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

ORIGINAL

PRINTED: 03/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435031		02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - COVINGTON HEIGHTS	3900 S CATHY AVE SIOUX FALLS, SD 57106

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F 000	INITIAL COMMENTS	F 000	Addendums noted with an asterisk per 3/11/15 telephone to facility administrator. KG/SDDOH/MF	
	Surveyor: 32335 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/17/15 through 2/19/15. Golden LivingCenter-Covington Heights was found not in compliance with the following requirement(s): F248, F281, F309, F312, F314, F386, F425, F431, and F441.		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. This applies to F248, F281, F309, F312, F314, F386, F425, F431, F441 and S237.	
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.	F 248	**F248 Activities Meet interest/needs of each resident** KG/SDDOH/MF 1. Resident [redacted] immediately began receiving activities based on individual assessed interest and needs. Residents residing in the facility will have activity needs re-evaluated to ensure activities are being provided based on individual interests and needs. All residents have the potential to be affected. 2. Administrator and activity Coordinator to review and revise as necessary the policy and procedure about the provision of activities for the individual resident as well as the group as a whole to include the findings cited on the deficiency by 3/17/2015. The Administrator or Designee will educate all staff on the policy and procedure about the	
	This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, record review, interview, calendar review, and recreation guide review, the provider failed to ensure 1 of 17 sampled residents (2) received activities based on individual assessed interests and needs. Findings include: 1. Review of resident 2's 12/15/14 Minimum Data Set assessment revealed she enjoyed music, animals, getting outside when the weather permitted, and religious activities. Random observations and interview with resident 2 from 2/17/15 through 2/19/15 revealed: *She was visibly impaired and acknowledged having very limited vision.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Executive Director (X6) DATE: 3/11/15

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

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F 248	Continued From page 1 *Did not come out of her room for group programs. *Ate supper meals in her room. *She enjoyed visiting but had difficulty visiting with her tablemates. *Observations included that she did not visit with her tablemates. *Her vision had gotten worse since she had been admitted. *Since she could not see she always worried that she would not be assisted back to her room after an activity. *Her radio was not on in her room. Review of resident 2's 10/10/14 care plan revealed interventions included: *"Please monitor my activity participation and provide 1:1's [one-to-ones] and/or small groups as necessary. *Please help me participate in my favorite activities at my highest level. Some of my interests are music (old time and country), dog, outdoors, religious and visiting." Review of resident 2's following recreation participation records revealed: *In December 2014 she had actively participated in spiritual programs twice, a special event once, and nail painting once. -She actively visited daily but did not say with who or where.. -A note read "visits with others during meals, otherwise mostly sleeps." *In January 2015 she had not attended a group program. -She received a one-to-one once. -A note read "Mostly does her visiting at meal time." *In February 2015 she had not attended any	F 248	provisions of activities for the individual resident as well as the group as a whole by 3/17/15. 3. The Activity Coordinator or Designee will audit 5 residents to ensure resident care plans and participation records appropriately meet the residents needs weekly x 4 weeks and monthly x 3 months. The Activity Coordinator or Designee will report results of audits monthly x 3 to the monthly Quality Assessment and Performance Improvement Committee for further review and recommendations.	4. 3/17/15

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F 248	Continued From page 2 group program. Review of resident 2's individual programming revealed she had received six one-to-one visits since she had been admitted on 6/11/14. Interview on 2/20/15 at 8:30 a.m. with the recreation services director revealed: *She was new in the position and had just returned from several weeks of personal leave. *They had brought in recreation directors from other providers while she was on leave, to focus on documentation. *She could not say how much activity the resident had been involved in. *Based on attendance reviews resident 2: -Had not participated in group programs. -Was to have received one-to-ones, but in reviewing the participation records agreed that had not happened. -Agreed resident 2 had not received activity based on her assessed needs and interests. Review of the provider's 2009 recreation services guide individual programming revealed: *"Programming will be offered to all residents who are unable or choose not to attend group activities. *Residents who are unable or prefer not to participate in group activities will be identified through the assessment process. *Structured individual interventions will be developed based on each resident's history and assessed needs and preferences. *The individual program will be scheduled based on resident preference as to day, time of day and duration. *Reasons a resident may prefer or require individual activities for some of the following	F 248		

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F 248	Continued From page 3 reasons: -Visual impairment.	F 248		
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 observation record review, interview, manufacturer's instructions and policy reviews, the provider failed to ensure: *One of one sampled resident (5) with a wound that required a dressing change was appropriately assessed and documented. *Medications had been given prior to signing the medication administration form for two of two randomly observed residents (11 and 22). *A wound vacuum (vac) (a vacuum dressing that creates negative pressure for wound healing) order had been transcribed correctly for one of one sampled resident (12). *Insulin given was marked with the expiration date for two of two randomly observed residents (4 and 21). Findings include: 1. Review of resident 5's physician's orders revealed: *"Cleanse with betadine on edges of wound. Apply aquacel to the wound base and cover with 4x[by]4 gauze and ABD [a bandage/dressing]. Change dressing twice a day." *Weekly skin assessment.	F 281	**F 281 Services provided meet professional standards** 1. Resident 5's wound was assessed, measured, and documented utilizing the Wound Evaluation flow sheet on 2/21/15. RN C immediately corrected charting by documenting a progress note stating date and time of medication administration* for resident 11. 2/18/2015 H/MF Resident 22's medication (Finasteride) was given at 11:27AM on 2/19/15. RN M immediately corrected charting by striking out original administration time and documented with appropriate administration time. Resident 12's MAR was updated to reflect 125 mm/Hg on 2/18/2015 at 12:46PM. Resident 21's insulin pen was disposed of and replaced on 2/17/2015. Resident 4's insulin pen was disposed of and replaced on 2/24/2015. Wound flow sheets were completed for all appropriate residents. All wound vac orders were immediately reviewed and changed as appropriate. All insulin pens were checked to ensure dates opened were on pens and that pens were not expired. All residents have the potential to be affected. 2. All nurses will be educated by the Director of Nursing or Designee regarding the wound care policy and procedure including the use of the wound flow sheet by 3/17/2015. Education regarding medication administration procedure will be provided by the Director of Nursing for all nurses by 3/17/2015. All Nurses will be educated by the	

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F 281	Continued From page 4 Interview on 2/20/15 at 11:00 a.m. with the registered nurse/unit coordinator regarding resident 5 revealed: *The wound was a result of a surgical procedure that had been completed over a year ago. -It was a chronic wound. *The resident's abdominal wound was assessed at a wound clinic monthly. *The nurses did not document an assessment of the wound other than to observe it during the dressing change. -They did not measure the wound or document measurements. -They relied on the wound clinic to do that. *She did not know why they had not been measuring the wound. -That should have been done. *The professional standard they would follow for wound assessment would have been based on their policies. *The documentation for the wound assessment should have been done on the Wound Evaluation Flow Sheet. Review of the provider's wound evaluation flow sheet had a checklist that addressed whether the wound was a pressure ulcer (wound caused by pressure) or another type of wound and included the option of it being a surgical wound. Review of resident 5's entire medical record revealed no wound evaluation flow sheet was found in the record. Interview on 2/20/15 at 2:30 p.m. with the interim director of nursing revealed they should have measured and documented the status of resident 5's abdominal wound.	F 281	Director of Nursing or Designee regarding transcribing orders into our electronic medical record by 3/17/2015. Education will be provided by the Director of Nursing or Designee on the process of insulin pens being marked with an open date as of the date opened and to follow manufacture's guideline for expiration dates of insulin pens by 3/17/2015. 3. The Director of Nursing or Designee will audit wound flow sheets for timely and accurate completion for 5 random residents with wounds weekly x 4 weeks and monthly x 3 months. The Director of Nursing or Designee will complete 5 medication distribution audits weekly x 4 weeks and monthly x 3 months. The Director of Nursing or Designee will complete audits of all wound vac orders as appropriate weekly x 4 weeks and monthly x 3 months. The Director of Nursing or Designee will complete audits of insulin pens for open dates and expiration for 5 random residents weekly x 4 weeks and monthly x 3 months. The Director of Nursing or Designee will report results of audits monthly x 3 to the monthly Quality Assurance and Assessment Committee for further review and recommendations.	4. 3/17/15

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F 281	Continued From page 5 Review of the provider's 2006 Clean Dressing Change policy revealed: *"Documentation guidelines may include: -Date, time, dressing change. -Wound size, site, depth, color, drainage. -If drainage is present, document amount, color, and odor, per facility procedure. -Progress of healing (or lack of progress). -Signature and title of nurse changing dressing." Surveyor: 33488 2a. Observation on 2/18/15 at 8:00 a.m. of registered nurse (RN) C entering resident 11's room for medication administration revealed: *She put on personal protective equipment (PPE) (gown and gloves) prior to entering his room. *She carried an insulin pen in her gloved hand. *She entered the room, closed the door, and was inside the room for five minutes. *When she exited his room she carried the insulin pen in her ungloved hand and walked back to the medication cart. *She set the insulin pen down on top of the medication cart and applied hand sanitizer to her hands. *She then placed the insulin pen in the top drawer of the medication cart and closed the drawer. Interview on 2/18/15 at 2:45 p.m. with RN C regarding the above insulin administration for resident 11 revealed: *The resident's insulin pen was co-mingled in the medication cart drawer with other insulin pens. *When asked how she cleaned the insulin pen she had replied she used the bleach wipes located in her bottom drawer of the medication cart. *She agreed she had not used any bleach wipes,	F 281		

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F 281	Continued From page 6 however she stated she had not administered his insulin as he had not yet eaten that day. Interview and review of the medical record on 2/18/15 at 3:00 p.m. with the interim director of nursing and the nurse consultant regarding resident 11 revealed: *He was on contact isolation precautions for a clostridium difficile (C-diff) infection (a bacterial infection spread through contact with stool). *His insulin was electronically signed as administered that morning at 8:01 a.m. by RN C. *Their expectation was if RN C had held his insulin medication she would not have documented the insulin in the electronic medical record (EMR) as having been given prior to an administration attempt. *They expected all staff administering medication to follow the instruction manual on EMR documentation for medication administration. Review of the provider's 2011 EMR instruction manual and interview with the nurse consultant on 2/18/15 at 3:38 p.m. regarding medication administration revealed: *An option that should have been checked when unable to administer a medication was "Hold/See nurses notes." *That would have been the option they would have expected RN C to choose instead of incorrectly documenting it as having been administered. Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, page 587, revealed, "Never document that you have given a medication until you have actually given it."	F 281		

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F 281	Continued From page 7 Surveyor: 32332 b. Observation and interview on 2/19/15 at 11:10 a.m. of RN M and RN L passing medications on the 500 wing revealed: *RN L had been orientating RN M, because it was her first day of work. *RN M had given resident 22 his morning medications. *RN M stated she had given him all of his morning medications as ordered and then signed them off as given. *When asked if RN M had ordered the Finasteride (for difficulty urinating) from the computerized pharmacy machine she stated she had not. *When RN M had checked resident 22's empty medication packets there was no empty packet for Finasteride. *RN M stated she thought she had given all the medication, but she had not given the Finasteride. It had not been in resident 22's medication drawer. *RN M had signed the Finasteride as given, but she had not given it. Interview with RN L at that time revealed: *He had notified the pharmacy "multiple times" the Finasteride had not been routinely dispensed from the provider's in-house computerized pharmacy machine. *The Finasteride needed to have been entered and dispensed out of the computerized pharmacy machine's emergency supply each day. *He stated the pharmacy had told him there was no way to set up the Finasteride to have been dispensed daily. Interview on 2/19/15 at 12:45 p.m. with the	F 281		

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F 281	Continued From page 8 interim director of nursing revealed RN M should not have signed off the Finasteride without having given it. 3. Review of resident 12's hospital discharge orders revealed she was to continue a wound vac 125 millimeters (mm)/mercury (Hg) (a measurement of pressure) to a right ankle wound. The dressing was to have been changed every Monday, Wednesday, and Friday. Review of resident 12's MAR revealed a 2/9/15 order for "Wound Vac at 12 mm/Hg to right ankle." The dressing was to have been changed every Monday, Wednesday, and Friday. *The above MAR had been signed as completed on 2/11/15, 2/13/15, and 2/16/15 indicating the wound vac had been running at 12 mm/Hg. Review of resident 12's progress notes on 2/11/15, 2/13/15, and 2/16/15 revealed the wound vac had been running at 125 mm/Hg. Observation on 2/18/15 at 1:55 p.m. of resident 12 receiving a wound vac dressing change revealed the wound vac was set at 125 mm/Hg. Interview with RN J and RN K at that time revealed RN J noted the transcription error on the morning of 2/18/15. RN K had assessed the wound vac and then changed the MAR to read 125 mm/Hg. Interview with the interim DON revealed her expectation had been the wound vac orders should have been transcribed correctly. Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2005, page 847 revealed , "A	F 281		

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F 281	Continued From page 9 registered nurse checks all transcribed orders against the original order for accuracy and thoroughness. If an order seems incorrect or inappropriate, the nurse consults the prescriber." Surveyor: 34030 4. Observation on 2/17/15 at 5:15 p.m. of registered nurse (RN) D giving medications revealed: *Medication for resident 21 included a Novalog insulin flex pen (a device for giving the med). *The insulin was from a pharmacy other than the one the provider used. *There was no open date or expiration date on the pen to tell when it was outdated for use. *RN D proceeded to administer it to the resident. Later observation of the same medication pass with the above nurse revealed: *Medication for resident 4 that included a Novalog insulin flex pen. *The insulin was from another facility. *There was no open date or expiration date on the pen to tell when it was outdated for use. *RN D proceeded to administer it to the resident. Review of the provider's May 2012 policy on medications brought to the facility by residents revealed those medications could be used only if labeled appropriately according to state and federal requirements. According to manufacturer's instructions for the above Novalog flex pen it was to be discarded fourteen days after the first use.	F 281		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	Continued From page 10 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to ensure two of two sampled residents (15 and 16) on hospice care had it combined into their plans of care. Findings include: 1. Review of resident 15's medical record revealed: *She had been admitted on 10/18/13. *She was currently on hospice care. *She had been receiving hospice services since 9/24/14. Further review of resident 15's medical record revealed she had a separate binder that contained all of the hospice provider's documents. Review of resident 15's 3/4/15 care plan revealed: *She had a "Potential for adverse drug reactions related to usage of 9+ [plus] meds [medications]." *Interventions had included hospice in decision making with medications. *"Resident transitioned to hospice cares; significant weight loss."	F 309	**F309 Provide care/services for highest well being** 1. Resident 15 and 16's Care Plans were reviewed and updated on 3/6/2015. Care plans for resident 15 and 16 were integrated with the hospice care plan on 3/6/2015. All resident's receiving hospice services will have care plan reviewed and integrated with the hospice care plan by 3/17/2015. All resident's receiving hospice services have the potential to be affected. 2. Administrator, Director of Nursing, and the Interdisciplinary team to collaborate with the hospice provider and review and revise as necessary the policy and procedure about Hospice care in the facility to include findings cited in the deficiency by 3/17/2015. Aseracare Hospice and the Living Center will meet monthly to discuss all residents receiving hospice services from Aseracare hospice. Weekly hospice visit schedule will be updated weekly and kept in an area for living center staff to review. Partnership with all hospice providers being utilized will be discussed at quality assurance and assessment meetings monthly as necessary. Education will be provided to all staff by the Director of Nursing or designee regarding hospice care and appropriate care planning for residents receiving hospice services by 3/17/2015.	

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F 309	Continued From page 11 *Interventions had included an expectation for intake and weight to decline as disease progressed. *It had not: -Addressed why she was on hospice. -Identified the services hospice provided to the resident. -Identified how pain management was achieved. -Identified what care was to have been provided by the provider and by hospice. Interview on 2/19/15 at 9:20 a.m. with the licensed social worker regarding resident 15 revealed: *The provider had not integrated hospice care plans into their care plans. *She agreed the hospice care plan needed to have been integrated into the provider's comprehensive care plan. *She confirmed the provider's comprehensive care plan needed to have been followed to provide care for her. Interview on 2/19/15 at 11:00 a.m. with certified nursing assistant (CNA) E regarding resident 15 revealed she had not known what services hospice were to have provided. Surveyor: 35121 Preceptor: 32331 2. Review of the resident 16's medical record revealed she: *Had been admitted on 9/10/14. *Was currently on hospice care. *Had been receiving hospice services since 12/3/14. Review of resident 16's 12/15/14 care plan revealed:	F 309	3. The Director of Nursing or Designee will complete audits of 5 care plans for residents receiving hospice services weekly x 4 weeks and monthly x 3 months. The Director of Nursing or Designee will report results of audits monthly x 3 to the monthly Quality Assurance and Assessment Committee for further review and recommendations.	4. 3/17/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	435031		02/19/2015

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F 309	Continued From page 12 *The resident was on hospice care. *Expected intake and weight to decline as disease progressed. *Refer to hospice and palliative (end of life) care regarding advanced directive (guidance for health care decisions). *Hospice counselor visits and social worker visits one time monthly. *Volunteer visits two times monthly. *Pet therapy when available. *Report behavior changes to physician and communicate with Hospice care. *Encourage resident to get out of bed for activities she would enjoy, meals, and change of scenery. *It did not address: -Why she was on hospice. -How pain management was achieved. -What care was to have been provided by the provider and by hospice. Interview on 2/19/15 at 10:28 a.m. with CNA G regarding resident 16 revealed she had not known what services hospice were to have provided. 3. Interview on 2/19/15 at 10:35 a.m. with registered nurse F regarding hospice services revealed: *Staff did not know for sure when hospice staff was expected to come. *Hospice staff were to have been giving a verbal report of services provided each day when they were done providing care. *Staff were to have signed a hospice form that showed they had been there and had provided services. Surveyor: 32331	F 309		

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F 309	Continued From page 13 Interview on 2/19/15 at 11:25 a.m. with the director of clinical services at the hospice agency regarding residents 15 and 16 revealed: *They had not integrated hospice care plans into the provider's care plans. *It was the responsibility of the provider to integrate the care plan provided by the hospice agency into the provider's care plan. Surveyor: 35121 Preceptor: 32331 Interview with the director of nursing on 2/19/15 at 1:28 p.m. regarding residents 15 and 16 revealed: *She agreed they did not have their care plans combined with hospice. *Staff had been relying on wing report sheets for hospice information. *Wing report sheets (communication sheet used by staff to direct cares for residents) were to have been updated with changes by the nurses or the CNAs. *She agreed the wing report sheet did not have any reference to hospice for resident 16. Review of the provider's October 2009 Interdisciplinary Care Plan policy stated the care plan was to guide in the provision of necessary care and services to attain or maintain the highest practicable physical, mental, and psycho (emotional)-social well being of the resident. It was to be reviewed and updated as necessary to address the residents needs. Review of the provider's 8/26/13 Hospice Care Services Agreement revealed the provider and hospice were to have developed a combined the care plan for each Hospice resident.	F 309		

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F 312	Continued From page 14	F 312		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Surveyor: 35121 Preceptor: 32331 Based on observation, interview, record review and policy review, the provider failed to perform oral hygiene for one of one sampled resident (1) who needed total assistance (full staff help). Findings include: 1. Observation on 2/19/15 at 10:02 a.m. of licensed practical nurse (LPN) N regarding resident 1 revealed she: *Was unable to find any oral (mouth) care supplies in his room. *Left room and returned with oral swabs, mouthwash, and a cup. *Performed oral care for him. Review of resident 1's 11/12/14 clinical health status assessment revealed he had "broken, loose or carious [cavities] teeth." Review of resident 1's 11/13/14 care plan revealed he was: *At risk for dental problems. *Relied on staff to do his oral care. *To have had oral care every two hours and as needed.	F 312	**F312 ADL Care Provided for Dependent Residents** 1. Oral care was immediately provided for resident 1. Care plan for resident 1 reviewed and updated on 3/9/2015. All residents needing assistance with oral cares were checked to ensure oral cares had been provided as appropriate. All residents have the potential to be affected. 2. Administrator, Director of Nursing and Interdisciplinary Team will review and revise as necessary the policy and procedure about providing oral care as well as the findings cited in the deficiency and ensuring adequate and appropriate supplies are available for use by 3/17/2015. All nursing staff will be educated by the Director of Nursing or Designee regarding the policy and procedure about providing oral care by 3/17/2015. 3. The Director of Nursing or Designee will audit 5 residents requiring assistance with oral cares to ensure oral care is completed based on the resident's individual needs weekly x 4 weeks and monthly x 3 months. The Director of Nursing or Designee will report results of audits monthly x 3 to the monthly Quality Assurance and Assessment Committee for further review and recommendations.	4. 3/17/15

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F 312	Continued From page 15 Interview on 2/19/15 at 9:53 a.m. with certified nurse aide (CNA) E revealed she stated the nurses were to have performed oral care for resident 1. Interview on 2/19/15 at 9:58 a.m. with LPN N revealed she stated the CNAs were to have performed oral care for resident 1. Interview on 2/19/15 at 10:30 a.m. with the administrator revealed the provider had no oral care policy. Review of the provider's October 2009 Interdisciplinary Care Plan policy stated the care plan was to guide in the provision of necessary care and services to attain or maintain the highest practicable physical, mental, and psycho (emotional)-social well being of the resident. It was to be reviewed and updated as necessary to address the residents needs. Interventions that had proved ineffective must have been changed immediately. Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing 8th Ed., St. Louis, Mo., 2013, pp. 786-787, revealed: *Patients with special needs require special oral hygiene methods. *Patients with decreased levels of consciousness need special attention.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores	F 314		

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F 314	Continued From page 16 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. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and guideline review, the provider failed to appropriately assess and reposition regularly one of one sampled resident (3) who had developed a pressure ulcer (a sore caused by unrelieved pressure that resulted in damage to tissue) to her bottom after being re-admitted into the facility. Findings include: 1. Review of resident 3's medical record revealed she had: *Been admitted on 3/1/13. *Recently been hospitalized on 12/17/14. *Returned from the hospital on 12/22/14 with two open areas to her right upper thigh that might have been caused by the Foley catheter (tube inserted into the bladder) strap. -Those areas had healed up. *Developed a new pressure ulcer to her bottom on 1/6/15. -There was no notification to the physician regarding that pressure ulcer until 1/30/15 when they asked to change treatment. *Developed a second pressure ulcer to her bottom on 1/27/15. *She had developed two pressure areas to her right foot documented on 2/10/15.	F 314	**F314 Treatment/Services to prevent/Heal Pressure Sores** 1. Resident 3 was repositioned immediately. Reposition order for resident 3 was updated on 3/6/2015. New Braden scale for Resident 3 was completed on 3/9/2015. All appropriate resident's Braden scales and reposition orders were reviewed and revised as appropriate. All residents have the potential to be affected. 2. Administrator, Director of Nursing, and interdisciplinary team to review and revise as necessary the policy and procedure for ensuring appropriate and timely interventions are identified and implemented for the individual at risk for pressure ulcers or with an identified pressure ulcer to include the findings cited in the deficiency by 3/17/2015. Education for all staff will be provided by the Director of Nursing or Designee regarding the policy and procedure for ensuring appropriate and timely interventions are identified and implemented for the individual at risk for pressure ulcers or with an identified pressure ulcer by 3/17/2015. Furthermore, education for nurses will be provided by the Director of Nursing or Designee regarding the appropriate utilization of the wound flow sheet and proper and timely completion of the Braden scale by 3/17/2015. 3. Audits will be conducted by	

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F 314	Continued From page 17 Review of resident 3's 12/22/14 Braden Scale for Predicting Pressure Sore Risk assessment revealed her Braden score was nineteen. That indicated she was not at risk for developing pressure ulcers. Review of resident 3's 9/18/14 Minimum Data Set (MDS) assessment revealed: *Her thinking ability was not impaired. *She had been at risk for developing pressure ulcers. *She needed limited assistance from one staff person for moving in bed. *She needed extensive assistance from one staff person for transfers. *She needed total assistance from one staff person for toilet use. *She needed total assistance from one staff person for bathing. Review of resident 3's 12/29/14 MDS assessment revealed: *Her thinking ability was not impaired. *She had been at risk for developing pressure ulcers. *She needed extensive assistance from two staff members for moving in bed. *She needed total assistance from two staff members for transfers. *She needed total assistance from one staff person for toilet use. *She needed extensive assistance from one staff person for bathing. Review of resident 3's wound evaluation flow sheet for the "right gluteus [buttock] (inner)" revealed: *The measurements were the following: -On 1/6/15: 1.3 centimeters (cm) in length, 0.7 cm	F 314	Director of Nursing or Designee weekly x 4 weeks and monthly x 3 months of 5 residents with pressure sores or at high risk for pressure sores to ensure all interventions are in place, Braden scale is completed appropriately, and proper documentation is in place. The Director of Nursing or Designee will report results of audits monthly x 3 to the monthly Quality Assurance and Assessment Committee for further review and recommendations.	4. 3/17/15

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F 314	Continued From page 18 wide, and 0.0 cm deep. -On 1/13/15: 0.6 cm in length, 0.6 cm wide, and 0.0 cm deep. -On 1/20/15: 0.5 cm in length, 0.5 cm wide, and 0.0 cm deep. -On 1/27/15: 1.3 cm in length, 2.0 cm wide, and 0.0 cm deep. -On 2/3/15: 1.0 cm in length, 2.0 cm wide, and 0.0 cm deep. -On 2/10/15: 1.3 cm in length, 1.0 cm wide, and 0.0 cm deep. -On 2/18/15: 0.6 cm in length, 1.4 cm wide, and 0.0 cm deep. *They had changed the treatment on 2/3/15 to Vasolex ointment and Mepilex dressing. Review of resident 3's wound evaluation flow sheet for the "right gluteus (outer)" revealed: *The measurements were the following: -On 1/27/15: 0.4 cm in length, 0.5 cm wide, and 0.0 cm deep. -On 2/3/15: 1.0 cm in length, 0.7 cm wide, and 0.0 cm deep. -On 2/10/15: and 2/18/15 there were no measurements documented. Review of resident 3's current undated care plan revealed: *A focus area for pressure ulcers. *The goal was for "pressure ulcer will heal without complication." -It had not identified the two pressure areas to her bottom or the two pressure areas on her right foot. *An intervention to "apply z-guard/barrier cream BID [two times per day] and PRN [as needed]. Dimethicone skin prep [preparation] to bottom and right upper thigh BID." -That was not the current treatment being used.	F 314		

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F 314	Continued From page 19 *Other interventions for the pressure ulcer focus area included: -"Complete Braden scale per living center policy. -Conduct weekly skin inspection. -Diabetic foot monitoring. -Do not massage over bony prominence. -Elevate foot or bed to prevent from pressing against foot of bed. -Follow up with podiatry [branch of medicine devoted to the foot] as needed. Has cellulitis [skin infection] of left foot. Treatment as ordered. -Provide pressure reducing wheelchair cushion; encourage to be up in wheelchair during the day. -Provide pressure reduction/relieving foam mattress to bariatric bed [used for obese individuals]. -Referral to wound clinic. -Rooke boots [insulated boots used to prevent pressure ulcers] on heel at night to keep pressure off heels." *There had been no repositioning plan addressed on the care plan for the pressure ulcers. Review of resident 3's 10/26/14 care plan revealed the same interventions listed above had been in place. Interview on 2/18/15 at 10:20 a.m. with resident 3 revealed the staff only repositioned her at night when she was in bed. Random observations from 2/17/15 through 2/19/15 of resident 3 during the day revealed she had been in her wheelchair. She needed staff assistance to reposition herself in the wheelchair. Review of resident 3's February 2015 medication administration record revealed a reposition program for every two hours while in bed had	F 314		

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F 314	Continued From page 20 started on 1/6/15. That had been the day the pressure ulcer had developed. Review of resident 3's interdisciplinary notes revealed: *There was no documentation she refused to be repositioned after the program had started on 1/6/15. *On 12/30/15 they had a nutrition, hydration, and wound meeting. -The recommendations had been "daily weights, RD [registered dietitian] will continue to monitor and provide further interventions as appropriate." *On 1/6/15 they had another nutrition, hydration, and wound meeting. -The recommendations had been the same as the meeting on 12/30/15. Interview on 2/18/15 at 3:15 p.m. with registered nurse (RN) F and RN Q regarding resident 3 revealed: *They had not started the repositioning program until after the pressure ulcer had developed on 1/6/15. That had only included being repositioned while in bed. *They had no repositioning program for when she was up in her wheelchair during the day. *RN Q was unclear how you would reposition someone while in a wheelchair. Interview on 2/19/15 at 1:30 p.m. with the interim director of nursing and RN P regarding resident 3 revealed: *The Braden form had been inaccurately completed upon her return from the hospital on 12/22/14. *As a general rule they did not document repositioning programs. *They were unable to provide documentation of	F 314		

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F 314	Continued From page 21 her being repositioned prior to the pressure ulcer developing. *They were also unable to provide documentation that she had refused to be repositioned. *There were no new interventions implemented after her return from the hospital on 12/22/14. Review of the provider's November 2014 Skin Integrity (skin that is whole, undamaged, and intact) Guideline revealed they should have repositioned residents every two hours and should have indicated the frequency on the care plan.	F 314		
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure 2 of 17 sampled residents (5 and 16) had physician's progress notes written according to the required schedule for visits. Findings include: 1. Review of resident 5's entire medical record revealed the last physician progress note was	F 386	**F386 Physician Visits- Review care/Notes/Orders** 1. The physician clinic notes for resident 5 and 16 were obtained on 3/9/2015. All residents have the potential to be affected. 2. The Director of Nursing or Designee will educate all nurses on the proper procedure for monitoring physician visits by 3/17/2015. 3. The Director of Nursing or Designee will randomly audit 5 resident charts ensuring the physician clinic notes are in the chart when appropriate weekly x 4 weeks and monthly x 3 months. The Director of Nursing or Designee will report results of audits monthly x 3 to the monthly Quality Assurance and Assessment Committee for further review and recommendations.	4. 3/17/15

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F 386	Continued From page 22 dated 6/10/14. Interview on 2/19/15 at 2:00 p.m. of the registered nurse/unit coordinator (RN) B regarding resident 5 revealed: *She was unable to find additional progress notes for the resident. *A later interview revealed she had spoken with the medical records department and had been told:- -Additional progress notes had not been found. -When residents go to the doctor (physician), the provider sends a form with them to fill out. -Physicians write "Dictation to follow," but that dictation had not been received. *She agreed physician's progress notes form each visit should have been in the resident's medical record. Surveyor: 35121 Preceptor: 32331 2. Review of resident 16's medical record revealed: *She was admitted on 9/10/14. *Physician's progress notes were dated 10/14/14 and 11/4/14 and were the only ones in her medical record. Interview on 2/19/15 at 10:20 a.m. with the health information manager regarding resident 16 revealed she: *Was unable to locate any other physician's progress notes for her. *Agreed they were to have been in the resident's medical record. Interview on 2/19/15 at 1:28 p.m. with the director of nursing regarding resident 16 revealed:	F 386		

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F 386	Continued From page 23 *They had no set process in place to ensure physician progress notes were being received and placed in her chart. *She agreed the physician progress notes needed to have been received and placed in the resident's medical record. Surveyor: 26180 Review of the provider's undated monitoring physician visits policy revealed it: *Addressed the necessity of timely visits by the physician. *It had not addressed the need to have copies of all physician progress notes on file.	F 386		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	**F 425 Pharmaceutical Services Accurate Procedures, RPH** 1. Resident 22's medication (Finasteride) was given at 11:27AM on 2/19/15. Resident 22's medication (Finasteride) was added to the computerized pharmacy machine system after a call was placed to the pharmacy on 2/20/2015. A report of medications manually dispensed from the computerized pharmacy machine within the last 7 days was reviewed on 3/9/2015 and any appropriate corrections made. All residents have the potential to be affected. 2. Administrator and Director of Nursing in collaboration with the consultant pharmacist will review and revise as necessary the policy and procedure as well as the dispensing system to ensure physician ordered medications are incorporated within the system by 3/17/2015. This review will include the findings cited in the deficiency and review of transcription of order accuracy and relay of order to pharmacist by 3/17/2015. Education will be provided by the Director of	

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F 425	Continued From page 24 This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, record review, interview, and policy review, the provider's consultant pharmacy failed to have a routine medication readily available to administer daily for one of one random resident (22). Findings include: 1. Observation on 2/18/15 at 7:25 a.m. of registered nurse (RN) D revealed she had just entered a medication request in the the provider's in-house computerized pharmacy machine for resident 22.. That machine dispensed pre-determined dosages of medication. Interview with RN D at that time revealed: *The medication Finasteride (for difficulty urinating) had been ordered by the physician on 12/16/15. *Finasteride 5 milligrams (mg) was to have been given daily in the morning. *The medication had not been dispensed routinely from the computerized pharmacy machine since it had been ordered. *She had notified the pharmacy the medication was not being dispensed "over a month ago." *Each time she needed to give the medication she had to enter it into the computer. The computerized pharmacy machine would then dispense it from the emergency supply. Observation and interview on 2/19/15 at 11:10 a.m. of RN M and RN L passing medications on the 500 wing revealed: *RN L had been orientating RN M, because it was her first day of work. *RN M had given resident 22 his morning medications.	F 425	Nursing or Designee to all nurses regarding the proper procedure for dispensing medications from the computerized pharmacy machine including proper transcription of orders, as well as the medication ordering process and the pharmacy delivery schedule by 3/17/2015. Furthermore, education will be provided by the Director of Nursing or Designee by 3/17/2015 to all nurses regarding physician ordered medications being incorporated into the computerized pharmacy machine system. 3. The Director of Nursing or Designee will complete audits for any unavailable medications for the past 7 days and review physician ordered medication incorporation with the computerized pharmacy machine system for 5 random residents weekly x 4 weeks and monthly x 3 months. The Director of Nursing or Designee will report results of audits monthly x 3 to the monthly Quality Assurance and Assessment Committee for further review and recommendations.	4. 3/17/15

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F 425	Continued From page 25 *RN M stated she had given him all of his morning medications as ordered, and then signed them off as given. *When asked if RN M had ordered the Finasteride from the computerized pharmacy machine she stated she had not. *When RN M had checked resident 22's empty medication packets there was no empty packet for Finasteride. RN M checked his medication drawer that also revealed no Finasteride. *RN M stated she thought she had given all the medication. However, she had not given the Finasteride, because it had not been in resident 22's medication drawer. *RN M had signed the Finasteride as given, but she had not given it. Interview with RN L at that time revealed: *He had notified the pharmacy "multiple times" the Finasteride had not been routinely dispensed from the computerized pharmacy machine. *The Finasteride needed to have been entered and dispensed out of the emergency supply each day. *He stated the pharmacy had told him there was no way to set-up the Finasteride to have been dispensed daily from the computerized pharmacy machine. Review of resident 22's 1/12/15 physician's orders revealed a 12/17/14 order for Finasteride 5 milligrams (mg) daily. Further investigation revealed: *Date dispensed: Blank. *Date received: Blank. *Status: "To be ordered." Interview on 2/19/15 at 12:45 p.m. with the interim director of nursing revealed:	F 425		

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F 425	Continued From page 26 *She had not known the medication was not being delivered routinely by the computerized pharmacy machine. *She called the provider's pharmacy and was told the Finasteride had not been ordered, and they had never filled the order. *The Finasteride had been coming out of the computerized pharmacy machine after the nurse had printed it out every day. Interview on 2/19/15 at 3:35 p.m. with the 300/400 wing unit coordinator and the RN consultant/executive director revealed: *The computerized pharmacy machine had been in use since November 2014. *The pharmacist had attempted to investigated the cause of the Finasteride not being routinely dispensed from the computerized pharmacy machine but could not determine the problem. *The pharmacist had been in communication with the general manager of the computerized pharmacy machine to solve the problem. *A print-out of the medications for resident 22 that had been dispensed by the computerized pharmacy machine had indicated ten days that Finasteride had not been removed from the machine from 12/18/14 through 1/26/15. *Those ten days, the medication would not have been given as ordered. *There had been no way of tracking if the pharmacy had been notified the medication was not able to have been routinely dispensed from the machine. *The pharmacist had no knowledge the medication was not being routinely dispensed by the machine. *The emergency supply of Finasteride came from the computerized pharmacy machine. The machine would not have flagged the concern for	F 425		

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F 425	Continued From page 27 resident 22, as other residents also received that medication. *The pharmacist had exited the building without talking to this surveyor. Review of the provider's 2/21/12 pharmacy delivery schedule policy revealed: *New orders were to have been faxed by 6:00 p.m. *The provider was to fax and clearly indicate any reorders in need before a scheduled delivery. *"Any orders faxed after hours but are needed for emergency situations, please call Pharmacy to make sure order has been received and medication is needed."	F 425		
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 reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to	F 431	**F 431 Drug Records, Label/ Store Drugs and Biologicals** 1. The instructions on the medication label for insulin orders were updated for resident 23 on 2/19/2015. All resident's insulin orders were reviewed and compared to corresponding label and any appropriate changes were made. All Fentanyl Patches were destroyed following the manufacturer's instructions following the incorrect destruction of Fentanyl Patches on 2/19/2015. All residents have the potential to be affected. 2. The Director of Nursing or Designee will educate all nurses on the proper labeling of medications as well as the policy and manufacture's instruction on proper destruction of Fentanyl Patches by 3/17/2015. 3. The Director of Nursing or Designee will audit 5 insulin labels	

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F 431	Continued From page 28 have access to the keys. 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. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 A. Based on observation, record review, interview, and policy review, the provider failed to have current and accurate instructions on a medication label for insulin orders that had changed for one of three randomly observed residents (23). Findings include: 1. Observation on 2/18/15 at 7:45 a.m. of registered nurse (RN) D preparing an insulin injection for resident 23 revealed: *The February 2015 medication administration record (MAR) revealed an order for Novolin R (fast-acting insulin for diabetes) 10 units subcutaneously (beneath the skin). The order had been dated 11/5/14. *RN D prepared an insulin syringe with 10 units of Humulin (Novolin) R. *The Humulin R insulin was stored in a prescription bottle dated 11/3/14. The prescription instruction on the bottle instructed "Give 8 units subcutaneously."	F 431	to ensure labels match the current orders weekly x 4 weeks and monthly x 3 months. The Director of Nursing or Designee will audit the destruction of up to 5 Fentanyl patches weekly x 4 weeks and monthly x 3 months. The Director of Nursing or Designee will report results of audits monthly x 3 to the monthly Quality Assurance and Assessment Committee for further review and recommendations.	4. 3/17/15

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F 431	Continued From page 29 Interview at that time with RN D revealed: *She was aware the prescription bottle label had not matched the insulin order on the MAR. *The label should have matched the order on the MAR. *The prescription order had changed in November 2014. *In other facilities she had worked she would have placed a sticker on the bottle indicating the insulin dosage had changed. A new prescription bottle would then have been ordered from the pharmacy. *She did not believe the provider had used dosage change stickers as she had been unable to locate them. Interview on 2/19/15 at 12:45 p.m. with the interim director of nursing and the unit 300/400 coordinator revealed: *The nurse entering a new insulin order should have notified the pharmacy of the order change. *That nurse should have added a dosage change sticker to the old bottle until the pharmacy could deliver a new bottle. Review of the provider's Medication Labels policy revealed: *"If the physician's directions for the use change or the label is inaccurate, the nurse may place a 'change of order-check chart' label on the container indicating there is a change in directions for use, taking care not to cover important information." "When such a label appears on the container, the medication nurse checks the resident's medication administration record or the physician's order for current information." "The dispensing pharmacy is informed prior to the	F 431		

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F 431	Continued From page 30 next refill of the prescription so the new container will contain an accurate label." Surveyor: 34030 B. Based on interview, policy review, and manufacturer's instructions, the provider failed to destroy fentanyl (a narcotic pain medication) patches in a secured manner according to two of two nurses (B and C) interviewed. Findings include: 1. Observation and interview on 2/19/15 at 7:50 a.m. with unit coordinator B regarding destruction of fentanyl patches revealed: *They were destroyed by: -Two nurses who would sign off on the used patches. -Folding them in half and placing them in the locked sharps container on the side of the medication cart. *That sharps container would then: -Be placed in an unlocked container in the utility room until it was picked up for disposal. That room had a key pad lock on the door that all staff had access to. -Have been easy to access to obtain the fentanyl patches for possible abuse. Interview on 2/19/15 at 8:00 a.m. with registered nurse C regarding destruction of fentanyl patches revealed the same process as above. Review of the provider's May 2012 medication destruction policy revealed medications such as fentanyl patches should have been flushed down the toilet per manufacturer's instructions. Review of undated manufacturer's instructions for	F 431		

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F 431	Continued From page 31 fentanyl patches revealed: *"Fold the used fentanyl transdermal system [patches] in half so that the sticky side sticks to itself." *"Flush the used fentanyl transdermal system down the toilet right away. A used fentanyl transdermal system can be very dangerous for or lead to death in babies, children, pets, and adults who have not been prescribed fentanyl transdermal system." Interview on 2/19/15 at 2:10 p.m. with the interim director of nursing revealed she agreed fentanyl patches were not being destroyed according to the provider's policy or manufacturer's instructions.	F 431	* Resident 5's dressing was changed on 2/21/15. RN A was educated on proper dressing change techniques on 3/12/15. RG/SDDOH/MF **F441 Infection Control, Prevent Spread, Linens** 1. [redacted] It was determined that resident 24 had appropriate footwear and resident 24 wore appropriate footwear in common areas after being observed not wearing appropriate footwear in common areas on 2/19/2015. Glucometers were all cleaned with antimicrobial (disinfectant) wipes by 2/20/2015. All residents have the potential to be affected. 2. Administrator, Director of Nursing and Interdisciplinary Team will review and revise as necessary the policy and procedure about infection prevention and control including the findings cited in the deficiency by 3/17/2015. The review will include proper dressing change infection control procedures, glucometer cleaning procedure, and proper footwear to be worn in	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program 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		

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

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F 441	Continued From page 32 prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, interview, and policy review, the provider failed to ensure appropriate infection control practices were followed for: *One of four sampled residents (5) who received a dressing change completed by one of one registered nurse (RN) (A). *One of one randomly observed resident (24) who was ambulated barefoot to the shower room by one of one certified nursing assistant (CNA) (H) . *Two of two glucometer cleaning technique by two of two RNs (D and I). Findings include: 1. Observation on 2/19/15 at 9:50 a.m. revealed RN A entered resident 5's room to complete a dressing change on her abdomen. *RN A did the following:	F 441	common areas by residents. The Director of Nursing or Designee will provide education regarding infection prevention and control for all staff by 3/17/2015. The education will include proper resident footwear to be worn in common areas for all staff and glucometer cleaning and infection control procedures during dressing changes for nurses by 3/17/2015. 3. The Director of Nursing or Designee will conduct audits of 5 random wound dressing changes, 5 glucometer cleanings, and for appropriate resident footwear in common areas weekly x 4 weeks and monthly x 3 months. *The Director of Nursing or designee will report results of audits monthly times 3 months to the Quality Assurance and Assessment Committee for further review and recommendations. KG/SDDOH/MF	4. 3/17/15

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F 441	Continued From page 33 -Established a clean field on the resident's night stand by laying two paper towels on the corner. -Laid out the packages of supplies for the dressing change next to it. *Washed and dryed her hands using three paper towels for drying. *Turned the water faucet off with her paper towels, and then continued drying her hands. *Put gloves on. *Removed the resident's abdominal dressing and disposed of it in the garbage container next to the table. *Removed her gloves. *Washed her hands using the same process as listed above for approximately seven to ten seconds and continued to dry her hands with the contaminated paper towels she had used to turn the faucet off. *After putting another pair of gloves on she cleaned around the wound area with several squares of gauze. *With soiled gloves she went to to the counter and retrieved another package of gauze, touching the box of gauze with her soiled gloves and finished cleaning the wound. *Removed her gloves and washed her hands using the same process as listed above for approximately 7-10 seconds and continued to dry her hands with the contaminated paper towels she had used to turn the faucet off with. *After putting a clean pair of gloves on, she used a Betadine swab (a swab with a disinfectant) to clean around the edges of the wound. *Opened a package with a large Aquacel bandage and laid it on the wound. *Picked the used bandage off the wound and laid it on the discarded packages that she had laid on the paper towels she had used to create a clean field on the night stand.	F 441		

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F 441	Continued From page 34 *Got some tape ready to apply the bandage. *Picked up the bandage and re-applied it to the wound securing it with the tape. *Picked up all the discarded packages and threw them away. -She left the two paper towels on the night stand. *Touched the resident's disposable brief at the upper rim, and determined that needed to be changed as it had blood and drainage on it. *Assisted the resident to get out of bed to go to the bathroom. *Picked up the pair of scissors and put them back in the resident's drawer across the room where other supplies were kept. *Tied up the garbage. *With the same soiled gloves on, she opened the night stand drawer and got some powder out for the resident. *Removed her gloves and again washed her hands for about eight seconds, drying them with three towels, shutting the faucet off, and continued drying her hands with the same paper towels. *Put a new set of gloves on and assisted the resident in putting a cream on her legs. *Threw the paper towels on the night stand away. *Never cleaned the night stand after using it for a place to store new and discarded items used in the wound dressing change. Interview on 2/19/15 at 10:20 a.m. with RN A regarding the above dressing change revealed she: *Concurred that she was probably not washing her hands an acceptable length of time each time she washed them. *Agreed the paper towels were contaminated after she had shut the faucet off with them. *Had not thought the Aquacel dressing was dirty	F 441		

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F 441	Continued From page 35 at the time she laid it on the overbed table, but she agreed she should not have laid it on the table after it had been laid on the wound. *Agreed she had not cleaned the night stand after using it for new and used dressing supplies. -That should have been done. Interview on 2/19/15 at 11:30 a.m. with RN/unit coordinator B revealed she confirmed: *The expectation would have been for the nurse to wash her hands for longer than she had. *The paper towels that had been used to turn the faucet off should not have been used to complete drying her hands. *The Aquacel bandage should not have been laid on the overbed table after it had laid on the resident's wound. *The overbed table should have been cleaned after the dressing change was completed. 2. Observation on 2/19/15 at 7:45 a.m. revealed CNA H was walking with resident 24 down the hall into the tub/shower room. The resident had no shoes or stockings on. Interview at that time with CNA H revealed she had not noticed the resident had no shoes on when she walked down the hallway with her. Interview on 2/19/15 at 10: 45 a.m. with RN/unit coordinator B revealed it would have been an infection control issue for any resident to walk down the hallway barefoot. 3. Interview on 2/19/15 at 2:45 p.m. with the interim director of nursing revealed: *There had been several infection control breaches during the wound dressing change with resident 5. *It would have been an infection control concern	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435031		02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - COVINGTON HEIGHTS	3900 S CATHY AVE SIOUX FALLS, SD 57106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 36 for any resident to have been walking down the hall barefoot. Review of the provider's 2011 Handwashing/Hand Hygiene policy revealed: *"Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: -c. Before and after direct resident contact for which hand hygiene is indicated by acceptable professional practice. -q. After contact with a resident's mucous membranes and body fluids or excretions. v. After removing gloves or aprons." *The procedure for hand washing included "Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel." Surveyor: 34030 4. Observation and interview on 2/17/15 at 5:30 p.m. of RN D regarding the EvenCare glucometer (a device to check blood sugar results on a resident) use and cleaning revealed: *She took the glucometer into three different residents' rooms to use. *She used alcohol wipes to clean the glucometer after each use. *She was unsure what was supposed to be used to clean the glucometers but thought it was alcohol wipes. Observation on 2/18/15 at 7:30 a.m. of RN I regarding glucometer use and cleaning revealed she also used alcohol wipes to clean the glucometer. Review of the provider's undated procedure for	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435031		02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - COVINGTON HEIGHTS	3900 S CATHY AVE SIOUX FALLS, SD 57106

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F 441	Continued From page 37 cleaning the EvenCare glucometer revealed: *Clean the meter between each resident with antimicrobial (disinfectant) wipes. *Wipe the meter thoroughly and let dry for at least one minute to disinfect it. Review of the manufacturer's undated instructions for cleaning and disinfecting the EvenCare glucometer revealed the same instructions as above. There was also a list of acceptable disinfectant products to be used and none of them were plain alcohol wipes. Interview on 2/19/15 at 2:10 p.m. with the interim DON revealed she agreed glucometers were not being disinfected correctly.	F 441		

ORIGINAL

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

PRINTED: 03/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	(X3) DATE SURVEY COMPLETED
	435031		**02/18/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - COVINGTON HEIGHTS	**3900 S CATHY AVE** **SIOUX FALLS, SD 57106**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 2/18/15. Golden LivingCenter-Covington Heights (Building 01, original 1973 structure) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 3/11/15

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

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MAR 12 2015
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ORIGINAL

PRINTED: 03/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02 - BUILDING 02** B. WING _____	(X3) DATE SURVEY COMPLETED
	435031		**02/18/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - COVINGTON HEIGHTS	**3900 S CATHY AVE** **SIOUX FALLS, SD 57106**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 2/18/15. Golden LivingCenter-Covington Heights (Building 02, 1995 acute care and therapy addition) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 3/11/15

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SD DOH L&C

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.

ORIGINAL

PRINTED: 03/04/2015
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	10683		02/19/2015

NAME OF PROVIDER OR SUPPLIER: GOLDEN LIVINGCENTER - COVINGTON HEIGH

STREET ADDRESS, CITY, STATE, ZIP CODE: 3900 S CATHY AVE, SIOUX FALLS, SD 57106

(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 000	Initial Comments	S 000		
	Surveyor: 32335 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 2/17/15 through 2/19/15. Golden LivingCenter Covington Heights was found not in compliance with the following requirement(s): S237.			
S 237	44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS Tuberculin screening requirements for healthcare workers or residents are as follows: (2) A new healthcare worker or resident who provides documentation of a positive reaction to the Mantoux skin test shall have a medical evaluation and chest X-ray to determine the presence or absence of the active disease; and This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to evaluate and obtain chest x-rays for two of two sampled employees (J and O) who had a positive reaction to the skin test for tuberculosis (TB). Findings include: 1. Review of employee J's medical information revealed she had a positive skin test for TB prior to her employment with the provider. On the provider screening tool for TB she had answered no to having fever, chills, night sweats, fatigue,	S 237	**S237 Tuberculin Screening requirements** 1. Chest x rays are scheduled to be completed by 4/1/2015 for employee J and employee O. All residents have the potential to be affected. 2. Administrator or Designee will provide education to the Director of Clinical Education and Business Office assistant on the Tuberculin policy by 3/17/2015. 3. The Administrator or Designee will audit up to 5 new employee files for the appropriate documentation regarding Tuberculin Screening weekly x 4 weeks and monthly x 3 months. The Administrator or Designee will report results of audits monthly x 3 to the monthly Quality Assurance and Assessment Committee for further review and recommendations.	4. 3/17/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Executive Director (X6) DATE: 3/11/15

RECEIVED MAR 12 2015 SD DOH L&C

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	10683		02/19/2015

NAME OF PROVIDER OR SUPPLIER: GOLDEN LIVINGCENTER - COVINGTON HEIGH

STREET ADDRESS, CITY, STATE, ZIP CODE: 3900 S CATHY AVE, SIOUX FALLS, SD 57106

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S 237	Continued From page 1 cough, weight loss, sputum (mucus coughed up from the lower airway) production, and blood in sputum. There was no signature from a medical professional that indicated the employee had been evaluated for TB. There had been no chest x-ray completed. Review of employee O's medical information revealed a note that stated "positive reactor [to TB] due to medications." On the provider screening tool for TB he had answered no to having fever, chills, night sweats, fatigue, cough, weight loss, sputum production, and blood in sputum. There was no signature from a medical professional that indicated the employee had been evaluated for TB. There had been no chest x-ray completed. Interview on 2/19/15 at 9:20 a.m. with the clinical educator responsible for employee TB screening revealed: *Neither employee J or O had received a chest x-ray for being a positive reactor to TB. *There was no signature on the provider TB screening tool that indicated the employees had been evaluated by a medical professional. Interview on 2/19/15 at 9:50 a.m. with the administrator revealed a chest x-ray should have been obtained for employees J and O. Review of the provider's December 1998 Tuberculosis Exposure Control Plan policy revealed if an associate had a past positive skin test for TB they should have obtained an x-ray.	S 237		