [loss of bladder and/or bowel control].</p> <p>**Resident has stage 2 to right ischial bone."</p> <p>*The goals had been:</p> <p>- "Resident will have no further skin breakdown."</p> <p>- "Stage 2 will heal."</p> <p>*Some of the interventions had been:</p> <p>- "Pressure redistribution w/c [wheelchair] cushion and pressure redistribution mattress."</p> <p>*A focus area of deep tissue injury noted to each heel.</p> <p>*The goals had been to heal those.</p> <p>*On 11/26/14 the interventions had been Prevalon boots and a foam foot board over the wheelchair pedals for protection.</p> <p>- It had not stated when the boots were to be on.</p> <p>*On 12/1/14 it was added the Prevalon boots were to be on while in bed.</p> <p>Review of the resident's care plan that was instituted on 6/30/15 revealed:</p> <p>*He still had as a focus of a "stage 2 to his right ischial bone."</p> <p>*He was to have no further skin breakdown for a goal through 9/23/15.</p> <p>- "Stage 2 will heal."</p> <p>*Interventions had included a pressure redistribution w/c cushion and mattress.</p> <p>*The Prevalon boots were no longer on the care plan for prevention of breakdown to the resident's heels.</p> <p>*The foam board was no longer included to be used on the w/c pedals.</p> <p>Interview on 6/30/15 at 4:35 p.m. with the MDS nurse confirmed she had missed putting the Prevalon boots on the new care plan.</p>	F 314		

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F 314	<p>Continued From page 75</p> <p>Observation on 6/30/15 from 12:45 p.m. through 2:30 p.m. revealed: *Resident 8 was transferred to his bed from his wheelchair at 12:45 p.m. by certified nursing assistant (CNA) G. *His Prevalon boots were not put on his feet to protect his heels. *At 2:30 p.m. CNA H had assisted with a dressing change with registered nurse (RN) M for resident 8. *He was in bed at that time. *He still did not have his Prevalon boots on his feet for heel protection. *RN M and CNA H had not placed them on his feet before they had left his room. *His heels had been unprotected for one hour and forty-five minutes.</p> <p>Interview on 6/30/15 at 4:25 p.m. with CNA H confirmed he had forgotten to put the Prevalon boots on resident 8 before he had left the room. He agreed they should have been on the resident for protection.</p> <p>Observation and interview with the physical therapist aide (PTA) J on 6/30/15 at 4:25 p.m. revealed: *Resident 8's wheelchair had a cushion in the seat. *Upon inspection by PTA J she confirmed it had not been a pressure relieving cushion. *It had not been the correct cushion for resident 8 and would not help prevent breakdown or healing of a pressure ulcer. *She had not known what had happened to the cushion that was to have been in his wheelchair or when it had been removed. *She stated it could have happened when his</p>	F 314			

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F 314	<p>Continued From page 76</p> <p>wheelchair had been washed but she had not known for sure.</p> <p>Observation and interview on 7/1/15 at 8:03 a.m. with the director of nursing (DON) confirmed the cushion on resident 8's w/c pedals was not thick enough to be effective in preventing pressure to the resident's heels. The w/c pedals were sharp and easily felt through the pad.</p> <p>Interview on 7/1/15 with the DON confirmed staff used the 2007 Pressure Ulcer Staging Guide to stage a pressure ulcer. She further stated training was provided yearly to the nursing staff for documentation of pressure ulcers/skin concerns by the centralized training nurse for all of the Golden Living Centers in Rapid City. Review of that material revealed it had not addressed how to stage a pressure ulcer. It had contained a wound evaluation flow sheet, a risk identification/prevention sheet, and the revised 2013 Skin Integrity Guidelines. A sign in sheet to identify who had attended the training and what date it had been held was requested from the DON and the administrator on 7/1/15 and again on 7/2/15 at 8:03 a.m. It had not been received by the survey exit on 7/2/15 at 2:05 p.m. Thus it was unknown who had attended that training.</p> <p>Review of the provider's 2007 Pressure Ulcer Staging Guide for an unstageable pressure ulcer revealed:</p> <p>*It was a full thickness tissue loss.</p> <p>*The base of the ulcer was covered by yellow, tan, grey, green, or brown slough.</p> <p>*Until enough eschar [dark, dead tissue] was removed to expose the base of the wound the true depth could not be determined.</p> <p>*If the depth could not be determined it can not</p>	F 314			

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F 314	<p>Continued From page 77 be staged.</p> <p>Review of the provider's revised 2013 Skin Integrity Guidelines revealed: *The interdisciplinary plan of care would address problems, goals, and interventions to prevent pressure ulcers. *Pressure reducing cushions would be used in wheelchairs of residents who used it as a primary mode of transportation. *Weekly skin evaluation and observations were to determine if care plans were consistently implemented, evaluated, and revised to meet the resident's needs.</p> <p>Review of the provider's RN assesment coordinator job description revealed the essential job duties for that position had been accurate and thorough completion of the MDS, Care Area Assessments, and the Care Plans.</p> <p>Surveyor: 26632 2. Review of resident 1's medical record revealed: *She had been admitted on 4/16/14 from the hospital. *She had a stage three (subcutaneous fat may be visible, slough may be present) pressure ulcer to her coccyx (tailbone). *That pressure ulcer had closed on 5/19/14. *On 12/28/14 a stage two (partial thickness loss of tissue, a shallow open wound with a red pink wound bed) pressure ulcer had been noted. *That stage 2 pressure ulcer measured 4.0 centimeters (cm) in length, 2.0 cm in width, and less than 0.1 cm in depth to the top of her sacrum (upper tailbone). No drainage had been noted. *Her Braden pressure ulcer development risk assessments on:</p>	F 314		

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F 314	<p>Continued From page 78</p> <p>-12/10/14 was 12 that indicated high risk for developing a pressure ulcer.</p> <p>-1/22/15 and 2/25/15 was 11 that indicated high risk.</p> <p>-5/26/15 was 9 that indicated severe risk.</p> <p>Continued review of the documentation of the sacrum pressure ulcer revealed measurements and condition of the pressure ulcer included:</p> <p>*1/5/15, Stage two 2.9 cm length, 0.4 cm width, and less than 0.1 cm in depth with no drainage. Mepilex border dressing (type of absorbent soft silicone dressing).</p> <p>*1/12/15, Stage two 0.5 cm length, 0.1 cm width, and less than 0.1 cm in depth with no drainage. Mepilex border dressing.</p> <p>*No measurements noted for the week of 1/19/15.</p> <p>*1/26/15, Stage two 1.2 cm length, 0.5 cm width, and less than 0.1 cm in depth with no drainage. Mepilex border dressing.</p> <p>*2/2/15, Unstageable (slough [yellow, tan, gray, green, or brown tissue] that covers the base of the ulcer) 1.3 cm length, 1.0 cm width, and less than 0.1 cm in depth with no drainage but 100 percent (%) slough described as "black moist." Mepilex border dressing.</p> <p>*No measurements noted for the week of 2/9/15.</p> <p>*2/16/15, Stage two 3.5 cm length, 3.0 cm width, 1.3 cm depth and tunneling (open area underneath edges of wound) noted. Brown, thin, large amount of drainage. 100% odorous black, green, and gray slough. Complaints of pain. Mepilex border dressing with Santyl (removes dead tissue) ointment. Physical therapy doing E-Stim (electrical stimulation of tissue for healing) and debridement (removing dead tissue).</p> <p>*2/23/15, No stage noted. 3.5 cm length, 3.0 cm width and no depth on form. Brown, thin, large</p>	F 314			

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F 314	Continued From page 79 amount of drainage. Slough present with no description or amount. Turning schedule initiated and to be kept up minimal amount of time for meals. *3/3/15, Staging and measurements with new treatment orders by outpatient wound care (OPWC). Was being seen by OPWC. Unstageable sacral ulceration. 3.0 cm length, 0.7 cm width, and 2.0 cm depth. Undermining (open area under edges of wound) present. *3/12/15, Unstageable sacral ulceration. 3.0 cm length, 0.8 cm width, and 2.0 cm depth. Undermining present. Was seen by OPWC. *3/19/15, Unstageable sacral ulceration. 3.0 cm length, 2.7 cm width, and 1.7 cm depth. Undermining present. Negative pressure wound treatment initiated. Was seen by OPWC. *3/25/15, Did not go to outpatient wound care. *4/2/15 Unstageable sacral ulceration. 2.5 cm length, 0.1 cm width, and 2.9 cm depth. No undermining present. Negative pressure wound treatment continued. Was seen by OPWC. *4/15/15, Unstageable sacral ulceration. 2.0 cm length, 2.0 cm width, and 1.9 cm depth. No undermining present. Negative pressure wound treatment continued. Was seen by OPWC. *4/20/15, Stage four sacral pressure ulcer. 2.2 cm length, 1.4 cm width, and 1.7 cm depth. Undermining present. Measured by provider wound care nurse. *4/26/15, Stage four sacral pressure ulcer. 2.3 cm length, 1.8 cm width, and 1.5 cm depth. Undermining present. Measured by provider wound care nurse. *5/4/15 Stage four sacral pressure ulcer. 2.0 cm length, 1.6 cm width, and 2.2 cm depth. Undermining present. Measured by provider wound care nurse. *5/11/15, Stage four sacral pressure ulcer. 1.9 cm	F 314			

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F 314	<p>Continued From page 80</p> <p>length, 1.4 cm width, and 1.1 cm depth. Undermining present. Measured by provider wound care nurse.</p> <p>*5/20/15, Unstageable sacral ulceration. 1.9 cm length, 1.3 cm width, and 2.0 cm depth. Undermining present. Negative pressure wound treatment continues. Was seen by OPWC.</p> <p>*6/4/15, Unstageable sacral ulceration. 1.5 cm length, 1.5 cm width, and 2.0 cm depth. Undermining present. Negative pressure wound treatment discontinued due to insufficient decrease in measurement and development of a blister to the edge of the wound. Was seen by OPWC.</p> <p>*6/11/15, Unstageable sacral ulceration. 1.3 cm length, 1.3 cm width, and 2.3 cm depth. Undermining present. Was seen by OPWC.</p> <p>*6/16/15, Stage four sacral pressure ulcer. 1.0 cm length, 0.6 cm width, and 1.7 cm depth. Undermining present. Measured by provider wound care nurse.</p> <p>*6/23/15, Stage four sacral pressure ulcer. 1.2 cm length, 0.8 cm width, and 0.8 cm depth. Undermining present. Measured by provider wound care nurse.</p> <p>Review of resident 1's interdisciplinary progress notes revealed on:</p> <p>*12/12/14 Her skin was intact (no open areas).</p> <p>*2/15/15 "Resident stage II [two] pressure sore of her sacrum is getting worse and it has a really bad smell. Fax _____ [physician name] if we can order a wound culture."</p> <p>*2/16/15 "Resident does C/O [complain of] pain at site, mostly at edges. Staff educated on proper turning techniques and to keep resident off her bottom as much as possible."</p> <p>Observation of the dressing change for resident 1</p>	F 314		

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F 314	<p>Continued From page 81</p> <p>on 6/30/15 at 10:20 a.m. with licensed practical nurse/wound care nurse P revealed measurements of 1.2 cm in length from top to bottom, 0.6 cm in width from left to right, 1.1 cm in depth, and undermining present that at the deepest measured 2.2 cm. Refer to F281, finding 2.</p> <p>Review of the weekly head-to-toe skin checks from 7/1/14 through 1/31/15 revealed: *Two weeks had no documentation a skin check had been completed in July 2014. *Two weeks had no documentation a skin check had been completed in September 2014. *The entire month of October 2014 had no documentation a skin check had been completed. *One week had no documentation a skin check had been completed in November 2014. *One week had no documentation a skin check had been completed in December 2014.</p> <p>Interview on 7/2/15 at 7:45 a.m. with the director of nursing (DON) revealed she: *Was aware resident 1 had developed a pressure ulcer, had acquired an infection of that pressure ulcer, and was on continuous bedrest to assist with healing the pressure ulcer. *Thought the admitted pressure ulcer from 4/16/14 had not totally healed, and there had been undermining that eventually surfaced. *Had not realized the OPWC orders had not been followed. *Had initiated documentation of the turning and repositioning schedule for resident 1 on 6/24/15. *Had initiated that turning schedule, so resident 1 was positioned on her right when she ate her meals.</p> <p>3. Review of the provider's undated Skin Integrity</p>	F 314			

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F 314	<p>Continued From page 82</p> <p>Guideline policy included:</p> <ul style="list-style-type: none"> *To promote healing of wounds of any type whether there when admitted or acquired after admission. *A routine schedule was to be developed to review residents with wounds or at risk for developing wounds on a weekly basis and document those findings. *The DON or designee would be responsible to implement and monitor the skin integrity program. *The interdisciplinary plan of care would address problems, goals, and interventions directed toward the prevention of pressure ulcers and/or identified skin integrity concerns. *If there was a decline in skin integrity pressure redistribution surfaces would be reviewed for appropriateness. *Reposition every two hours or as needed and tolerated. Indicate frequency in the plan of care. *Treatment protocols included: <ul style="list-style-type: none"> -For stage two pressure ulcers use of dressings included: non-adherent composite dressings and foam dressings. -For stage three pressure ulcers use of dressings included: those indicated for stage two pressure ulcers and negative pressure wound therapy. -For stage four pressure ulcers use of dressing included: both those indicated for stage two and three pressure ulcers. <p>Review of the provider's 2007 Pressure Ulcer Staging Guide revealed:</p> <ul style="list-style-type: none"> *An unstageable pressure ulcer was a full thickness tissue loss. *The base of the ulcer was covered by yellow, tan, gray, green, or brown slough. *Until enough eschar was removed to expose the base of the wound the true depth could not be determined. 	F 314			

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F 314	Continued From page 83 *If the depth could not be determined it could not be staged. Review of the provider's 2008 Wound Bed Interventions Guideline to decrease the incidence of infection interventions included: *Effective wound cleansing to remove debris. *Topical antiseptics such as Dakin's solution. *Oral antibiotics used only if the infection extends beyond the ulcer margin.	F 314		
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Surveyor: 26632 Based on record review, guideline review, interview, and job description review, the provider failed to ensure one of six sampled residents (10) with behaviors, mental, and psychosocial needs had been met. Findings include: 1. Observation and interview on 7/2/15 at 10:00 a.m. with resident 10 revealed: *"Everything had gone pretty good here until recently." "She got mad a little while back and was upset, because her brother-in-law had died. So you know how that can stress you out?" *She used to be able to go outside and have a	F 319	F319 D Treatment/Service for mental/psychosocial difficulties Resident #10 psychosocial history has been reviewed and revised Residents residing in the facility with psychosocial concerns have the potential to be affected in a similar manner. * Residents with psychosocial concerns will be reviewed and care plans revised as indicated, [redacted] to ensure resident's psychosocial needs are being met by the Social Service Director with the Social Service Consultant. Social Service Director has been re-educated on care plan development to meet residents' psychosocial needs. within the next 30 days	* 7/31/15 K&S/sooH/JJ

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F 319	<p>Continued From page 84</p> <p>cigarette. Now she needed a supervisor with her if she wanted to go out and have a cigarette. That was new.</p> <p>*She just wanted to go out and talk with people the way she used to.</p> <p>*She was stressed and could not get a supervisor to go out with her. She got angry. "Talk about acting like a 10 year old. I was real angry."</p> <p>-So she went out and was in the parking lot, then when she had to come back in she got so mad she pulled the fire alarm.</p> <p>*"That was when they stuck me. They gave me a shot and told me it was to make me sleep. I don't take meds [medications] that I don't know what they are for.</p> <p>-They did that to me four or five times. It didn't make me sleep. It made me angry.</p> <p>-They should put a picture of a dog on my door that says "Beware of Dog". That is how I feel."</p> <p>*She thought a couple of the nurses were "bull dogs". They were the ones that gave her the shots. "They said I was combative. I was not combative."</p> <p>*Now they wanted her to move to another facility "because I am combative."</p> <p>*She relayed that one certified nursing assistant (CNA) who was holding her when they gave her the shot, the resident used her long fingernails to get the CNA and pointed to her neck were she had "gotten" the CNA.</p> <p>*A new resident had come in on 7/1/15, and that resident also smoked. When the staff saw her warning this new resident about not being able to smoke they moved resident 10 to a different table away from the new resident.</p> <p>Refer to F222, finding 1.</p> <p>Review of a 5/4/15 psychosocial history and assessment for resident 10 by the social services</p>	F 319	<p>Director of Nursing or designee will complete 5 random audits weekly x 4 weeks then monthly x 2 months to ensure residents with psychosocial needs have been met. Results will be reviewed at monthly QAPI meetings for further recommendations.</p> <p><i>of the residents care planned Psychosocial needs and social services director documentation for accuracy</i> KG/SOPH/JJ</p>		

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F 319	<p>Continued From page 85</p> <p>(SS) worker revealed:</p> <ul style="list-style-type: none"> *A history of depression and anxiety. *An active smoker and required supervision to smoke for safety as she had failed the smoking assessment. Due to her history of falls she required supervision. *Was alert and oriented to person, place, time, and self. She was limited regarding safety awareness. *Was able to make herself known and was able to understand others well. *"Was pretty upbeat and usually did not trigger for any mood indicators." *Would have rather lived on her own, but understood she was not able to do that due to her medical limitations. <p>Review of the provider's 12/1/14 Admission Guidelines for Smoking revealed:</p> <ul style="list-style-type: none"> *Should the resident choose to smoke they would have to be assessed for safety. *If they were determined to have been independent to smoke they could do so outside. *If they did not pass the assessment then arrangements could be made with family to come up and assist resident. <p>Interview of 7/1/15 at 4:30 p.m. with the SSD revealed resident 10 had not passed the smoking assessment to have been able to smoke unsupervised. She agreed staff had been supervising resident 10 when she smoked. She had not thought that resident 10's behaviors had been related to her not being able to smoke. She had thought resident 10's behaviors were only related to dementia. Resident 10 did not have a physician's diagnosis of dementia.</p> <p>Review of the provider's August 2011 SSD job</p>	F 319		

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F 319	Continued From page 86 description revealed: "General Purpose: Identify and provide for each residents social, emotional and psychological needs, and the continuing development of the resident's full potential during his/her stay at the facility and to assist in the planning of his/her discharge."	F 319			
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, record review, interview, and professional standard review, the provider failed to ensure one of one sampled resident (2) at nutritional risk received the necessary care to ensure no further weight loss or nutritional concerns occurred. Findings include: 1. Review of resident 2's entire medical record revealed he had several diagnoses that nutrition and diet might impact including: *He was an insulin dependent diabetic (loss of blood sugar (BS) control). *Had diagnosis of:	F 325	F325G Maintain Nutritional Status unless unavoidable Resident #2 nutritional status has been reviewed and revised by the Registered Dietician. Residents residing in the facility experiencing weight loss or have a nutritional risk have the potential to be affected in a similar manner Residents who are experiencing weight loss or have a nutritional risk have had their nutritional status reviewed and revised by the Registered Dietician. The Dietary Manager, Registered Dietician, Director of Nursing and Interdisciplinary team have reviewed the Golden Living Weight Monitoring and Nutrition Risk Meeting policy. Nursing staff have been reeducated on following care plan interventions to prevent weight loss.	* 7/3/15 KG/5000 H/JJ	

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F 325	<p>Continued From page 87</p> <ul style="list-style-type: none"> -Depression (mood was feeling down). -Congestive heart failure (poor heart function). -High blood pressure. -High cholesterol. <p>Review of resident 2's weight record revealed: *On 3/5/15 he weighed 157.5 pounds (lb). *On 4/2/15 he weighed 140.5 lb. -That was a 17 lb or 10.7% weight loss in one month. *His weight on 6/3/15 was 145.5 lb.</p> <p>Review of resident 2's progress notes revealed his physician was not notified of the above 17 lb weight loss.</p> <p>Review of resident 2's June 2015 BS record revealed: *His BS was below 100 three times. *His BS was between 101-199 thirty-one times. *His BS was between 200-299 forty-one times. *His BS was between 300-399 thirty-four times. *His BS was over 400 six times. *The normal range for BS was 70 - 100.</p> <p>Random observation of resident 2 from 6/29/15 in the afternoon through 7/2/15 revealed: *He came out to the dining room very early every morning. *He liked hot chocolate and peanut butter. *After meals he returned to his room and laid down on his bed. *Staff had to encourage him to come out to the dining room for breakfast. *He had a big container of cheese balls in his room.</p> <p>Interview on 6/1/15 at 11:50 a.m. with resident 2's daughter revealed:</p>	F 325	<p>Registered Dietician or designee will complete 5 random audits weekly x 4 weeks then monthly x 2 months to ensure care plans are being followed for residents with nutritional risk to prevent weight loss. *Results will be reviewed at monthly QAPI meetings for further recommendations.</p> <p>of resident weights to include resident 2 KG/SOPH/JJ</p> <p>The RD will report the results to QAPI monthly. KG/SOPH/JJ</p> <p>* All resident weight variances of a 5 pound loss or gain must be reweighed and reported to the charge nurse. The charge nurse will then notify the dietary services manager for follow up. KG/SOPH/JJ</p>	

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F 325	<p>Continued From page 88</p> <ul style="list-style-type: none"> *He liked his ethnic food as that was part of his culture and background. -She tried to bring that food to him whenever she could. *He had recently been to the dentist and needed to have a lot of dental work done. *She was unaware he had lost any weight. <p>Interview on 6/30/15 at 11:20 a.m. with the dietary services manager (DSM) revealed:</p> <ul style="list-style-type: none"> *He had a significant weight loss. *They had reviewed him at their monthly weight meeting for a month. -His weight had stabilized now. *They encouraged his family to bring ethnic food for him because he liked that kind of food. *He came out to the dining room very early in the morning and always ate two packets of peanut butter and a cup of hot chocolate. -He then returned to his room. -It was sometimes difficult to get him to come back out. *When he selected his own meals he circled everything on the menu. -When the food came he had four or five glasses of juice and milk plus all the food. -He would not eat very much of any of it. -Their plan was to assist him in ordering a more reasonable meal, so he might eat more. *They had also started him on a daily nutritional supplement drink. <p>Review of resident 2's 4/14/15 nutrition assessment by the registered dietitian (RD) revealed:</p> <p>*"_____[name of resident] with weight loss over that past 2 months. Stating he just doesn't feel like eating. PO [per oral/eating] approximately 25% daily. RSD [resident] has been taking snacks.</p>	F 325			

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F 325	<p>Continued From page 89</p> <p>discussed the importance of eating more at meals. RSD is open to fortified foods. stating no new issues with chew or swallow. DM [diabetic mellitus] with glucometers (BS tests) in fair control (150-250's) .</p> <p>*Interventions:</p> <ul style="list-style-type: none"> -ConCHO (concentrated carbohydrate) diet order (diet for diabetics). -Offering/encouraging TID [three times per day] snacks. <p>Begin to fortify [boost nutritional value of food served] all meals.</p> <p>Review of the nutrition care team meeting minutes revealed his weekly meal intake from 4/20/15 through 5/12/15 was 40% or less.</p> <p>Telephone interview on 6/30/15 at 4:30 p.m. with the RD on 6/30/15 revealed he confirmed the above interview with the DSM.</p> <p>Interview on 6/30/15 at 4:15 p.m. with the social services designee regarding resident 2 revealed: *He denied he was depressed when she had assessed him. *She had not seen any indicators of depression with him. -He slept a lot and was a loner. -When she had spoken earlier in the day with his daughter about his weight loss the daughter said a family member had commented to him about gaining weight. He had always been very concerned about his weight, so he probably quit eating when that comment was made.</p> <p>Interview on 7/2/15 at 8:15 a.m. with the Minimum Data Set (MDS) assessment coordinator regarding resident 2 revealed: *He had not indicated he had any dental concerns</p>	F 325			

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F 325	Continued From page 90 when she did the dental portion of the MDS. *He would not always talk to her when she went to do the assessment, if he would not talk to you there was nothing more that she could do. *They had not received any information back from the dentist regarding his dental concerns. -They had two referral forms from the dentist from his last visits, but there was no information on them. Review of resident 2's 5/18/15 care plan revealed activity interventions included invite to food related activities. Review of resident 2's June 2015 activity participation records revealed he had not been invited to any food related activities. Review of resident 2's 5/18/15 care plan revealed: *It had not addressed: -His significant weight loss. -His daily average meal intake was currently between 35-40%. -How they ensured a staff person sat with him to select his meals. -The nutritional supplement. -How the provider accommodated his preference for ethnic food if the family was unable to do so. -His high BS readings. -How they addressed the high BS nutritionally. -How they fortified his food. -Any dental issues.	F 325		
F 329 SS=G	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or	F 329		

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - BLACK HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 NORTH 7TH STREET RAPID CITY, SD 57701
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F 329	<p>Continued From page 91</p> <p>without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on interview, record review, and policy review, the provider failed to have an appropriate diagnosis for two of seven sampled residents (10 and 14) who had been given multiple medication doses of antipsychotics and an antidepressant. Findings include:</p> <p>Surveyor: 26180 1. Observation and interview on 7/2/15 at 10:00 a.m. with resident 10 revealed: *"Everything had gone pretty good here until recently." "She got mad a little while back and was upset, because her brother-in-law had died. So you know how that can stress you out?"</p>	F 329	<p>F329 G Drug Regimen is free of unnecessary drugs</p> <p>Resident # 10 has had drug regimen reviewed by the pharmacy consultant and in collaboration with physician revisions to regimen have been made as appropriate. Resident #14 has been discharged from the facility so no corrective action could be taken.</p> <p>Residents residing in the facility who are administered antipsychotic medications have the potential to be affected in a similar manner</p> <p>Residents who are currently receiving antipsychotic medications have had their regime reviewed by the pharmacy consultant and in collaboration with physician revisions to regimen have been made as appropriate.</p> <p>The Director of Nursing, Pharmacy Consultant and Medical Director has reviewed the Golden Living Antipsychotic monitoring policy.</p> <p>Licensed Nursing staff has been reeducated on the Golden Living Antipsychotic monitoring policy.</p>	<p>* 7/31/15 KG/5000H/JS</p>
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F 329	<p>Continued From page 92</p> <p>*She used to be able to go outside and have a cigarette. Now she needed a supervisor with her if she wanted to go out and have a cigarette. That was new.</p> <p>*She just wanted to go out and talk with people the way she used to.</p> <p>*She was stressed and could not get a supervisor to go out with her. She got angry. "Talk about acting like a 10 year old. I was real angry."</p> <p>-So she went out and was in the parking lot, then when she had to come back in, she got so mad she pulled the fire alarm.</p> <p>**"That was when they stuck me. They gave me a shot and told me it was to make me sleep. I don't take meds [medications] that I don't know what they are for.</p> <p>-They did that to me four or five times. It didn't make me sleep. It made me angry.</p> <p>-They should put a picture of a dog on my door that says "Beware of Dog." That is how I feel.</p> <p>*She thought a couple of the nurses are bull dogs. They were the ones that gave her the shots. They said I was combative. I was not combative."</p> <p>*Now they wanted her to move to another facility "because I am combative."</p> <p>*She relayed that one certified nursing assistant (CNA) who was holding her when they gave her the shot, the resident used her long fingernails to get the CNA and pointed to her neck were she had "gotten" the CNA.</p> <p>*A new resident had come in on 7/1/15, and that resident also smoked. When the staff saw her warning this new resident about not being able to smoke they moved resident 10 to a different table away from the new resident.</p> <p>Surveyor: 26632 Review of resident 10's interdisciplinary progress</p>	F 329	<p>Director of Nursing or designee will complete 5 random audits weekly x 4 weeks then monthly x 2 months to ensure the Golden Living Antipsychotic monitoring policy is being followed.* Results will be reviewed at monthly QAPI meetings for further recommendations.</p> <p><i>and report to QAPI monthly. KG / SDPOH / JJ</i></p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	<p>Continued From page 93</p> <p>notes from 6/7/15 through 7/1/15 revealed:</p> <p>*On 6/7/15 at 6:45 a.m. "Resident is alert with confusion and able to make all needs know to staff using call light."</p> <p>*On 6/14/15 at 6:55 p.m. "Resident is alert and oriented with confusion at times." "Always ask staff to go out and smoke."</p> <p>*On 6/16/15 at 9:16 a.m. "Resident is alert and can be confused at times." "She requires assistance to go out to smoke. She cannot pass the smoking assessment."</p> <p>*On 6/22/15 at 9:39 p.m. the following documentation revealed:</p> <p>-Situation: At about 1900, [7:00 p.m.] resident was reported to be in the middle of the facility parking lot and stating she was going to leave. Resident hit a parked car of another family member's and scratching it with her WC [wheelchair] and attempting to leave.</p> <p>-Background: History of UTI [urinary tract infection], altered mental status [not thinking clearly], dementia [decreased thought process].</p> <p>-Assessment: Resident refused any and all cares and vital signs [blood pressure, pulse, and breathing per minute] but is noted to be confused and combative towards staff. Resident trying to stand and get out of chair while WC is being pushed by staff and grabbing staff's hands.</p> <p>-Response: Resident was assisted by staff back onto the sidewalk and back into facility. Resident's sister called as requested. Once sister arrive, resident was assisted down to her room. At 1955 [7:55 p.m.] on call MD [medical doctor] was paged. At 2030 [8:30 p.m.] MD paged again. At 2120, [9:20 p.m.] call from _____ [MDs name] received with orders noted."</p> <p>*On 6/23/15 at 2:54 a.m. "St. [straight] cath [catheterization (tube to drain urine) of urinary bladder] done as ordered. Resident tolerated well.</p>	F 329		
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F 329	<p>Continued From page 94</p> <p>Results pending."</p> <p>*On 6/23/15 at 1:38 p.m. "Received UA [urinalysis] [urine test results] and faxed to _____ [MDs name]."</p> <p>*On 6/23/15 at 8:25 p.m. a note by the social services (SS) worker revealed: "Earlier a mood assessment was completed with resident. She scored 5 for mild depression. She answered yes to thoughts that she would be better off dead and that she has had thoughts in the past of hurting herself but not at the time. As SS was leaving for home this evening found resident in the street trying to leave. Brought her back to facility and she refused to come in. She continued to try to leave and 4 times almost tipped chair over going down the sloping drive and off the curb. She made comments that hurting her self would be ok and being better off dead. These comments were made a few times. She is refusing to come into facility. She states that her behavior is ok and disagrees that being in the road is a safety risk."</p> <p>*On 6/23/15 at 9:00 p.m. the following documentation revealed:</p> <p>- "Situation: At 1900, [7:00 p.m.] facility SS worker found resident in the street trying to leave facility. SS brought her back to facility and resident refused to come in. Resident continue to try and leave 4 times and almost tipped her w/c [wheelchair] over while going down the sloping driveway and off the curb.</p> <p>- Background: Hx [history] of altered mental status, UTI.</p> <p>- Assessment: Resident apparently disoriented and confused. Resident is not thinking clearly and cognitive [thinking; reasoning] status is severely altered. Resident refuses any care from any and all staff.</p> <p>- Response: Resident was brought back several times for safety purposes. One on one and at</p>	F 329		

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F 329	<p>Continued From page 95</p> <p>times two staff to 1 for safety and monitoring. PRN [as needed] medication administration attempted and refused. Call to her niece made. Niece arrived to assist in reassuring resident but resident continued to be agitated and attempt to elope. Call to MD at 2025 [8:25 p.m.] with order to send to _____ [name of hospital] for psych [psychiatric] eval [evaluation] via [by] ambulance. Ambulance on scene and here to transport resident at 2035 [8:35 p.m.]. At 2040, [8:40 p.m.] report called to _____ [name of registered nurse at hospital]. Awaiting update at this time."</p> <p>*On 6/24/15 at 1:44 a.m. "At 2330, [11:30 p.m.] call received from _____ [name of hospital] ER [emergency room] that resident is being sent back to facility. Resident verbalized no intentions to harm self in ER and displayed no behaviors while in the ER. Resident returned at 0030, [12:30 a.m.] with new orders for antibiotics for present UTI as well as progress notes regarding medications administered while in the ER. Resident assisted to bed with no concerns noted at this time. Will continue to monitor."</p> <p>*On 6/24/15 at 6:43 p.m. "Received orders for Ativan [anti-anxiety medication] solution 2 mg [milligram] per ml [milliliter] injection et [and] for a wandeguard [personal alarm device] R/T [related to] recent attempts to leave."</p> <p>*On 6/24/15 at 9:30 p.m. Medication administration of 1 mg of Haldol (antipsychotic medication) intramuscularly (IM). "Resident is exit seeking and combative to staff."</p> <p>*On 6/24/15 at 10: 43 p.m. the following documentation revealed:</p> <p>-Situation: "Resident is repeatedly attempting to elope from facility. Has opened exit doors at least x [times] 3 starting at 1930 [7:30 p.m.] exiting x 2. Resident hitting at staff and grabbing door handles and side rails and attempting to stand</p>	F 329		
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F 329	<p>Continued From page 96 when wheel chair is in motion.</p> <p>-Background: Present UTI-currently on antibiotics therapy. Eloping and combative behaviors noted previous two days.</p> <p>-Assessment: Resident is noted to be confused, combative, and danger to self at this time.</p> <p>-Response: Earlier this shift, order was received for IM Ativan. Pharmacy called for medication. Medication unavailable at this time and not in our medication dispensing unit. Pharmacy continued with communications with MD for alternative medication. New order received. During this time, resident was supervised 1 on 1 [one staff person for one resident] at nurse's station by staff to prevent elopement. PRN oral medication administration attempted without success. IM injection of Haldol given as ordered. Family was notified and came to facility to help facilitate ADLs [activities of daily living that includes dressing, toileting, eating and personal care] with success. Family appreciative towards staff. Will continue to monitor and assess."</p> <p>*On 6/25/15 at 4:58 p.m. "Haldol 2 mg IM given. Resident left building three times. On third time, resident became combative with staff, attempting to hit staff, swinging at CNA [certified nursing assistant], nurse, et management. Resident re-directed for brief time et [and] brought into the hallway, where she then pulled the fire-alarm."</p> <p>*On 6/25/15 at 5:19 p.m. "Resident left building three times, stating that she was 'leaving this damn place'. Resident was stopped by nurse et CNA and explained to her why she needs to stay here for her safety. Resident re-directed back into building. A different resident left the building to leave with her son et this resident attempted to leave with the other resident. Nursing was able to re-direct resident, but she became combative, swinging to hit staff et kicking at nurse. Resident</p>	F 329		
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F 329	<p>Continued From page 97</p> <p>brought back into building et re-directed for a short time. Resident went down the hallway et pulled the fire-alarm, after being asked not to by nurse. Nurse assigned CNA to do one-on-one with resident; PRN dose of IM Haldol given per MAR [medication administration record]."</p> <p>*On 6/26/15 at 8:44 p.m. a late entry "Resident was trying to get out of the facility, and telling everyone that she will pull the fire alarm. Resident was stopped by nurse et CNA and explained to her why she needs to stay here for her safety. Nursing was able to re-direct but she's trying to hit staff. Given PRN dose of IM Haldol given per eMAR [electronic medication administration record]. She tries to kick staff while given the injection. After that she pours water on the laptop and still mad because she wants to go out."</p> <p>*On 6/28/15 at 8:19 p.m. "Haldol 2 mg IM given. Resident was trying to go out of the facility, and was very agitated."</p> <p>*On 6/28/15 at 9:49 p.m. "Resident was trying to get out the facility again at 2000, [8:00 p.m.] and she want [wanted] to go out and smoke. She was confused, she stated that she want to talk to the doctor on what's going on. Explained to the resident that she's living here and needs to stay here for her safety. Give PRN dose of IM Haldol given per eMAR. Resident is still agitated called her sister and they came to help calm her down. Resident sister help her to bed and finally goes to sleep."</p> <p>*On 6/30/15 at 9:09 p.m. "Haldol 2 mg IM given."</p> <p>*On 6/30/15 at 10:03 p.m. "Resident with increased agitation, admin [administered] one IM shot of Haldol and called family to come up to see res.[resident] Res. then called 911 and police officer showed up, explained situation to police without any issues. res is resting in bed at this time, family just left. will cont [continue] to</p>	F 329		
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F 329	<p>Continued From page 98 monitor."</p> <p>*On 7/1/15 at 12:43 p.m. a note by the SS worker. "Faxed _____ [MD] regarding resident behaviors. Family member is concerned about the behavior and said they have a Dr appt [appointment] schedule with _____ [MD] on 7/10/15. Discussed that we have request bed on 2nd fl [floor] _____ [another facility] for her safety."</p> <p>Interview on 7/1/15 at 5:30 p.m. with registered nurse O and licensed practical nurse N revealed: *Resident 10 had been having multiple episodes of trying to elope from the building. *She had been combative towards staff and had required one-on-one staff supervision. *They had not known why she had kept on trying to leave. *Agreed she was a smoker and had been assessed as unsafe to smoke alone on 4/27/15. *The provider's policy was only residents that did not have to be supervised to smoke could smoke. *Agreed staff had been supervising her since then for smoking. *Had not thought the Haldol she had received was a chemical restraint. *It had only been used to control her behaviors.</p> <p>Surveyor: 26180 2. Review of resident 14's 5/8/15 physician's orders revealed: *He was admitted on 5/8/15 and discharged on 6/18/15. *His diagnoses included: -A traumatic brain injury (TBI). -Mild cognitive impairment. *The following psychotropic (medications effecting mood and behavior) had been ordered:</p>	F 329		
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F 329	<p>Continued From page 99</p> <ul style="list-style-type: none"> -Haldol (treatment for psychosis/severe mental disorder) inject 2 milligram (mg) intramuscularly (IM) PRN (as needed) every eight hours for severe agitation. Start date 5/10/15. There was no time limit on the use of that medication. -Resperidone (treatment for psychosis/severe mental disorder) tablet - 0.25 mg per PEG Tube (tube placed into the stomach for nutrition and medication) three times a day related to mild cognitive impairment. Start date 5/14/15. -Seroquel (for psychosis) tablet 25 mg per PEG tube every four hours as needed for severe agitation. -Trazodone (depression) HCL (hydrochloride) tablet 25 mg every six hours as needed for ABS (agitated behavior scale) greater than 27. Start date 5/8/15. -Trazodone HCL tablet 50 mg every 6 hours as needed for ABS greater than 27. Start date 5/8/15. <p>Review of resident 14's 6/1/15 physician's orders revealed:</p> <ul style="list-style-type: none"> *His diagnoses remained unchanged from 5/8/15. *The following psychotropic had been ordered: <ul style="list-style-type: none"> -Haldol inject 2 milligram (mg) intramuscularly every eight hours for severe agitation. Start date 5/10/15. -Resperidone - 0.25 mg by mouth three times a day related to mild cognitive impairment. Start date 5/14/15 -Seroquel tablet 25 mg by mouth every four hours as needed for severe agitation. -Trazodone HCL 25 mg every six hours as needed for ABS greater than 27. Start date 5/8/15. -Trazodone HCL 50 mg every six hours as needed for ABS greater than 27. Start date 5/8/15. 	F 329		

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F 329	<p>Continued From page 100</p> <p>Review of nurses progress notes and the Medication Administration Record from 5/8/15 through 6/18/15 revealed he received the Haldol 2 mg IM on 5/20/15 for severe agitation.</p> <p>Review of resident 14's behavior log revealed: *On 5/20/15 he exhibited verbal behavior one time. *From 5/8/15 through 6/18/15 he exhibited behaviors thirteen times. *Those behaviors included: -Rejecting care four times. -Wandering four times, -Verbal behavior twice. -Physical behavior twice. -Other behavior once.</p> <p>Interview on 7/2/15 at 10:40 a.m. with the director of nurses regarding resident 14 revealed: *He was very confused and restless. *He was assigned a one-on-one staffing ratio to monitor him. *He was constantly wanting to leave the building and was a fall risk. *The ABS scale (measured agitation) was a scale the TBI unit he had come from used. -They did not have a copy of that scale and had not used it. -The nurses should have addressed that when they got the order for the medication using the ABS scale. *She agreed the diagnoses of mild cognitive impairment and severe agitation were not appropriate indicators for the use of an antipsychotic. *Not all behaviors had been documented. *She confirmed the nurses should have addressed those diagnoses with the admitting</p>	F 329		

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F 329	<p>Continued From page 101 physician.</p> <p>Review of the provider's 5/4/15 Antipsychotic Medication Review policy revealed: *The procedure was to "Ensure that the Medical Record of any Resident who receives antipsychotic medication contains documentation supporting the appropriateness and necessity for the use of the drug. *Antipsychotics are a class of psychiatric medication primarily used to manage psychosis (including delusions, hallucinations, or disordered thought) particularly in schizophrenia and bipolar disorder, and is increasingly being used in the management of non-psychotic disorders. *The Assessment of Psychotropic medications was a part of the policy. -That document was not found completed in resident 14's medical records. *Review to ensure that a consent form or documentation noting the risks and benefits for the use of an antipsychotic medication had been discussed with the resident and/or responsible party. -That had not been noted for resident 10.</p> <p>Review of the provider's 2/12/15 Behavior Management Guideline policy revealed: *"The use of any medication to control behaviors should always be considered a last resort to assist with managing a patient's/resident's behavior. *Antipsychotic drugs would not be used unless the clinical record documents that the patient/resident has one or more of the following "specific conditions", as dictated and documented by the physician: *A. Conditions other than Dementia"- This included a list of twelve diagnoses and had not</p>	F 329		
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F 329	<p>Continued From page 102 included: -Mild Cognitive Impairment. -Severe agitation. *Criteria: "All of the above highlight conditions/diagnosis where antipsychotic medications may possible be appropriate, but diagnosis alone do not warrant the use of an antipsychotic unless the following criteria are also met: -The behavioral symptoms present a danger to the patient/resident or others AND one or both of the following: -The symptoms are identified as being due to mania or psychosis (such as auditory, visual or other hallucinations; delusions, paranoia, or grandiosity); OR -Behavioral interventions have been attempted and included in the plan of care, except in an emergency." **When an antipsychotic medication is being initiated or used to treat an emergency situation related to one or more of the aforementioned conditions/diagnosis, the use must meet the above criteria and all of the following additional requirements: -1. The acute treatment period is limited to seven days or less; -2. A clinician in conjunction with the interdisciplinary team must evaluate and document the situation within 7 days to identify and address and contributing and underlying causes of the acute condition and verify the continuing need for an antipsychotic medications."</p>	F 329		
F 353 SS=F	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to</p>	F 353		

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F 353	<p>Continued From page 103</p> <p>provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632</p> <p>Surveyor: 26180 Based on observation, record review, interview, and policy review, the provider failed to maintain adequate staff to prevent resident's care issues and meet basic care needs for: *One of one sampled resident (2) had a change of condition. *One of two observed residents (4) during a dressing change to ensure privacy was maintained. *One of one resident group (Resident Council) and three of four confidential resident interviews regarding call lights not being answered in a</p>	F 353	<p>F353F Sufficient 24 hour Nursing Staff per care plans</p> <p>Unable to correct past nursing staffing</p> <p>Residents residing in the facility have the potential to be affected in a similar manner. <i>* 7/31/15 KF/SOOH/JJ</i></p> <p>Staffing levels have been reviewed and meet the resident's needs</p> <p>Executive Director or designee will monitor results of all plan of correction audits weekly x 4 weeks then monthly x 2 months to ensure they are reflective of needs of residents are being met. Results will be reviewed at monthly QAPI meetings for further recommendations.</p>	

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F 353	Continued From page 104 timely manner. *One of ten randomly observed residents (16) had been assessed for the capability to self-administer medications after set-up. *One of one sampled resident (14) using a seat belt that had been assessed. *Two of seven sampled residents (10 and 14) who had received chemical restraints for the management of behaviors. *One of one resident (10) who had eloped and one of one resident (2) with an incident involving missing property. *One of thirteen sampled residents (2) who did not receive activities based on their assessed interests and needs. *Four of thirteen sampled residents (1, 2, 9, and 10) had medically related social services provided. *One of one sampled resident (18) with methicillin resistant staphylococcus aureus and continued diarrhea had a thorough temporary care plan regarding infection control developed. *Nine of thirteen sampled residents (1, 2, 3, 4, 5, 8, 9, 10, and 11) care plans had been reviewed and revised as the resident's care needs had changed. *One of one sampled resident (2) whose medication was held and one of two sampled residents (1) with a pressure ulcer had physicians' orders that had been followed. *Two of three sampled residents (1 and 8) who had developed pressure ulcers (open areas on skin caused by unrelieved pressure that resulted in damage to the tissue) after admission into the facility. *One of one sampled resident (2) at nutritional risk received care to ensure no further weight loss or nutritional concerns had occurred. *One of forty medications administered to	F 353			

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F 353	Continued From page 105 resident (8) had been correctly labeled. *Three of fourteen sampled residents (1, 2, and 9) had accurate medical records. *Two of two sampled residents (4 and 18) who were identified with contagious multidrug-resistant organism (MDRO) (infections that are hard to treat because they do not respond to most antibiotics) and clostridium difficile (C-diff) (contagious bacterial infection) had an effective infection control measures was implemented, monitored, and maintained through an infection control program. Findings include: 1. Interview on 7/2/15 at 9:00 a.m. with the administrator and director of nursing revealed: *The provider's budget had been decreased for this fiscal year. *Staffing was not done according to how much care residents required. *They had not been aware the Minimum Data Set coordinator, infection control nurse, and the social services designee had not been able to complete their duties as assigned due to the work load. Refer to F157, F164, F166, F176, F221, F222, F226, F248, F250, F278, F279, F280, F281, F314, F319, F325, F329, F353, F431, F441, and F514.	F 353			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431	F431D Drug Records Label/Store Drugs & Biologicals Resident #8 nebulizer order has been clarified with physician and medication label has been corrected to match physician order.		

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F 431	<p>Continued From page 106 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: 32355 Based on observation, interview, and policy review, the provider failed to ensure accurate labeling for 1 of 40 medications administered (to improve breathing) to resident (8). Findings include:</p> <p>1. Observation on 6/30/15 at 11:48 a.m. of registered nurse (RN) A during medication administration of a nebulizer (device that turns</p>	F 431 <i>KG-5000H/JJ</i>	<p>Residents residing in the facility have the potential to be affected in a similar manner.</p> <p><i>All*</i> Resident's medication labels have been audited to ensure they match current physician orders. Licensed Nursing staff has been reeducated on the appropriate labeling of medication process if an order is changed by the physician.</p> <p>Director of Nursing or designee will complete 5 random audits weekly x 4 weeks then monthly x 2 months to ensure the medication label match physician orders.* Results will be reviewed at monthly QAPI meetings for further recommendations.</p> <p><i>and report to QAPI monthly, KG-5000H/JJ</i></p>	<p><i>*7/31/15</i> <i>KG-5000H/JJ</i></p>	

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F 431	<p>Continued From page 107</p> <p>liquid medication into a mist for inhaling into the lungs) treatment for resident 8 revealed: *She obtained a package containing multiple unit doses of Duoneb medication. *The medication directions for use on the package stated "Use 1 vial via [by] nebulizer four times daily." *She checked the medication directions on the package with resident 8's medication administration record (MAR). Resident 8's MAR revealed the Duoneb should be administered twice a day. *She administered the nebulizer treatment.</p> <p>Review of resident 8's MAR and the physician's orders revealed an order dated 6/17/15 for the Duoneb to be administered twice a day. The physician's order and MAR had not matched the order on the medication box.</p> <p>Interview on 6/30/15 with RN A at the time of the above observation revealed: *She had been aware the physician had recently changed the frequency of the Duoneb. *The staff member who had reviewed and changed the order should have notified the pharmacy department. The pharmacy would have sent out a new box. *The pharmacy would not send out a new label to apply to the package. *The provider did not have another process in place to alert the staff of an order change on the package.</p> <p>Interview on 7/1/15 at 7:45 a.m. with the director of nursing revealed: *The nurse should have checked with the pharmacy department to ensure they were aware of the order change on the Duoneb.</p>	F 431			

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F 431	Continued From page 108 *The provider had recently switched to a different type of pharmacy dispensing system. That system did not allow for label changes from the pharmacy. *The provider used to put a dose change or time change sticker on the medication package until the new label or medication had been received. They had stopped that process with the new dispensing system. *She agreed the provider should have had a process in place to indicate and alert the staff of an order change on all medication labels.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441	F441 F Infection Control/Prevent Spread Resident #4 medical record has been reviewed related to infection control concerns and plan of care has been revised as appropriate. Resident #18 has been discharged from the facility so no corrective action could be taken. Residents residing in the facility have the potential to be affected in a similar manner. Residents residing in the facility with known multidrug resistant organisms (MRDO) have been reviewed and care plans have been revised as appropriate.	* 7/31/15 KG/SCD/155

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F 441	<p>Continued From page 109</p> <p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632</p> <p>Surveyor: 32355</p> <p>A. Based on observation, record review, guideline review, interview, and policy review, the provider failed to ensure an effective infection control program was implemented, monitored, and maintained that addressed two of two sampled residents (4 and 18) who were identified with contagious multidrug-resistant organism (MDRO) (infections that are hard to treat because they do not respond to most antibiotics) and clostridium difficile (C-Diff) (contagious bacterial infection). Findings include:</p> <p>1. Observation on 6/29/15 at 6:00 p.m. of resident 4 revealed she had been sitting in her wheelchair (w/c) in the dining room. Her feet had been</p>	F 441	<p>Executive Director, Director of Nursing and Interdisciplinary team have reviewed the Golden Living Policies and Practices related to Infection Control</p> <p>Staff has been reeducated on Golden Living Policies and Practices related to Infection Control</p> <p>Director of Nursing or designee will complete 5 random audits weekly x 4 weeks then monthly x 2 months to ensure the Golden Living Policies and Practices related to Infection Control are being followed. Results will be reviewed at monthly QAPI meetings for further recommendations.</p> <p>and report to QAPI monthly, KCG/SOOTH/JT</p> <p>to include:</p> <ul style="list-style-type: none"> • residents with infection to ensure precautions are in place and followed. • dressing changes to ensure proper technique is used. • resident cares to ensure handwashing / glove use is correct. KCG/SOOTH/JT 	
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F 441	<p>Continued From page 110</p> <p>resting on the foot pedals of the w/c and were supported by Prevalon boots (type of pressure relieving device).</p> <p>Review of resident 4's medical record revealed: *An admission date of 12/7/11. *Diagnoses of Type II diabetes (uncontrollable blood sugar levels), pain, depression, and diabetic ulcers (wounds; open areas on skin) to her legs due to poor circulation (blood supply). *Currently had three diabetic ulcers with one on her right calf, one on the left great toe, and one on the left heel. *She had been on comfort measures and under the support of hospice care since 3/4/15. *The diabetic ulcer on her left heel had tested positive for methicillin resistant staphylococcus aureus (MRSA) (bacterial infection that is resistant to many antibiotics and highly contagious[easily spread to others]) in February of 2015. *She had required the left heel ulcer dressing to be changed twice a day. Those dressing changes were done by the nursing staff. *She had required staff support with transfers, bed mobility, dressing, personal hygiene, and toileting. *She had been at risk for skin breakdown and required the use of Prevalon boots for her legs and feet.</p> <p>Random observations from 6/29/15 through 7/2/15 of resident 4 revealed: *She had worn the Prevalon boots at all times. *No identifiable precautionary directions for the MRSA infection had been posted on her door, in her room for visitors, or for staff to follow.</p> <p>Interview on 6/30/15 at 5:20 p.m. with the</p>	F 441		
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F 441	<p>Continued From page 111</p> <p>infection control nurse revealed:</p> <p>*She had:</p> <ul style="list-style-type: none"> -Been aware of the MRSA in resident 4's left heel. -Considered the MRSA to be contained (no drainage going through the gauze dressing) since it was in one area and covered with a dressing. To her knowledge there had not been any drainage from the wound on the outside of the dressing. -Instructed the staff to follow standard precautions when providing personal care for the resident. Standard precautions had included gloves and good hand hygiene. <p>*Educated the staff on 2/17/15 regarding the MRSA in the resident's left heel and the precautions required to take care of her. She had recommended standard precautions with good handwashing.</p> <p>Review of resident 4's hospice notes from 5/6/15 through 6/15/15 revealed:</p> <ul style="list-style-type: none"> *There had been drainage from the left heel wound. *The drainage amount had been large to moderate. *The drainage had been serosanguineous in color (reddish and yellow). *At times the drainage had a foul odor. <p>Review of resident 4's undated Minimum Data Set Kardex report revealed:</p> <ul style="list-style-type: none"> *She had a skin and ulcer treatment with a "dressing to her feet." *It had failed to identify: -The MRSA infection to her left heel and any precautionary interventions that should have been used by the staff when assisting her with dressing changes and activities of daily living (ADLs) (personal care including mobility). 	F 441		

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F 441	<p>Continued From page 112</p> <p>Review of resident 4's undated resident care sheet revealed: *It had failed to identify: -The diabetic ulcers to her left foot and right calf. -The MRSA infection in her left heel and any precautionary interventions that should have been used by the staff assisting her.</p> <p>Review of the provider's 6/29/15 daily stand-up information revealed it had not identified resident 4's MRSA infection to her left heel. Nor did it identify any precautionary interventions that should have been followed by the staff.</p> <p>Review of resident 4's 6/16/15 revised care plan revealed: *Failed to identify: -The MRSA infection in her left heel until 6/23/15. No precautionary interventions had been in place for the staff to follow when assisting her with ADLs or dressing changes.</p> <p>Observation on 7/1/15 at 10:25 a.m. licensed practical nurse (LPN) B and hospice LPN D during a dressing change for resident 4 revealed: *The resident had been laying in her bed with the Prevalon boots on. *LPN D had: -Brought a plastic bag full of dressing supplies from her personal car for the staff to change the resident's dressing. -Laid that plastic bag on top of the resident's bedside table. -Put on a pair of clean gloves, opened the bag, and started to get dressing supplies from that bag. -Placed some of those dressing supplies directly on top of the resident's roommate's dresser.</p>	F 441		
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F 441	<p>Continued From page 113</p> <ul style="list-style-type: none"> -Put all of the dressing supplies in the resident's closet in the appropriate boxes. All of resident 4's dressing supplies had been in cardboard boxes that sat directly on the closet floor. -Retrieved the appropriate supplies necessary to change the dressing on the resident's left foot. -Placed all of those dressing supplies directly on top of the plastic bag she had brought in from her personal car. -Retrieved a box of gloves from the resident's closet and sat the box on top of the roommate's dresser. -Washed her hands, put on clean gloves, and put on a gown to cover her clothes. *LPN B: <ul style="list-style-type: none"> -Entered the room and retrieved a pair of gloves from the box. -Laid those gloves directly on top of the roommate's dresser. -Washed her hands, put on a gown, and those gloves that had been sitting on the top of the roommate's dresser. -Removed the resident's Prevalon boots and rested her feet directly on top of the bed covers. *There had been a large yellowish and reddish stain on the left Prevalon boot. That stain had been located where the left heel would have been placed. *The observation of the gauze dressing to the resident's left foot revealed a large amount of yellow and reddish colored drainage from the heel area. *LPN D continued with the dressing change while LPN B supported the resident's leg. She had: <ul style="list-style-type: none"> -Removed the dressing and disposed of it into a small trash can placed up against the roommate's dresser. -Removed her gloves and placed them in the small trash can. 	F 441		
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F 441	<p>Continued From page 114</p> <ul style="list-style-type: none"> - Washed her hands and put on clean gloves. *With those clean gloves LPN D had: <ul style="list-style-type: none"> -Opened up a blue disposable soaker pad and placed it underneath of the resident's feet. -Retrieved a package that had been sitting on top of the plastic bag, opened it, and took out the gauze. -Opened a new bottle of saline that had been sitting on the roommate's dresser and wet the gauze. -Cleaned the wound and placed the soiled gauze in the small trash can. The trash can had been full and the soiled supplies had started to touch the roommate's dresser drawers. *LPN D removed those soiled gloves. She had: <ul style="list-style-type: none"> -Retrieved a package from the resident's closet without washing or sanitizing her hands. -Placed that package on top of the roommate's dresser. -Retrieved a pair of gloves and placed them on top of the roommate's dresser. -Washed her hands and put on the gloves that had been placed on top of the roommate's dresser. -Applied the medication to the wound bed and wrapped the left heel with a gauze dressing. *LPN D and LPN B removed their gloves and gowns. They had disposed of them into the trash can next to the roommate's dresser. <p>Interview on 7/1/15 with LPN D and B after the above dressing change observation revealed:</p> <ul style="list-style-type: none"> *They had been aware of the MRSA in the left heel. *They had agreed: <ul style="list-style-type: none"> -The MRSA had not been contained due to the amount of drainage that had been observed on the outside of the dressing and in the Prevalon boot. 	F 441			

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F 441	<p>Continued From page 115</p> <ul style="list-style-type: none"> -The Prevalon boot needed to be washed or replaced. -The staff should have recognized the Prevalon boot was soiled and taken it to laundry for washing. -The plastic bag had not created a clean area for the dressing supplies. -The staff would have had to open the roommate's dresser drawers to obtain items when providing care for her. -They should not have placed any of the supplies or gloves on top of the roommate's dresser. -The above process had placed the roommate and other residents at risk for acquiring the infection. -They did not recognize the dressing change process had not been done in a sanitary manner. -The resident should have been placed on contact precautions. -There should have been proper disposable garbage waste containers and supplies accessible for the staff when they provided care for her. *There should have been precautionary instructions available for all visitors. *The LPN D had asked the facility multiple times to get a shelf for the resident's closet to put the dressing supplies on. She had informed the provider the boxes should not have been sitting directly on the floor. <p>Interview on 7/1/15 at 11:10 a.m. with the director of nursing and the infection control nurse revealed:</p> <ul style="list-style-type: none"> *The infection control nurse had: <ul style="list-style-type: none"> -Not been aware the resident's left heel wound had any drainage seeping through to the outside of the dressing. -Not done any visual assessments of the wound 	F 441		
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F 441	<p>Continued From page 116 or dressing.</p> <ul style="list-style-type: none"> -Relied upon the nursing staff to inform her on the condition of the wound. They had informed her that the MRSA was contained and standard precautions had been sufficient. -Not reviewed any of the hospice notes and assessments on any of the resident's diabetic ulcers. -Not monitored and watched the nursing staff or hospice nurse during a dressing change to ensure sanitary conditions had been maintained. <p>*They agreed:</p> <ul style="list-style-type: none"> -The resident should have been monitored to ensure standard precautions for the MRSA had been appropriate. -The dressing change had not been done in a sanitary manner. That had created the potential for the roommate and other residents in the facility to acquire the infection. <p>*The staff had been responsible to ensure any soiled linens were given to the laundry department to wash.</p> <p>*They had not been aware:</p> <ul style="list-style-type: none"> -All of the resident's dressing supplies had been sitting directly on her closet floor. -The hospice nurse had requested a shelf for those dressing supplies. <p>*They agreed the dressing supplies should not have been sitting on the floor.</p> <p>Surveyor: 26632 2. Review of resident 18's admission face sheet revealed:</p> <ul style="list-style-type: none"> *He had been admitted on 6/25/15 from another skilled nursing facility. *He had diagnoses that included MRSA in his urine. <p>Review of resident 18's history and physical -</p>	F 441		
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F 441	<p>Continued From page 117</p> <p>completed 7/1/15 by his primary physician revealed:</p> <ul style="list-style-type: none"> *He had been hospitalized for MRSA with urosepsis (a systemic reaction of the body to a bacterial infection that could be life threatening) and treated with intravenous (through the vein) antibiotics at the other skilled nursing facility. *He had chronic loose stools (bowel movements). *He had stated to the physician he had "Between 5 to 15 loose watery stools per day *He had problems with urinary retention (unable to empty bladder of urine) and had a urinary catheter (tube to empty urine) in place. *Discussion notes by the physician included: <ul style="list-style-type: none"> -Chronic diarrhea, history of microscopic colitis (inflammation of the colon). -Would plan for testing of his stool for clostridium difficile (contagious infection of the intestine) due to his recent antibiotic therapy. <p>Review of resident 18's nurses noted revealed:</p> <ul style="list-style-type: none"> *On 6/15/15 at 5:58 p.m. an admission note. That had not mentioned his previous MRSA infection diagnosis of his urine. *On 7/1/15 at 10:36 p.m. Resident went to physician appointment at 3:00 p.m. and was back at 5:02 p.m. *Has a diagnosis of diarrhea. *Has new orders that included to get a stool sample for C. difficile (clostridium difficile.) <p>Interview on 7/2/15 at 9:55 a.m. with licensed practical nurse N and registered nurse O revealed:</p> <ul style="list-style-type: none"> *They had not been aware resident 18 had a previous diagnosis of MRSA in his urine. *They confirmed no infection control precautions had been put in place while both the MRSA in urine and the possibility of C.Diff had been ruled out. 	F 441		
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F 441	Continued From page 118 Surveyor: 32355 Review of the provider's 1/6/15 MRSA guideline revealed: *Description, "In healthcare facilities, the main mode of transmission [spreading] to other patients is through human hands." *Precautions: -"LTCFs [long-term care facilities] should make a decision on a case by case basis whether contact precautions are needed." -"Risk of transmission increases in the following situations and therefore, contact precautions [prevention] should be considered with a heavy draining wound." *Room considerations, "Infected or colonized residents should be placed in private room or cohorted [someone with the same infection]." Review of the provider's August 2012 Isolation - Categories of Transmission-Based Precautions policy revealed: *"Standard precautions shall be used when caring for residents at all times regardless of their suspected or confirmed infection status." *"Transmission-Based Precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others." *Examples of infections requiring contact precautions include, but are not limited to: -"Infections with MDRO [multidrug-resistant organism]" -"Heavily draining wounds with noncontained drainage" *Resident placement, "Place the individual in a private room if possible." *Gloves and gowns should be worn upon entering the resident's room and disposed of prior to	F 441			

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F 441	<p>Continued From page 119 leaving the room. *The facility will implement a system to alert staff to the type of precaution resident requires." *When transmission-based precautions are implemented the infection preventionist or designee shall: -Ensure that protective equipment (i.e. [such as], gloves, gowns, masks, etc.) is maintained outside of the resident's room so that everyone entering the room can access what they need. -Post the appropriate notice on the room entrance door, so that all personnel and staff will be aware of precautions, or be aware that they must first see a nurse to obtain additional information. -Ensure that an appropriate linen barrel/hamper and waste container, with appropriate liner, are placed in or near the resident's room."</p> <p>Surveyor: 26632 3. Review of the provider's 12/18/14 Infection Control Policy revealed the objectives of their infection control policies and practices were to: *Prevent, detect, investigate, and control infections in the facility. *Maintain a safe, sanitary, and comfortable environment. *Establish guidelines for implementing isolation precautions. *Establish guidelines for the availability and accessibility of supplies and equipment necessary for standard and transmission based precautions. *Maintain records of incidents and corrective actions related to infections.</p> <p>Interview on 7/2/15 at 9:55 a.m. with the infection control nurse revealed: *She kept track of residents who were using and had used antibiotics.</p>	F 441		

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F 441	<p>Continued From page 120</p> <p>*She used the Beer's (list of symptoms to indicate a possible infection) list to indicate if the resident was appropriate for the use of the antibiotic.</p> <p>*She checked for cultures and what organism had been present.</p> <p>*She checked if the appropriate antibiotic had been used according to the sensitivity test from the culture test result.</p> <p>*She did not complete any monitoring of staff infection control practices.</p> <p>*She presented an annual skills fair for the licensed nurses and medication aides that included handwashing and glove use.</p> <p>Surveyor: 32355 Review of the provider's unsigned and undated Infection Control Nurse job description revealed: *General purpose: -"Eliminating infection risks to residents and personnel through surveillance of multiple activities and practice. -Teaching information pertinent to infection control and isolation to all involved employees. -Implementing monitoring and surveillance programs in an effort to identify and reduce infection hazards in the facility."</p> <p>Surveyor: 28057 B. Based on observation, interview, and policy review, the provider failed to ensure infection control processes were followed for: *Two of three observed residents (1 and 8) during dressing changes. *Hand washing and glove use during one of three observed resident's (9) personal cares by certified nursing assistant (CNA) (I). Findings include:</p>	F 441		

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F 441	<p>Continued From page 121</p> <p>1. Observation on 6/30/15 at 2:30 p.m. during a dressing change for resident 8 revealed registered nurse (RN) M:</p> <ul style="list-style-type: none"> *Washed her hands and put clean gloves on her hands. *She then washed the pressure ulcer on the resident's ischium (bottom). *She then applied ointment to the ulcer and placed a clean dressing over the ulcer. *She dated the dressing on the outside. *She then removed her gloves and washed her hands. *She stated that had been her usual procedure. <p>Interview on 7/1/15 at 2:55 p.m. with the director of nursing confirmed she would have expected RN M to have changed her gloves and washed her hands after cleansing the wound and before she had applied the ointment and clean dressing to the pressure ulcer.</p> <p>Review of the provider's revised August 2014 Handwashing/Hand Hygiene policy revealed hands were to be cleaned before and after handling clean or soiled dressings.</p> <p>Surveyor: 26632</p> <p>2. Observation on 6/29/15 from 3:45 p.m. through 4:00 p.m. of CNA I during personal care for resident 9 revealed:</p> <ul style="list-style-type: none"> *Put clean gloves on without washing her hands. *Touched multiple surfaces in the room. *Put a gait belt on resident 9 and assisted her to stand, pivot (rotate), and sit on a bedside commode (portable toilet). *While resident 9 was standing she pulled down her pants and incontinent brief. *When she was done using the commode CNA I took personal wipes from a drawer and cleansed 	F 441		
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F 441	<p>Continued From page 122</p> <p>her bottom.</p> <p>*Helped her stand, pulled up her incontinent brief and pants, pivoted, and sit down in her wheelchair.</p> <p>*CNA A then emptied the commode in the toilet, rinsed the commode in the hand sink, and emptied the commode again into the toilet.</p> <p>*When she emptied the commode she touched the inside part of it.</p> <p>*CNA then put the commode in the closet and shut the closet door.</p> <p>*She took her gloves off , gathered the garbage, and then washed her hands.</p> <p>*Took the garbage to the soiled utility room and used hand sanitizer.</p> <p>Interview on 6/29/15 at 4:00 p.m. with CNA I confirmed that was her usual routine when she provided personal care to residents. She agreed she had contaminated many surfaces with her gloves.</p> <p>Surveyor: 26632</p> <p>3. Observation on 6/30/15 from 10:19 a.m. through 10:40 a.m. of a dressing change for resident 1 revealed:</p> <p>*Physical therapy assistant (PTA) J put on gloves without washing her hands.</p> <p>*PTA J then:</p> <ul style="list-style-type: none"> -Assisted licensed practical nurse (LPN) P with repositioning resident 1 onto her right side. -Touched resident 1's buttocks (bottom) to assist LPN P with seeing the wound. -Touched the bedding and the incontinent brief when LPN P changed it and cleansed resident 1's bottom. -Without removing or changing her gloves reached into her pocket three times to check her cell phone. 	F 441		

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F 441	<p>Continued From page 123</p> <p>Surveyor: 32355</p> <p>C. Based on observation, interview, and policy review, the provider failed to ensure infection control processes were followed or developed for:</p> <ul style="list-style-type: none"> *Resident care supplies stored on the floor in two of two observed areas (medical storage room and medical record room). *Five of five randomly observed oxygen concentrator filters being currently used by residents. *One of one randomly observed nebulizer for one of one observed resident (8) treatment by one of one registered nurse (RN) (A). *One of one observed housekeeping office with no soap or towel dispenser at the handwashing sink. *One of one observed beauty salon sink that was not disinfected between each resident's use. <p>Findings include:</p> <p>Surveyor: 26632</p> <p>1. Observation on 6/29/15 at 4:30 p.m. and again on 6/30/15 at 10:00 a.m. revealed boxes of resident care supplies in the medical records office. Those boxes were stored directly on the floor. In the medical supply room there was two boxes of medical supplies also stored directly on the floor. Interview on 6/30/15 at 10:00 a.m. with the medical records staff person revealed she was aware supplies should have not been stored directly on the floor. The supplies that were in her office had been stored there as they did not fit in the medical supply room. That had been ongoing for a few months.</p> <p>Review of the provider's 2/12/15 Safety and Disaster Management policy revealed to store supplies on well-constructed shelves and racks.</p>	F 441		
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F 441	<p>Continued From page 124</p> <p>Surveyor:32355</p> <p>2. Random observations from 6/29/15 through 7/1/15 throughout the facility revealed:</p> <ul style="list-style-type: none"> *Five residents' oxygen concentrators were in use. *The oxygen concentrator filters had been dusty with a whitish powder noted on them. *Some nebulizer sets had not been taken apart, and the nebulizer apparatus had been attached to the machine. <p>Interview on 7/1/15 at 7:35 a.m. with LPN B regarding the cleaning of the resident's oxygen concentrator filters revealed:</p> <ul style="list-style-type: none"> *The maintenance supervisor was responsible for the cleaning and upkeep of the oxygen concentrator filters. *She had been unsure of his schedule for the cleaning of the filters. <p>Interview on 7/1/15 at 7:40 a.m. with the DON regarding the cleaning of the residents' oxygen concentrator filters revealed:</p> <ul style="list-style-type: none"> *The nursing staff had been responsible for the cleaning of the oxygen concentrator filters. *They should have been cleaned every Sunday by the nursing staff. *She had not been aware the oxygen concentrator filters were dirty. *There was no documentation process in place to ensure the filters had been cleaned every Sunday. *The provider did not have a policy and procedure in place for the cleaning of the residents' oxygen concentrator filters. <p>3. Observation on 6/30/15 at 11:45 a.m. of RN A revealed:</p>	F 441		
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F 441	<p>Continued From page 125</p> <p>*She: -Had prepared and set-up resident 8 to do a nebulizer treatment (medication to improve breathing). -Entered the room and retrieved the nebulizer apparatus. The entire apparatus had not been taken apart and was attached to the machine. -Had taken apart the apparatus and went into the bathroom and rinsed out the medication chamber. -Placed the medication in the chamber and attached it to the rest of the apparatus. *After the resident had completed the nebulizer treatment she attached the apparatus to the nebulizer machine.</p> <p>Interview on 6/30/15 with RN A at the time of the above observation revealed that had been her usual process to clean the nebulizer apparatus.</p> <p>Interview on 7/1/15 at 7:40 a.m. with LPN B revealed: *She would have wiped the nebulizer mask with an alcohol wipe and rinsed the chamber out with water. *She would have put the apparatus back together and and attached it to the machine.</p> <p>Interview on 7/1/15 at 7:45 a.m. with the DON revealed: *The nursing staff should have rinsed out the chambers with water everyday. *She had not monitored the staff administering the nebulizer treatments to ensure they were following the provider's policy and procedure.</p> <p>Review of the provider's May 2012 Oral Inhalation Administration policy revealed: **When treatment is complete, turn off nebulizer</p>	F 441			

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F 441	Continued From page 126 and disconnect T-piece, mouth piece, and medication cup." **"Rinse and disinfect the nebulizer equipment according to manufacturer's recommendations, or wash pieces (except tubing) with warm, soapy water daily. Rinse with hot water. Allow to air dry completely on paper towel." **"Once a week/three times a week/daily disinfect the equipment by using a microsteam bag in the microwave for time recommended on bag or soaking for 5 minutes in 70% (percent) isopropyl alcohol and then rinse with sterile water." **"When equipment is completely dry, store in a plastic bag with the resident's name and the date on it. Surveyor: 26632 4. Observation on 6/30/15 at 8:45 a.m. of the housekeeping office revealed a handwashing sink. No handsoap dispenser or paper towel dispenser was present. Interview with the housekeeping supervisor at that time confirmed that. She also stated the housekeepers would use that sink to wash their hands. 5. Interview on 6/30/15 at 8:20 a.m. with the beautician revealed she did not sanitize the hair washing sink between residents. She stated she only rinsed the sink with water and was not aware she should have sanitized it.	F 441		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and	F 514		

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F 514	<p>Continued From page 127 systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review and interview, the provider failed to ensure 3 of 14 sampled residents (1, 2, and 9) had accurate medical records. Findings include:</p> <p>1. Review of resident 9's medical record revealed: *Her family had called her attending physician and asked for discharge orders on 5/22/15. *The physician had not agreed to the request and stated if they wanted to discharge it would have been considered against medical advice (AMA). *The physician stated "If they do not want to follow medical advice I suggest they seek a new physician and if they take her out of her SNF [skilled nursing facility] AMA please send a 30 day notice that will see her for emergency only until they can establish with another PCP [primary care physician]." *A facsimile on 6/25/15 from the above physician in regards to a laboratory test result revealed the physician stated "I have been fired as her physician ~ [about] 2 wks [weeks] ago. I was told they were leaving AMA 2 wks ago. Confused to why they didn't leave & [and] who is her new physician."</p>	F 514	<p>F514 E Medical Records Complete/Accurate</p> <p>Resident # 1, 2, and 9 Facility is unable to correct past entries in medical records *7/31/15 KG/SDDH/JJ</p> <p>Residents residing in the facility have the potential to be affected in a similar manner. [REDACTED] *KG/SDDH/JJ [REDACTED]</p> <p>Staff has been reeducated on appropriate medical record documentation practices</p> <p>Director of Nursing or designee will complete 5 random audits weekly x 4 weeks then monthly x 2 months to ensure t completion and accuracy. Results will be reviewed at monthly QAPI meetings for further recommendations* and report Monthly to QAPI. KG/SDDH/JJ</p> <p>for accurate documentation KG/SDDH/JJ</p>	
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F 514	<p>Continued From page 128</p> <p>*A facsimile on 6/15/15 to the above physician from the SSD revealed: -"The _____ [family's name] would like to take _____ [resident 9] home on 6/18/15. I have attempted to visit with her cancer doctors but have not been successful. They have prepared their home for her return. Therapy will complete a home visit." -The physician replied "The _____ [family's name] have fired me, didn't you get the note I sent last week?" "I was told I'm no longer her Doctor by her son."</p> <p>Interview on 7/1/15 at 8:20 a.m. with the SSD revealed: *The 5/22/15 physician's note had not been received until 6/25/15. *She had sent the 6/15/15 note before she had received those 5/22/15 notes. *She had been working very hard on finding resident 9 a new physician. *She agreed there was no further documentation that she had contacted other physicians.</p> <p>2. Review of resident 1's medical record revealed: *A note from her admitting physician of his retirement on 6/19/15. *There was no documentation a new physician had been contacted to have taken over her care.</p> <p>Interview on 7/2/15 at 8:00 a.m. with the SSD revealed: *Resident 1 had a new attending physician. *She had not updated her chart including the face sheet. *She agreed staff would not have known which physician to contact.</p>	F 514		
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F 514	Continued From page 129 Surveyor: 26180 3. Review of resident 2's entire medical record revealed: *Documentation was incomplete regarding: -Behaviors exhibited prior to the administration of antipsychotic medications being administered. -Follow-up of planned interventions for activities. -Social services interventions addressing psychosocial aspects of care. -Dental progress notes regarding ongoing dental care needs. -Care plan being reviewed and revised as changes occurred.	F 514			

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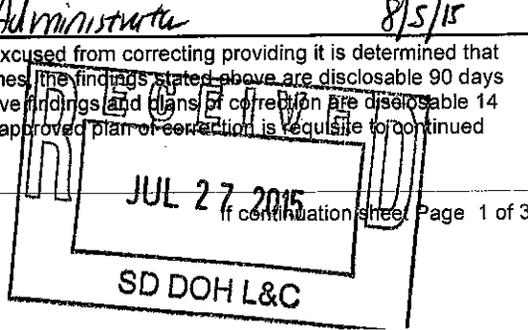
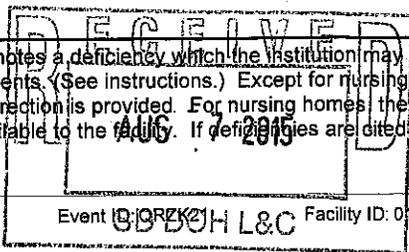
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - BLACK HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 NORTH 7TH STREET RAPID CITY, SD 57701
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K 000	<p><i>Addendums noted with an asterisk per 7/30/15 telephone to facility administrator. LF/SDDH/JJ</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 6/30/15. Golden LivingCenter-Black Hills was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K025 and K069 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	<p>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</p>	
K 025 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain the thirty minute fire resistive rating of smoke barrier walls. One of four smoke barrier walls (at the service wing) had unsealed</p>	K 025	<p>K 025C Smoke Barriers</p> <p>Both penetrations were corrected by the maintenance director, with 5/8ths sheet rock along with fire approved rated caulking.</p> <p>All residents residing in the facility have the potential to be affected.</p> <p>Both penetrations will be put on a quarterly PM for a year and will be reevaluated after that for appropriateness.</p>	<p>*7/6/15 LF/SDDH/JJ</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Matthew Parson</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8/5/15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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K 025	Continued From page 1 openings above the ceiling. Findings include: 1. Observation at 2:30 p.m. on 6/30/15 revealed the smoke barrier wall at the service wing had an two inch diameter unsealed opening around category 5 wiring penetrations above the corridor ceiling. There was also an opening approximately five inches by five inches above the first unsealed opening. Those openings negated the thirty minute fire resistive rating of the smoke barrier wall. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated he was a new employee at the facility as of June 2015.	K 025	<i>* The maintenance director or designee will report the correction of this deficiency to the quality assurance committee. LF/SDDOH/JJ</i>	
K 069 SS=C	This deficiency could potentially affect all sixty-nine residents of the facility. NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on record review and interview, the provider failed to maintain the connection for the kitchen range hood extinguishing system to the fire alarm system in accordance with National Fire Protection Association 96. Findings include: 1. Record review at 9:00 a.m. of the range hood extinguishing system inspection report dated 01/23/15 revealed the system's manual pull station did not activate the alarm. The alarm was activated when the test link was cut. The activation of the automatic fire-extinguishing system must activate the fire alarm signaling	K 069	K 069C Kitchen Range Hood Ext. System Maintenance director had Western States Fire Protection come and inspect system. No deficiencies cited in report. Pull station is currently working properly. All residents residing in the facility have the potential to be affected. Manual pull station will be checked with semi-annual kitchen hood inspection.	* 7/7/15 LF/SDDOH/JJ

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K 069	Continued From page 2 system. Interview with the maintenance supervisor at the time of the record review revealed he was unaware of the report's comments. He stated he was a new employee with the facility as of June 2015. This deficiency could potentially affect all sixty-nine residents of the facility.	K 069	* the semi-annual inspection reports will be reviewed by the maintenance director to ensure all further comments from the inspection company are addressed. The maintenance director or designee will report correction of this deficiency to the quality assurance committee. LF/5000H/JJ	
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ORIGINAL

PRINTED: 07/13/2015
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10665	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/02/2015
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S 000	Initial Comments Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 6/29/15 through 7/2/15. Golden LivingCenter - Black Hills was found not in compliance with the following requirements: S166 and S355.	S 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. S 166 Occupant Protection Continuous front door alarm will be engaged if front door cannot be actively monitored. All residents residing in the facility have the potential to be affected. Department head team has been reeducated that continuous alarm is to be activated if the front door cannot be monitored actively. Manager on Duty will sign off on record log prior to leaving in order to ensure that front door alarm has been activated. Results will be reviewed at monthly QAPI meetings for further recommendations x3 months.	
S 166	44:04:02:17(1-10) OCCUPANT PROTECTION The facility must take at least the following precautions: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents; (3) Provide a call system for each...resident bed and in all toilet rooms and bathing facilities routinely used by...residents. The call system must be capable of being easily activated by the...resident and must register at a station serving the unit; (4) Provide handrails firmly attached to the walls on both sides of all resident corridors in nursing facilities; (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors in nursing facilities. Other exterior doors must be locked or alarmed. The alarm must be audible at a designated nurses' station and may not automatically silence when the door is closed;	S 166		

Addendums noted with an asterisk per 7/30/15 telephone to facility administrator and DON. K.G./S.D.O.H./J.J.

everyday to include weekends and holidays. K.G./S.D.O.H./J.J.

**7/31/15
K.G./S.D.O.H./J.J.*

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

Martin Rose

STATE FORM

RECEIVED
AUG 7 2015
SD DOH L&C

WOLG11

RECEIVED
JUL 27 2015
SD DOH L&C

(X6) DATE

8/5/15

Continuation sheet 1 of 5

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10665	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2015
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S 166	<p>Continued From page 1</p> <p>(7) Portable space heaters and portable halogen lamps may not be used in a facility; (8) Household-type electric blankets or heating pads may not be used in a facility; (9) Any light fixture located over a...resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof lamp; and (10) Any clothes dryer must have a galvanized metal vent pipe for exhaust.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 28057 Based on observation, interview, and policy review, the provider failed to ensure one of six exit doors (the main entrance door) had been alarmed, locked, or attended at all times. Findings include:</p> <p>1. Observation throughout the survey from 6/29/15 at 3:15 p.m. through 7/2/15 at 2:00 p.m. revealed the main entrance door had a two-toned alarm that sounded when the door was opened. It had not continued to sound until silenced by the staff. The door was in sight of the business office manager when she was at work and at her desk. The door was unattended from 5:00 p.m. until 7:00 a.m. or later every day.</p> <p>Interview on 7/1/15 at 4:40 p.m. with the business office manager confirmed she had usually worked until 5:00 p.m. Occasionally she would stay a little later if she had work to finish. She agreed she was not at her desk a hundred percent of the time</p>	S 166		
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S 166	<p>Continued From page 2</p> <p>during her work day. She usually had not worked on weekends.</p> <p>Interview on 7/1/15 at 4:45 p.m. with certified nursing assistant (CNA) K confirmed: *She would not have gone to check the entrance door if the usual two-toned alarm had sounded in the evening. *She would have thought it had been a family member leaving the facility. *She would have responded if the bracelet activated alarm had sounded. That alarm had sounded differently.</p> <p>Interview on 7/1/15 at 4:50 p.m. with CNA L confirmed: *She would not have gone to check the entrance door if the usual two-toned alarm had sounded in the evening. *She would have responded promptly if the bracelet activated alarm had sounded.</p> <p>During the above interview both CNAs agreed when the two-toned alarm sounded in the evening they thought it was a family member leaving to go home.</p> <p>Interview on 7/1/15 at 4:40 p.m. with the administrator confirmed that door had not had an alarm in use that would have sounded continuously when the door was opened at any time during a twenty-four hour period. He had not known there was that type of alarm available until he further investigated and reported back to this surveyor. Such an alarm existed, but it had not been utilized for quite some time. He had not known a state rule had existed to ensure an exit door was to have been alarmed, locked, or attended at all times. He agreed only the two-toned alarm and the bracelet alarm system</p>	S 166		

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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) COMPLETE DATE
S 166	<p>Continued From page 3</p> <p>were on at all times. He agreed staff would not have been alerted if a resident without a bracelet had gone out the door.</p> <p>Review of the provider's undated Elopement Guideline Policy revealed: *A specific system had been developed to notify staff that an external door had been opened. *If a door alarm had been rendered inoperable an employee was to have physically and visually monitored the door at all times. *Monitoring was to have been continuous without exception. *Only the executive director or designee was allowed to authorize the disabling of the alarm system.</p>	S 166		
S 355	<p>44:04:12:05 PROVISION OF SOCIAL SERVICES</p> <p>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.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 26180 Based on interview the provider failed to ensure</p>	S 355	<p>S 355 Provision of Social Service</p> <p>Contract has been created between social worker and our social worker designee for _____ ^{monthly} consults. <i>KG/SADPH/JJ</i></p> <p>All residents residing in the facility have the potential to be affected.</p> <p>Contract has been put into place and terms are understood between both parties.</p> <p>Social service contract will be reviewed annually in July at QAPI for revision and/or renewal.</p>	<p><i>7/31/15</i> <i>KG/SADPH/JJ</i></p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10665	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/02/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - BLACK HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 N 7TH ST RAPID CITY, SD 57701
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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) COMPLETE DATE
S 355	<p>Continued From page 4</p> <p>they had a contract with a licensed social worker (LSW) to provide at a minimum quarterly consultation to their social services designee (SSD). Findings include:</p> <p>1. Interview on 6/30/15 at 4:00 p.m. with the social services designee revealed she:</p> <ul style="list-style-type: none"> *Was not a licensed social worker. *Had worked in another facility as the social work assistant prior to coming here in September 2014. *Had a LSW who was her consultant, but she was unsure if they had a contract with the LSW or not. <p>Interview on 7/2/15 at 11:00 a.m. with the executive director revealed:</p> <ul style="list-style-type: none"> *They did not have a contract with the LSW who provided consultation to their SSD. *He had spoken with the LSW, and she confirmed: <ul style="list-style-type: none"> -They did not have a contract. -Because they were all part of the same corporate organization she had never had a contract. *He was not aware the contract was required. 	S 355	<p>* The first quarterly consult is scheduled for August 2015. The administrator will monitor quarterly to ensure the consultations occur and report to QAPI quarterly. K&L/SPDH/JJ</p>	