

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

ORIGINAL

PRINTED: 05/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435045	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/07/2015
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 3901 S MARION RD SIOUX FALLS, SD 57106
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<p>F 000</p> <p>F 226 SS=E</p>	<p>INITIAL COMMENTS</p> <p>Surveyor: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/5/15 through 5/7/15. Good Samaritan Society Sioux Falls Village was found not in compliance with the following requirements: F226, F250, F252, F281, F309, F314, F329, F431, and F441. 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, observation, interview, and policy review, the provider failed to thoroughly investigate two of two residents (5 and 7) injuries of unknown origin and one of one resident (28) with an incident involving missing property. Findings include:</p> <p>1. Review of resident 7's nursing services progress note revealed: *On 4/19/15, 11:20 a.m. "Res [resident] roommate notified staff that res had a fall in her room. Res was found sitting on buttocks in middle of room with walker beside her. She had her shoes on at the time of the fall, Roommate states res tripped over garbage can that was next to there roommate's bed. Garbage can moved</p>	<p>F 000</p> <p>F 226</p>	<p>Initial Comments</p> <p>Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by State law. For the purpose of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facilities allegation of compliance in accordance with Section 7305 of the State Operation Manual.</p>	
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Addendums noted with an asterisk per Williams telephone to facility administrator. DK1000HMF

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Helen O'Neill* TITLE: Administrator (X6) DATE: 5-29-15

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 226	<p>Continued From page 1</p> <p>between chairs against the wall as fall prevention intervention measure. Res does c/o (complain of) r [right] knee pain and R [right] rib area pain. No bruising lumps or abrasions noted."</p> <p>*4/21/15, 8:24 a.m. "Left message at [name of physician] office about resident's left hand. She had fallen on Sunday and was found sitting on the floor, Now her left thumb/wrist area is swollen, red, warm to the touch. She is rubbing and guarding the area. Occasionally complains of pain with motion/movement."</p> <p>*4/21/15, 10:24 a.m. "Received phone call back from Dr. for an order to xray left thumb/hand due to pain and swelling."</p> <p>*4/21/15 The provider was notified the resident's finger was fractured.</p> <p>Interview on 5/7/15 at 7:45 a.m. with registered nurse (RN) P regarding resident 7 revealed: *She had completed the post fall assessment. *The resident complained of pain in her knee and her rib area. *She had completed range of motion on the resident and denied the resident had complained of pain in her finger or hand. -The resident had dementia (confusion), so it was possible that she did not recognize the pain in her hand. *She confirmed no one had completed a separate investigation when it was discovered the resident had a fractured finger. -She agreed there could have been another incident that had caused the fracture, but the resident would not have been able to report that because of the confusion. *RN O had done the assessment at the time the resident had complained her hand hurt.</p> <p>Interview on 5/7/15 at 8:40 a.m. with RN O</p>	F 226	<p>F 226 Develop/Implement Abuse and Neglect Etc. Policies</p> <p>Unable to rectify the circumstances and the investigation process with resident 7 and 5. A new inventory sheet will be completed for resident 28 to re-verify personal belongings.</p> <p>All staff will receive education on mandated reporting including our abuse and neglect policy and procedures as well as potential abuse/neglect by June 3rd. The administrator or designee will provide additional training on the investigation process at June department meetings for all departments which will be completed prior to June 26, 2015.</p> <p>Administrator, social services, and DNS will review personal inventory process and education will be provided to all staff during June department meetings which will be completed prior to June 26, 2015.</p>	
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F 226	<p>Continued From page 2</p> <p>regarding resident 7 revealed she: *Had completed the nursing assessment when the resident showed signs her hand was hurting. *Thought it was odd they thought the injury to her hand was related to the fall two days earlier, because nothing had been mentioned about hurting her hand in that fall. *Had been told by the staff in the secured unit resident 7 had not fallen during the night but had not done any further investigation to rule out if there had not been another incident to cause the injury to the hand. -She probably should have. *Agreed the injury to the resident's hand was at that time an injury of unknown origin.</p> <p>Surveyor: 35625 2. Observation and interview with RN T and RN U on 5/5/15 at 2:30 p.m. during a dressing change with resident 5 revealed: *A large purple bruise was noted on the outer part of the left thigh. *They were aware of the bruise but referred this surveyor back to RN A for further information.</p> <p>Observation and interview with licensed practical nurse (LPN) B on 5/6/15 at 10:00 a.m. revealed the following: *Upon request of the surveyor, LPN B measured three bruises: -A purple bruise 35.6 centimeters (cm) in length to the left outer thigh -A purple bruise 29.2 cm in length to the left inner thigh -A yellow bruise 40.6 cm that extended around the knee.</p> <p>Review of an internal investigative report form</p>	F 226	<p>Executive Director, Administrator, and DNS met with center's three social workers on May 18, 2015 for continued education on their role in investigation process and how to complete a thorough investigation. The investigation team (DNS, SS, Admin) will meet daily during the week to review incident reports and suggestion/concern forms to ensure incidents are being investigated thoroughly. A spreadsheet will be used to track reportable incidents and suggestion/concerns. The QAPI Coordinator or designee will audit the tracking spreadsheets to ensure incidents are being thoroughly investigated weekly X 4 and then monthly X3. The QAPI coordinator will report the findings to the QAPI committee at least monthly.</p>	6-26-15	

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F 226	<p>Continued From page 3</p> <p>415 dated 4/27/15 regarding resident 5 revealed: *Certified nursing assistant (CNA) V had reported a bruise to traveling nurse W. *The location of the bruise was not identified on the form. *There was no documentation traveling nurse W had investigated the bruise.</p> <p>Review of the initial report sent to the South Dakota Department of Health (SD DOH) on 4/29/15 at 8:00 p.m. regarding resident 5 revealed: *A bruise to the left knee, and left inner and upper leg. *A portion of that report had been illegible. *It had been completed by RN T.</p> <p>Review of the five-day investigation report regarding resident 5 had been sent to SD DOH on 5/4/15 at 3:55 p.m. and revealed: *The bruise "may be r/t [related to] resident fall on 4/20/15 when he fell out of his w/c [wheelchair.]" **Resident currently on coumadin regularly has PT/INR [measures clotting time of the blood] labs." **Resident had been hospitalized on 3/16/15 r/t [related to] cellulitis." **Per staff-resident uses mechanical lift [equipment to transfer resident from place-to-place] at times for safety during transfers and per documentation-resident has used the mechanical lift at times during the past 2 weeks." **"...sling for the mechanical lift does go between resident legs and may have caused bruising to resident inner leg." *Staff interviews were not documented in the report. *They had not documented when the resident had used the mechanical lift.</p>	F 226			

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F 226	<p>Continued From page 4</p> <p>*There was no documentation staff had been observed using the mechanical lift after the above incident had occurred.</p> <p>*The report did not contain evidence to substantiate or not substantiate potential abuse.</p> <p>Interview on 5/6/15 at 5:00 p.m. with the administrator, executive director, director of nursing (DON), and RN F revealed they:</p> <p>*Were unaware of what interviews had been conducted as part of the investigation..</p> <p>*Called licensed social worker associate (LSWA) E to gather more information. That phone call revealed she:</p> <p>-Had not interviewed staff as part of the investigation.</p> <p>-Had used documentation in the electronic medical record to obtain information regarding what equipment was used for transfers.</p> <p>-Was unaware of provider's form #415 from 4/27/15 that referenced the bruise.</p> <p>*Had called RN A to gather more information and that phone call revealed she had:</p> <p>-Discovered the bruising on 4/29/15 to the left upper and inner thigh when completing a dressing change.</p> <p>-Not filled out the initial reporting form or five working day investigation report.</p> <p>-Conducted interviews with traveling nurse W and CNA V regarding the bruise on knee from 4/27/15.</p> <p>-She had not completed any additional interviews.</p> <p>*They acknowledged additional relevant interviews were not conducted.</p> <p>*Confirmed five working day investigation report summary did not contain information regarding specific dates and times of the use of the mechanical lift.</p> <p>*Agreed the investigation had not been</p>	F 226			

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F 226	<p>Continued From page 5 completed thoroughly to determine if neglect or abuse had occurred.</p> <p>Surveyor: 32335 3. Observation and interview with RN A and resident 28 on 5/5/15 at 11:15 a.m. revealed: *She had reported to RN A she was missing a ring as of this morning. *RN A had taken her to her room. *An unidentified staff member had entered the room stating they had looked for the ring. *She had stated they had moved the bed when RN A asked about it. *RN A then moved the bed and found two remotes that had fallen but no ring. *She looked in a few drawers. *She stated they would contact her daughter. *The resident stated her daughter would not know about the ring missing. She had the ring last night, and her daughter had not been to visit since. *After leaving the resident's room RN A stated the resident was confused a lot.</p> <p>Interview on 5/6/15 at 3:50 p.m. with RN A revealed: *She had not filled out an incident report nor started an investigation regarding resident 28's missing ring. *She had not reported the initial incident to the South Dakota Department of Health as required. *She stated the ring had been found last night after she had left at 4:00 p.m. *It had not been found prior to the end of her shift. *She could not verify the ring had been found, as the resident was still not wearing a ring. *There had been no investigation conducted regarding the missing ring.</p>	F 226			

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F 226	Continued From page 6 Interview on 5/6/15 at 5:00 p.m. with the administrator regarding resident 28 and the missing ring revealed: *She had not been aware of the missing ring until she had been asked by surveyor 26180 to see the incident report. *She had immediately questioned LPN B who stated she had not known about a missing ring. *She then had her contact the daughter who stated she was not missing a ring. *They had not checked her inventory list to verify she had a ring to begin with. *They had not interviewed any staff, and they had not completed an investigation into the matter. 4. Review of the provider's June 2014 Abuse and Neglect policy revealed: *The purpose of the policy included to ensure: -"The center has in place an effective system that, regardless of the source, prevents mistreatment, neglect and abuse of residents and misappropriation of their property." -"To ensure that all identified incidents involving injuries of unknown origin are promptly investigated to determine probable cause of unknown origin." **"If a staff member receives an allegation of abuse, neglect or misappropriation of resident property...the staff member will take measures to protect the resident, provided the safety of the staff is not jeopardized. The staff member will then report the allegation to a supervisor." **"The charge nurse or licensed nurse will be notified immediately, assess the situation to determine whether any emergency treatment or action is required and complete an initial investigation. If this is an injury of unknown origin, he or she also will attempt to determine the cause	F 226			

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F 226	Continued From page 7 of the injury." *Staff were to notify the administrator immediately of any incidents of resident abuse, misappropriation of resident property, and injury of unknown origin. *Staff were expected to document that notification. *The investigative team was to review all incidents promptly and investigate further if needed. *The investigation was to include interviews with staff and residents involved in the incident.	F 226			
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and job description review, the provider failed to ensure social service interventions were implemented to assist the resident with adjusting to her new living situation before increasing an anti-depressant medication, and therapy interventions were appropriate for one of one sampled resident (3) new to the facility. Findings include: 1. Interview and observation on 5/5/15 at 1:30 p.m. with resident 3 and her husband revealed: *She had a stroke in 2010.	F 250	F 250 Provision of Medically Related Social Service * for resident 3. DK/DOH/MF Unable to change the events of the dose increase of Zoloft on 12/8/2014 Talk to the physician and spouse about trying a dose reduction to determine if the medication level is needed at this time. If a resident is showing signs/symptoms of depression, behaviors, insomnia, or anxiety the charge nurse will communicate these with the social worker prior to initiating a psychoactive medication to determine if there is any other any non-pharmacological intervention that could be considered.		

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F 250	<p>Continued From page 8</p> <ul style="list-style-type: none"> *She could still communicate verbally, but it took her awhile to respond. *She had answered questions before she fell asleep during the interview. *He visited her everyday for approximately eight hours per day. *He assisted her with breakfast and lunch. *He mentioned the doctor had referred her to group therapy, because he thought she was more depressed. *The husband had not felt group therapy would be beneficial since she was slow in responding. *Staff had told him they did not have group therapy in the facility. *Staff had not attempted to refer her to one-on-one counseling. <p>Review of resident 3's medical record revealed:</p> <ul style="list-style-type: none"> *She had been admitted on 11/5/14. *She had been on Zoloft (anti-depressant medication) 50 milligrams (mg) by mouth every night at bedtime. *On 12/4/14 in a physician's progress note it stated "She does not seem depressed at this point time she is on the sertraline [Zoloft]." *On 12/6/14 a fax had been sent to the physician asking to increase her Zoloft per family request. *The fax stated they had noticed her to be more withdrawn. *The physician had increased the Zoloft to 100 mg on 12/8/14. *There had been no documentation regarding non-pharmacological interventions attempted prior to the dose increase. *There had been no documentation of assisting the resident to adjust to her new environment. *On 4/30/15 the physician had made a referral to group therapy. *On 5/1/15 the facility had sent a fax to the 	F 250	<p>The interdisciplinary team will be included in these discussions to assist with interventions and staff will document the results of these interventions. Non-pharmacological interventions will be added to the care plan.</p> <p>Interdisciplinary team will be educated to review resident care plans on individual non-pharmacological interventions that should be initiated when a decline in mood or behaviors are seen prior to initiating a psychoactive medication. A review of Social Service policy II.B.3a-Behavioral Causes and Interventions will be reviewed along with II.G1-Grief and Loss Interventions will be shared. The social workers will be given a copy of GSS P/P-Providing Medically Related Social Services. Education on mood and behavioral documentation will also be provided. This education will be provided on nursing meeting on June 10, UAP meeting June 11th and CNA meeting on June 17th as well as at other departmental meetings held in June that will be completed by June 26th.</p>		

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F 250	<p>Continued From page 9</p> <p>physician that stated "You gave order for group therapy for depression. We don't have "group" therapy but do have [provider name] services that we can get. Husband declined this and doesn't feel she would be able to communicate well and doesn't feel that she's depressed. Can we d/c [discontinue] order?"</p> <p>*There had been no documentation regarding the conversation with the husband where he had declined individual therapy.</p> <p>Interview on 5/7/15 at 8:00 a.m. with licensed social worker associate (LSWA) E, administrator, executive director, assistant director of nursing (ADON) F, and the director of nursing regarding resident 3 revealed:</p> <p>*LSWA E had not followed-up on the group therapy referral.</p> <p>*A nurse had told her that she had spoken to the husband.</p> <p>*They had all agreed group therapy had not been an appropriate referral for her.</p> <p>*There was no system in place to identify who had been responsible for following up on the referral or who was to document the necessary communication.</p> <p>*LSWA E could not provide documentation regarding any interventions attempted in that first month to help her adjust to the new environment before increasing her anti-depressant medication.</p> <p>Review of the January 2015 social worker job description revealed they would have:</p> <p>*Provided or arranged for social services for residents and family members.</p> <p>*Completed all documents related to social work.</p> <p>*Educated families and residents regarding placement, care, and rights.</p> <p>*Responded appropriately to residents' verbal</p>	F 250	<p>The Social Worker or designee will review all new orders for psychoactive medications including dosage increases to ensure the new procedure was followed. This information will be reviewed at Quality of Life on a monthly basis. This audit will include documentation by staff regarding the success/failure of these interventions. This audit will be done weekly X4 and then monthly X3. The DNS or designee will report audit findings to the QAPI committee monthly, the committee will determine if further auditing is needed.</p>	6-26-15

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F 250 F 252 SS=C	Continued From page 10 and non-verbal expressions of needs. 483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Surveyor: 25107 Based on observation and interview, the provider failed to ensure: *Toilet paper and paper towels were stored in a manner to protect them from accidental chemical contamination on four of four housekeeping carts. *The floors and equipment were maintained in a clean condition in four of five serving kitchens (400 wing, rehabilitation (rehab), friendship, and secured unit). *Heaters located in bathing rooms were kept free from buildup of lint (two of two heaters in the 400 wing bathing rooms and two of two heaters in the 200 wing bathing rooms). Findings include: 1. Observation and interview with housekeeper K on 5/5/15 at 11:00 a.m. of a housekeeping cart in the 200 hall revealed: *Three packages of tri-fold paper towels and one roll of toilet paper were stored on the bottom shelf of the housekeeping cart. *One package of paper towels had dried water damage, and the roll of toilet paper had a wet spot on it.	F 250 F 252	F 252 Safe/Clean/Comfortable/Homelike Environment Plastic barrier was installed on housekeeping carts to protect paper products stored on the cart from accidental chemical contamination from the mop buckets on May 7, 2015. If new housekeeping carts are purchased in the future these barriers will be added or a different style of cart will be considered to protect paper products from accidental chemical contamination. QAPI coordinator or designee will audit carts quarterly for one year to ensure installation on all carts and report to the QAPI committee. Dining rooms in 400 wing, rehabilitation unit, friendship, and secured unit were cleaned including floors and equipment including stove tops, refrigerators, cambros, and carts. A cleanable surface was installed in the Rehab Kitchen above the stove to allow for easier cleaning of grease residue. One will be installed in the 400 serving		

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F 252	<p>Continued From page 11</p> <p>*The paper towels and toilet paper were used to resupply dispensers throughout the building. *Those items were stored next to a mop bucket that was approximately two thirds full and contained Providence floor cleaner and extra microfiber mop heads. *The housekeeper would take a new mop head out of the chemical solution in the bucket each time she needed to mop. *The mop heads were saturated in floor cleaner and dripped when removed from the bucket. *There was nothing on the housekeeping cart to prevent the drips and splashes from the mop heads or bucket from splashing onto the paper towels and toilet paper.</p> <p>Observation and interview with the director of environmental services on 5/5/15 at 11:30 a.m. of the housekeeping cart in the 200 hall confirmed the contamination on the toilet paper and paper towels. He agreed there was nothing preventing them from being contaminated with chemical from the mop bucket.</p> <p>Further observation on 5/5/15 from 11:30 a.m. to 4:00 p.m. revealed all four housekeeping carts were set-up with paper towels and toilet paper. Those paper products were stored on the bottom shelf next to the mop bucket.</p> <p>2. Interview on 5/5/15 at 11:40 a.m. with two random family members in the 400 wing dining room revealed they were concerned with the cleanliness of the serving kitchen.</p> <p>Observation on 5/5/15 at 11:45 a.m. of the 400 wing serving kitchen revealed: *There was a build-up of dirt and debris where the floor met the wall. There was dirt and food</p>	F 252	<p>kitchen as soon as materials are obtained and before June 26, 2015.</p> <p>Cleaning plan was reviewed by Director of Dining Services, Environmental Services Director and team leaders for housekeeping and dietary. Responsibilities were left as originally planned that housekeeping will clean the main part of all of the dining rooms, dietary staff will be responsible for the deep cleaning in the prep kitchen areas once a week. The floors for the prep kitchen areas in all dining rooms in the building were added to the schedule for the deep cleaning with the floor machine once a month. Dining room floors were already on this rotation. Refrigerators in all dining rooms will be pulled out once a quarter and cleaned behind by housekeeping staff. Training will be held with dining services staff on June 3, 2015 on cleaning procedures and expectations for day to day cleaning as well as weekly, monthly and quarterly deep cleaning tasks for how these areas are to be cleaned.</p> <p>Audits will be done by environmental services director, dining services director, or designee weekly X 8,</p>		

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F 252	<p>Continued From page 12</p> <p>debris in the corners of the floor under the cabinets and by the steam table.</p> <p>*The mop boards and bottom third of the east wall had multiple food splatters on it.</p> <p>*The exterior of the stainless steel refrigerator had a yellow residue surrounding the area around the handle.</p> <p>*The door gasket on the refrigerator was covered with food debris.</p> <p>*The wall above the stove was covered with a grease residue</p> <p>*The stove had a grease residue on the top and food splatters on the front.</p> <p>Observation on 5/5/15 at 11:57 a.m. of the serving kitchen in the rehab dining room revealed:</p> <p>*There was a moderate amount of food crumbs and debris on the floor under the toe kick of the cabinets and next to the refrigerator.</p> <p>*The stove top was covered with a sticky grease residue.</p> <p>*The wall behind the stove was also covered with a grease residue.</p> <p>Observation on 5/5/15 at 12:10 p.m. of the serving kitchen in the friendship dining room revealed:</p> <p>*Two of three grey carts had a moderate amount of a black slimy residue across the top shelf.</p> <p>*There was a moderate amount of food crumbs and food splatters on the exterior of the two blue cambrois (insulated food carts used to move food).</p> <p>*The floor around the dish machine was covered with a brown residue.</p> <p>*The walls by the dish machine had multiple food splatters on them.</p>	F 252	<p>monthly X 3 and results reported to the QAPI committee by environmental services director or dining services director. QAPI committee will review to determine the need to continue audits based on if the process has been improved.</p> <p>Heaters identified as needing cleaning in the 400 and 200 wing bathing rooms were cleaned by May 12. The heaters were added to the TELS maintenance tracking system to be cleaned on a quarterly basis.</p> <p>QAPI Coordinator or designee will audit quarterly times 4 and report to the QAPI committee who will review and determine the need for continued audits based on if improvements to the process are made.</p>	6-26-15	

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F 252	<p>Continued From page 13</p> <p>Observation on 5/5/15 at 2:20 p.m. of the serving kitchen in the secured unit revealed: *The exterior of the stainless steel refrigerator had a yellow residue surrounding the area around the handle. *There was a moderate amount of food crumbs and debris on the floor under the toe kick of the cabinets.</p> <p>Observation on 5/6/15 from 8:00 a.m. to 10:00 a.m. revealed all of the above observations were still there.</p> <p>Observation and interview with the housekeeping supervisor on 5/6/15 from 10:15 a.m. to 10:30 a.m. revealed: *Housekeeping was responsible for cleaning the floors in the serving kitchens located in the 400 hall, rehab, and the secure unit. *The dietary department was responsible for everything in the serving kitchen in the friendship dining room. *The dietary department was responsible for the equipment and walls in the 400 hall, rehab, and the secured unit. *She confirmed the condition of the floors in all areas and agreed they should have been cleaned.</p> <p>Observation and interview with the director of dietary services on 5/6/15 from 10:45 a.m. to 11:00 a.m. revealed: *He confirmed the conditions listed above in each kitchen and agreed it should have been cleaned. *He confirmed the walls and equipment in the kitchens and the friendship dining room were the dietary departments' responsibility. *The cleanliness of the kitchens had recently been identified as a concern by the provider.</p>	F 252			

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F 252	Continued From page 14 They were starting to work on a plan to correct the above listed issues. 3. Observation on 5/5/15 from 2:00 to 2:10 p.m. of the heaters in the two shower rooms (one in each) located in the 400 hall revealed they were both full of lint. Observation on 5/6/15 at 8:45 a.m. of the heaters in the shower room and whirlpool room of the 200 hall revealed they were both full of lint. Interview with the housekeeping supervisor on 5/6/15 at 10:15 a.m. in regards to the heater revealed she thought the maintenance department was responsible for cleaning those heaters. Interview with the director of maintenance and environmental services on 5/7/15 at 10:55 a.m. revealed: *The heaters were on the housekeeping check list. *They were to be cleaned every six months. *The heaters were last cleaned eight months ago.	F 252			
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: 33488 A. Based on record review, interview, and policy review, the provider failed to appropriately assess, investigate, and intervene for 1 of 13	F 281	F 281 Services Provided Meet Professional Standards Unable to perform an assessment on resident 25. Unable to destroy the Tylenol for resident 8. Unable to back date the treatment records of resident 3.		

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F 281	<p>Continued From page 15 sampled residents (25) after a fall. Findings include:</p> <p>1. Review of the 2/2/15 fall incident report for resident 25 revealed she: *Had an unwitnessed fall on 2/2/15. *Was found on the floor in her bathroom. *Was reported to have been alert and oriented times three (person, place, and time known). *Denied pain and dizziness. *Reported to the nurse she slid to the floor, because she could not hold onto the bar in the bathroom. *Had been asked if she was wheeled into the bathroom or had assistance, but she could not remember.</p> <p>The above incident report assessment for resident 25 had been filled out as follows: *She had been oriented only to person and place. *She was confused and had impaired memory. *She had an elevated temperature of 99.5 degrees Fahrenheit immediately following her fall when her vitals were taken. *She had a pain level of 1, but it was not clear where the pain was located. *There was no follow-up assessment had been performed regarding the resident's pain or elevated temperature. *No neurological (mental awareness) checks were performed by nursing staff to determine if she had no head trauma. *There was no follow-up investigation regarding why she had fallen or what had occurred since she was unable to remember.</p> <p>Review of resident 25's November 2014 Brief Interview for Mental Status (BIMS) revealed: *Her cognition (mental awareness) level that had</p>	F 281	<p>Neurological checks will be done on all unwitnessed falls. If variances in vital signs are seen follow-up vital signs will be done. Complaints of pain at the time of the fall will be reassessed. Changes in cognition will be reassessed. The provider will be made aware of the reassessments. Nurses/UAPs will only give medications that they have set up and prepared. Nurses/UAPs will sign the e-MAR and e-TAR as soon as a medication or treatment has been completed.</p> <p>All nurses/UAPs will be educated on the need for a complete assessment of a resident who has fallen; if a fall is unwitnessed neuro checks will be started. If a resident complains of pain, has abnormal vital sign, or changes in cognition or function a reassessment of these areas will be done and reported to the provider. A review of the Policy Fallen or Injured Resident- II.F.2 and A Fall Occurs: Now What- II.F.2a will be done. Nurses and UAPs will be educated on the proper administration of medications using Procedure I.I.M.8b- Administration of Medications. The DNS will provide this education on Nurses Meeting June 10,</p>		

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F 281	<p>Continued From page 16 been done during her last assessment had revealed a score of 10. *That score reflected some cognitive impairment, but she would be interviewable and able to recall most information when asked.</p> <p>Review of the 2/3/15 fax to resident 25's physician the following day revealed: *Her temperature had increased to 100.6 degrees Fahrenheit. *She had complaints of a lack of energy and had a loose stool after lunch. *Other residents in the facility also had elevated temperatures at that time according to the fax.</p> <p>Review of resident 25's medical record revealed she: *Was transported to the hospital for evaluation on 2/4/15 for shortness of breath and fever. *Died in the hospital from complications of influenza A on 2/10/15.</p> <p>Interview on 5/7/15 at 10:15 a.m. with the director of nursing, the administrator, and the executive director regarding resident 25's fall and lack of appropriate assessment and investigation of the fall and the events leading up to and following that fall revealed they had not disagreed that: *The elevated temperature should have been further investigated and followed-up on. *Neurological checks should have been done as a safety precaution in the event of an unwitnessed fall. *She was not orientated times three (person, place and time known), but was in fact only oriented times two (person and place). That might have been a sign of a head injury or other disease process that had not yet been identified. *It was unclear if her pain was incorrectly</p>	F 281	<p>UAP meeting June 11, and CNA meeting June 17, 2015.</p> <p>The MDS Coordinator or designee will review the Falls UDAs, progress notes, and incident reports of residents who have fallen to assure complete assessments and follow-ups have been done and that the provider was made aware of changes. Staff Development or designee will observe medication passes to assure medications are given by the person who set up and prepared that same medication. Staff Development or designee will review the e-TAR to assure staff signs off treatments after they are completed. These audits will be done weekly X4 and then monthly X3, the ADONs will report their audit findings to the QAPI committee monthly and the committee will determine if further auditing is needed.</p>	6-26-15
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F 281	<p>Continued From page 17</p> <p>documented as a level of one when the nurse who had performed the assessment stated the resident had denied pain.</p> <p>Review of the provider's June 2014 Fallen or Injured Resident policy revealed: *If the fall was not witnessed neurological checks were required and documented on the Neuro-Check flowsheet. *The physician's comments regarding the fall should have been documented on the "SBAR" (Situation, Background, Assessment, and Recommendation) flowsheet. *Monitor the resident's condition and document interventions.</p> <p>Surveyor: 26180 B. Based on observation, interview, and policy review, the provider failed to ensure one of one sampled resident (8) had a medication administered by the medication aide (P) who prepared the medication. Findings include:</p> <p>1. Observation on 5/5/15 at 12:02 p.m. revealed medication aide (MA) N: *Set-up a medication to give to resident 8 which he refused to take. *Called registered nurse (RN) P on the phone and explained to her resident 8 had refused to take his Tylenol (pain medication). -The RN agreed she would come into the secured unit and try to get resident 8 to take the medication. *Took the plastic container with the Tylenol in it and wrote the resident's name on the cup. She placed the cup in the locked medication drawer of the medication cart.</p>	F 281			

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F 281	<p>Continued From page 18</p> <p>Further observation on 5/5/15 at 12:07 p.m. revealed RN P came into the secured unit and verified in the electronic medication record that resident 8 was to have received Tylenol. She then: *Took the plastic cup from the medication cart with resident 8's name written on it. *Verified by observation the medication matched the medication in the medication card. *Approached resident 8 and gave him the Tylenol.</p> <p>Interview on 5/5/15 at 5:00 p.m. with RN P revealed: *She confirmed she had given a medication to a resident that had been set-up by another staff person. *She did not think that was a problem, because she had verified the medication in the cup with the resident's medication card. -She was unsure if administering a medication that another person had set-up was an acceptable practice or not.</p> <p>Review of the provider's September 2012 administration of medication policy revealed "Administer only those medications that you prepared. Do not ask anyone else to administer medications that you prepared."</p> <p>Interview on 5/7/15 at 10:45 a.m. with the director of nursing confirmed staff should not have administered a medication to a resident that had been set-up by another staff person.</p> <p>Surveyor: 32335 C. Based on record review, interview, and policy review, the provider failed to ensure signatures</p>	F 281			

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F 281	Continued From page 19 had been documented on the treatment administration records for one of five sampled residents (3) who had been receiving a pressure ulcer (wound or open area over a bony area usually caused by unrelieved pressure) treatment. Findings include: 1. Review of resident 3's medication administration records and treatment administration records revealed: *In January 2015 and February 2015 there were two signatures not documented for the DuoDerm treatment to her left outer ankle. *In March 2015 there had been two of six signatures not documented for the cleanse wound per facility protocol treatment. *In April 2015 there had been two of eight signatures not documented for the cleanse wound per facility protocol treatment. Interview on 5/7/15 from 8:00 a.m. through 8:50 a.m. with the administrator, executive director, assistant director of nursing F, and the director of nursing regarding resident 3 revealed the nurses should have signed their initials on the above records to verify the treatment had been completed. Review of the provider's September 2012 Documentation policy revealed documentation of all treatments would be written by an authorized professional. For any entry in a medical record the person completing the entry should have signed and dated the entry.	F 281			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309			

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F 309	<p>Continued From page 20</p> <p>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.</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 one of one sampled resident (20) receiving Hospice services had the Hospice care plan added to and a part of the provider's care plan. Findings include:</p> <p>1. Review of resident 20's entire medical record revealed she had started receiving Hospice services on 1/15/15.</p> <p>Review of resident 20's 1/8/15 care plan revealed: **Focus: The resident has a terminal prognosis r/t [related to] senile degeneration of the brain, depression, HTN E/B [hypertension evidenced by] decline of health. Date initiated 1/8/15. *Interventions: Work with nursing staff to provide maximum comfort for the resident by working cooperatively with [name of Hospice agency] to ensure residents spiritual, emotional, intellectual, physical and social needs are met. Hospice nurse visits 2xwk [two times per week], HHA [home health aide] 3xwk [three times per week], MSW [masters social worker] 1xwk [one time per week] CH 1xwk [chaplain one time per week]. [name of provider] or hospice nurse to update doctor as needed." *It had not identified specifically what services the</p>	F 309	<p>F 309 Provide Care/Services for Highest Wellbeing</p> <p>Resident 20's care plan has been updated to include what Hospice staff will do while in the center and what the center staff is responsible to provide.</p> <p>All residents who elect Hospice will have care jointly provided by Hospice and center staff and will be reflected in the care plan. The care plan will state who will provide psychosocial, physical, emotional needs, and equipment/supplies provided by Hospice.</p> <p>All care team staff will be educated on the importance of having a care plan that defines what cares the Hospice team will provide and what the center staff will provide. Nursing staff will be educated as to where they can access the Hospice information when needed. The DNS will provide this education on Nurses Meeting June 10, UAP meeting June 11, and CNA meeting June 17, 2015.</p>	

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F 309	Continued From page 21 provider was responsible and what services Hospice was responsible. Interview on 5/6/15 at 4:45 p.m. with licensed practical nurse G regarding resident 20 revealed: *He had only been in his position about two months. *He was not sure where he would access specific information about what the Hospice provider was responsible for in caring for the resident. Interview on 5/6/15 at 5:00 p.m. with registered nurse L regarding resident 20 revealed: *Their care plan had not addressed what Hospice was responsible for. *They had a copy of the Hospice care plan. *A review of the care plan at that time revealed it did not match the provider's care plan. The Hospice care plan stated the MSW visited one time per month, and the chaplain visited twice a month. Review of the provider's September 2012 Hospice Services Provided in a Skilled Nursing Facility policy revealed: **A coordinated comprehensive plan of care shall be jointly developed by the center and hospice. Hospice participation in the care plan conference and input from the hospice representative is required. *The hospice provider's plan of care is integrated with the center's comprehensive care plan, thus the reference to "joint plan of care."	F 309	The ADONs will audit the medical records of Hospice residents to assure the care plan has jointly been developed and that the care plan clearly defines who will provide what services to the resident. This audit will be done weekly X4 and then monthly X3, the ADONs will report these audit findings to the QAPI committee monthly and the committee will determine if further auditing is needed.	6-26-15	
F 314 SS=D	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	F 314			

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F 314	<p>Continued From page 22</p> <p>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: 32335 Based on observation, record review, interview, and policy review, the provider failed to change treatment, maintain appropriate wound documentation, and document treatments had been given consistently for two of five sampled residents (3 and 4) with pressure ulcers (wound or open area over a bony area usually caused by unrelieved pressure). Findings include:</p> <p>1. Observation on 5/5/15 at at 10:50 a.m. of registered nurse (RN) A and RN U changing the dressing for resident 3 revealed: *She had a pressure ulcer on her left outer ankle. *When RN U had taken her sock off there was no dressing on her ankle. *The old dressing had not been in the resident's sock. *They had not known what had happened to the dressing. *They had applied wound cleaner and DuoDerm to the pressure ulcer after taking measurements.</p> <p>Review of resident 3's wound data collection sheets and her wound RN assessment forms revealed: *She had been admitted on 11/5/14 with a pressure ulcer to her left ankle.</p>	F 314	<p>F 314 Treatment/Services to Prevent/ Heal Pressure Sores</p> <p>Orders for resident #3 will be reviewed and confirmed with the physician to verify appropriate treatment for the wound. The Pressure Ulcer Healing Chart (GSS #290) will be used to track the progress of resident 3s wounds over time. The Daily Wound Data sheet will be completed by the nurses on a daily basis. The RN Wound Assessment will be completed on a weekly basis by the MDS nurse or designee. The dressing will be checked for placement every shift to ensure the dressing remains intact.</p> <p>Resident # 4 will have the wounds measured by the MDS Coordinator to ensure the same person completes the measurement and staging of the wound. The MDS Coordinator will complete the Pressure Ulcer Healing Chart (GSS #290) on a weekly basis along with the RN Wound Assessment. If the wound does not progress within 14 days, the Pressure Ulcer Healing Chart and the current treatment plan will be sent to the physician to determine the appropriate changes in the treatment.</p>		

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F 314	<p>Continued From page 23</p> <p>-It had measured 0.5 centimeters (cm) in length and 0.7 cm in width.</p> <p>-There had been no measurement for depth or any identification comments documented.</p> <p>*On 11/23/14 it had measured 0.6 cm in length and 0.4 cm in width.</p> <p>*There were no measurements from 11/23/14 through 1/15/15 for that pressure ulcer.</p> <p>*There was documentation from 2/20/15 through 3/19/15 for a pressure ulcer on the right ankle with it being closed on 3/19/15.</p> <p>*There was no documentation for the left inner ankle pressure ulcer identified on the physician's order report.</p> <p>Review of resident 3's physician's order summary report from 11/1/14 through 5/31/15 revealed the following orders:</p> <p>*On 11/5/14 heel lift boots for heel protection and pressure reduction for patients at high risk for skin breakdown when in bed. That was still a current order.</p> <p>*On 11/7/14 DuoDerm (specific type of pressure ulcer dressing) to left outer ankle. Change every three days and as needed if soiled/loose. Use skin prep prior to applying one time a day every three days. That order had ended on 3/2/15.</p> <p>*On 12/30/14 they had discontinued wound care services she had received from an outside source.</p> <p>*On 3/2/15 DuoDerm to left and right ankle. Change every three days and as needed if soiled/loose. Use skin prep prior to applying one time a day every three days. That ended on 3/4/15.</p> <p>*On 3/4/15 "DuoDerm to left and right outer ankle. Change every 3 days and as needed if soiled/loose. Use skin prep prior to applying. As needed for wound treatment use skin prep prior</p>	F 314	<p>The Pressure Ulcer Healing Chart will be sent to the wound clinic for all appointments to communicate the progress of the wound healing.</p> <p>All the residents with a stage 2 through stage 4 and unstageable will be monitored at least weekly by the MDS coordinator and daily by the floor or charge nurse. All residents will have a head to toe skin assessment completed on a weekly basis on the resident's bath day. All new admits will have a head to toe assessment upon admission.</p> <p>The Pressure Ulcer healing Chart (GSS #290) and the Pressure Ulcer Monthly Report (GSS #155) will be used for all residents who have a stage 2 through stage 4 ulcer, including unstageable ulcers. These tools will be used to monitor the progress of the wounds and be a method of communication between the nursing staff and the physician. The MDS nurses will receive additional wound training from American Medical Technologies. Email sent to him 5-28-15 to confirm the date in June, awaiting his response. This training will include proper measuring, staging, documentation, infection control techniques, and</p>	
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F 314	<p>Continued From page 24</p> <p>to applying. And one time a day every three days for wound treatment Use skin prep prior to applying." That ended on 3/10/15.</p> <p>*On 3/10/15 "Cleanse wound per facility protocol. Apply skin sealant to periwound [the tissue surrounding the wound]. Cut to fit Hydrogel (pressure ulcer dressing) to wound bed. Cover with boarded foam. Change daily. Left and right outer ankles and left inner ankle. One time a day." That ended on 3/26/15.</p> <p>*On 3/26/15 an order identical to the 3/10/15 treatment. There was no change. That ended on 4/9/15.</p> <p>*On 4/9/15 an order identical to the 3/10/15 treatment. That ended on 4/15/15.</p> <p>*On 4/15/15 Collagen dressing to wound bed on left outer ankle and cover with bordered foam dressing one time a day. That ended on 4/30/15.</p> <p>*On 4/30/15 DuoDerm to left outer ankle one time a day every four days. That ended on 5/1/15.</p> <p>*On 5/1/15 an order identical to the 4/30/15 one.</p> <p>*No change in treatment had been requested from 11/7/14 through 3/2/15.</p> <p>Review of resident 3's medication administration records and treatment administration records from 1/1/15 through 5/5/15 revealed staff had not signed off on the necessary dressing changes on a consistent basis. Refer to F281, finding C.</p> <p>Interview on 5/5/15 at 1:30 p.m. with resident 3's husband revealed the staff had not always put on the heel protector boots when she was in bed.</p> <p>Interview on 5/7/15 from 8:00 a.m. through 8:50 a.m. with the administrator, executive director, assistant director of nursing (ADON) F, and director of nursing (DON) regarding resident 3 revealed:</p>	F 314	<p>identifying the need to change the treatment. The licensed nurses received training on staging, measuring, and the physiology of ulcers on Wednesday May 13th by a physician resident. Contacted [redacted] Sanford Wound Clinic to complete follow up training this fall. Waiting to receive availability dates. When a resident is referred to the wound clinic, the charge nurse will contact the wound clinic for assessment documentation of the wound.</p> <p>DNS or designee will audit this process weekly X4, monthly X3. DNS or designee will report to the QAPI committee at least monthly for review.</p>	<p>D4SDDH/MF</p> <p>X4/06/15 D4SDDH/MF</p>

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F 314	<p>Continued From page 25</p> <ul style="list-style-type: none"> *The ADON and DON were on their computers attempting to locate the dates of when the pressure ulcers all started. *They stated the original left outer ankle pressure ulcer had healed on 11/23/14 and reopened on 1/14/15. *That had not matched the above wound data information from 11/23/14 where the measurements were 0.6 cm in length and 0.4 cm in width. *The left inner ankle pressure ulcer began on 2/27/15. *They were unable to locate the wound data collection information on that pressure ulcer. *The right outer ankle pressure ulcer started on 3/4/15. *They had no explanation why the treatment had not been changed since 11/7/14. *Since they thought the left outer ankle pressure ulcer had healed they stated the DuoDerm treatment was being used as a protective measure from 11/23/14 through 1/14/15. *That order had not been changed to reflect that information. <p>Review of the provider's September 2012 Pressure Ulcers policy revealed:</p> <ul style="list-style-type: none"> *A resident who had entered the facility with a pressure ulcer would have received the necessary treatment and services to promote healing, prevent infection, and prevent new pressure ulcers from developing. *Changes should have been reported to the resident's primary care provider and family. *Documentation of the primary care provider notification, physician's orders received, family notification, and resident's responses to any treatment should have followed the provider's procedures as well. 	F 314			

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F 314	<p>Continued From page 26</p> <p>*At a minimum weekly documentation was recommended to provide a review of the pressure ulcer.</p> <p>*If the pressure ulcer did not show evidence of progress toward healing within fourteen days the pressure ulcer and the resident's overall clinical condition should have been reassessed.</p> <p>*Reevaluation of the treatment plan and modification of the current interventions also might have been indicated.</p> <p>Surveyor: 33265</p> <p>2. Review of the resident 4's complete medical record revealed:</p> <p>*She was admitted on 2/14/15.</p> <p>*She had a pressure ulcer on her right buttock when she was admitted.</p> <p>*Twenty-four Wound Data Collection entries and fourteen Wound RN (registered nurse) Assessments were made in the medical record since she had been admitted.</p> <p>-Multiple RNs and licensed practical nurses (LPNs) had made entries.</p> <p>*On 2/14/15 RN Z had documented the wound had tunneling (wound branched out in different directions and a clock face was used to describe directions) at 10, 1, and 8 o'clock. The stage (size, depth and type of tissue involved) of the pressure ulcer was not documented.</p> <p>*On 2/18/15 RN A had documented the wound was a stage 3 (open wound through skin and into tissue) with tunneling at 12 to 5 o'clock.</p> <p>*On 2/24/15 LPN B had documented there was no tunneling.</p> <p>*ON 2/25/15 LPN W had documented there was tunneling at 4 to 5 o'clock.</p> <p>*On 3/4/15 RN A had documented the wound had tunneling at 10 to 2 o'clock that was 2.5 cm in</p>	F 314			

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F 314	<p>Continued From page 27</p> <p>depth.</p> <p>*On 3/11/15 two different RNs assessed the pressure ulcer.</p> <p>-RN A had documented the size as one centimeter (cm) in length, 2.8 cm in width and 2.8 cm in depth.</p> <p>-RN Y had documented the size as 0.6 cm in length, and 1.0 cm in width with tunneling at 12 o'clock 4 cm deep, 2 o'clock 3 cm deep, 3 o'clock 1.9 cm deep, 6 o'clock 2.2 cm deep, and 9 o'clock 0.7 cm deep. She was unable to see the bottom of the wound, but staged the wound as a stage 4.</p> <p>*On 3/19/15 RN U had documented the stage as a stage 3 with tunneling from 12 to 5 o'clock that was 4 cm deep.</p> <p>*On 3/26/15 RN A had documented the stage as a stage 4.</p> <p>*On 4/2/15 RN U had documented the tunneling from 12 to 5 o'clock with a depth of 3.8 cm.</p> <p>3. Observation on 5/6/15 at 2:05 p.m. of resident 4's pressure ulcer wound care by RN A and LPN B revealed RN A:</p> <p>*Positioned the resident and assembled equipment.</p> <p>*Then put on clean gloves.</p> <p>*Following the irrigation and cleaning of the wound she took off used gloves and put on new gloves.*Returned to the plastic container of supplies and moved items within the box until the pad of measuring papers were found.</p> <p>*Removed one of the sheets of measuring paper from the pad and added that to the supplies.</p> <p>*Picked up an ink pen from the bedside table and used it to mark the depth of the wound on the cotton swab that had been placed inside the wound.</p> <p>-The pen was used at the area on the cotton</p>	F 314			

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F 314	<p>Continued From page 28</p> <p>swab that comes in contact with the edges of the wound.</p> <p>*Returned the pen to the bedside table.</p> <p>*Put the pen into her pocket at the end of the procedure.</p> <p>Interview and record review on 5/6/15 at 3:20 p.m. with RN A concerning resident 4's pressure ulcer revealed she:</p> <p>*Had started as the wound care nurse for the 300, 500, and 600 wings in February 2015.</p> <p>*Had not had any specific wound care or pressure ulcer training for the position.</p> <p>*Believed resident 4's pressure ulcer was improving, because there were signs the edges were growing inward.</p> <p>*Assessed the wound weekly including staging the wound.</p> <p>*Was not able to describe the difference between a stage 3 and a stage 4 pressure ulcer.</p> <p>*Had not used a flashlight to look into the wound to see the tissue involved.</p> <p>*Could not describe the type of tissue (fat, muscle, tendon, or bone) at the bottom of the wound.</p> <p>*Stated the previous nurse who had done wound care told her the stage of the wound when the resident was admitted.</p> <p>*Had not known other nurses were assessing and staging the wound.</p> <p>*After reviewing the wound data documentation completed since resident was admitted on 2/14/15 she could not explain the large differences documented in the:</p> <ul style="list-style-type: none"> -Measurements of the wound. -Descriptions of the tunneling. -Depths of the tunnels. -Staging. <p>*Had never heard of or seen the two facility</p>	F 314			

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F 314	<p>Continued From page 29</p> <p>forms: -PUSH - Pressure Ulcer Health Chart (#290) -Pressure Ulcer Monthly Report (#155). *Thought resident 4 had gone to the wound clinic a couple times. - She stated the wound clinic had not provided measurements or staging in their documentation. -She found documentation from two wound clinic visits on 3/25/15 and 4/9/15.</p> <p>Interview and record review on 5/7/15 at 8:25 a.m. with the director of nursing (DON), the administrator, and the corporate executive director concerning resident 4's pressure ulcer revealed the DON: *Had been providing individual training to the three wound care nurses. -The three wound care nurses had not received any specific training in pressure ulcers or wound care since taking the position. *Stated there was a wound specialist that came in once a month as a consultant. *Thought RN A was the only nurse doing the pressure ulcer assessments on her wings. *Could not explain the large differences in measurements, tunneling, and staging in the Wound Data Collection documents. *Was not aware the wound clinic had not shared documentation on assessments such as measurements and staging. *Needed to look up the Pressure Ulcer Healing Chart (form # 290) and Pressure Ulcer monthly Report (form # 155) referenced in the facility's Pressure Ulcer Practice Guidelines. She had created a spreadsheet to fill in some of the same data. However she had not used those two forms to track pressure ulcer healing for resident 4. *Agreed the items next to or touching a pressure ulcer wound needed to be clean. The pen should</p>	F 314			

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F 314	Continued From page 30 not have entered and left the clean area as was observed. 4. Review of the provider's June 2014 Pressure Ulcer Practice Guidelines revealed: *There was to have been a completed head-to-toe skin assessment performed during the admission process. *At a minimum weekly documentation was recommended. *Approved Society forms were to be used to document pressure ulcer/wound evaluations. The PUSH Tool - Pressure Ulcer Healing Chart (form # 290) and the Pressure Ulcer Monthly Report (form #155) were listed for use. *Stage 3 was described as a wound with full thickness tissue loss where fat was visible but not bone, tendon or muscle. *Stage 4 was described as a wound with full thickness tissue loss with exposed bone, tendon, or muscle. Review of the provider's November 2013 Wound Dressing Change procedure revealed: *Listed purposes as to promote wound healing and keep wound free of infection. *Nurse should gather and open all needed supplies then put on gloves.	F 314			
F 329 SS=D	483.25(l) 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 without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose	F 329			

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F 329	<p>Continued From page 31 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: 26180 Based on record review, interview, and policy review, the provider failed to ensure two of four sampled residents (8 and 13) had an appropriate indication or timely attempts at a gradual dose reduction with the use of a psychotropic (for mental illness treatment) medication. Findings include:</p> <p>1. Review of resident 8's physician's orders revealed and order for Seroquel Tablet (treatment of psychosis) 25 MG (milligrams) to give one tablet at bedtime (HS) for agitated dementia (memory loss). It had not clarified what was meant by agitated dementia.</p> <p>Random observations of resident 8 from 5/5/15 through 5/7/15 revealed he:</p>	F 329	<p>F 329 Drug Regimen is Free From Unnecessary Drugs</p> <p>Resident 8 will continue to be reviewed at Quality of Life meetings. Staff will be educated to capture behavior with more focused documentation on mood and behavior including severity. Will consult with pharmacist and medical director and primary physician to review behaviors in regards to medication administration and make adjustments accordingly.</p> <p>Antipsychotic medications resident 13 was on during survey visit was Mirtzapine 30mg at bedtime, Lorazepam 0.25 mg twice a day, Olanzapine 2.5 mg twice a day, Ativan PRN 0.5 mg 3 times a day. On 5/21/15 Mirtzapine was decreased to 15 mg once a day at bedtime will monitor results and work with consulting pharmacist, medical director and primary physician for further medication adjustments. Resident will be monitored at Quality of Life meetings.</p> <p>Provider's medical director and consultant pharmacist will be meeting regularly to review residents on</p>		

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F 329	<p>Continued From page 32</p> <p>*Exhibited no physical behavior at other residents or staff.</p> <p>*Was very sleepy and slept most of the day.</p> <p>*Refused medications at times, and slept through meals and his wife's visit.</p> <p>Review of resident 8's 4/24/15 Minimum Data Set assessment revealed he had rejected care at times. No other behaviors were identified.</p> <p>Review of resident 8's 12/5/14 Care Area Assessment (CAA) revealed: *Behaviors and Psychotropic Drug Use were areas that triggered and required further review. *The Psychotropic Drug Use CAA revealed: -He received an antipsychotic medication daily. -The medication put him at risk for falls. -The review of that CAA directed staff to focus on eliminating the underlying cause of the behavior being treated with the psychotropic medication in order to be able to stop use of the medication. *The Behavioral symptoms CAA revealed: -"Res [resident] behavioral status worsened as compared to last assessment period, as res rejected cares during assessment timeframe, which triggered behavioral status CAA. -Illness or conditions that caused behavior problems included infection. -Res also had a diagnosis of vascular (heart function related) dementia which could have been a main factor impacting res behavioral status."</p> <p>Review of resident 8's behaviors from 1/1/15 through 5/6/15 revealed the behaviors had not presented a danger to the resident or others. There was random documentation that he had exit sought (attempted to leave the unit), and verbal abuse. None of those behaviors had occurred in the past month.</p>	F 329	<p>psychotropic medications and make recommendations for decreasing medications to attending physicians as they see appropriate. Residents on psychotropic meds are discussed during monthly Quality of Life meetings involving the interdisciplinary team. Medical director quality of life meeting notes can be used as supplemental documentation to send to attending physicians when the recommendation to change the dosage of the psychotropic medication is made. Recommendations for non-pharmacological interventions related to medication changes will be handled as addressed in plan of correction for F 250. Education for this topic is also addressed in F 250.</p> <p>Consultant Pharmacist will audit monthly X6 to ensure appropriate responses were returned and recommendations for medication are review by the attending physician. DNS or designee will report audit findings to QAPI committee for review at least monthly.</p>	6-26-15

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F 329	<p>Continued From page 33</p> <p>Review of resident 8's monthly pharmacy consultations revealed: *4/8/14: "[Name of resident] receives Quetiapine (same as Seroquel) 25 mg QHS for behavioral or psychological symptoms of dementia since January 2014. Federal regulations require that antipsychotics used to manage behavior or stabilize mood be evaluated quarterly and undergo GDR [gradual dose reduction] attempts in 2 separate quarter in the first year in which a resident is admitted, or after the facility has initiated the medication, then at least annually UNLESS CLINICALLY CONTRAINDICATED. -For antipsychotic therapy, it is recommended that a/prescriber document an assessment of risk versus benefit, including that it continues to be a valid therapeutic intervention for this individual; and b) the facility interdisciplinary team ensure that the care plan includes ongoing monitoring of specific target behaviors; documentation of 1) A DANGER to self or others 2) desired outcome(s) 3) the efficacy of individualized, non-pharmacological approaches and 4) potential adverse consequences." -The physician declined the recommendation stating "Pt [patient] is very stable in a nursing home facility with close observation, will look at it again in the future." *10/7/14: "[Residents name] has received Seroquel 25 mg at HS for behavioral or psychological symptoms of dementia since January 2014. CMS [Center for Medicare Services] regulations require at least quarterly review of behavioral symptoms to determine the effectiveness of the antipsychotic and the potential for reducing or discontinuing the dose. Federal regulations require that antipsychotics used to manage behavior or stabilize mood be</p>	F 329			

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F 329	<p>Continued From page 34</p> <p>evaluated quarterly and undergo GDR [gradual dose reduction] attempts in 2 separate quarter in the first year in which a resident is admitted, or after the facility has initiated the medication, then at least annually UNLESS CLINICALLY CONTRAINDICATED."</p> <p>-Recommendation: Please re-evaluate the need for the continued use of Seroquel 25 mg QHS perhaps considering a gradual dosage reduction to Seroquel 12.5 mg QHS with the end goal of discontinuation of therapy if possible."</p> <p>-The physician declined the recommendation stating "Pt [patient] on low dose, very stable, has done much better clinically on the Seroquel."</p> <p>-The physician had not defined what was meant by agitated features.</p> <p>*4/3/15:-[Name of resident] has dementia and is receiving Seroquel 25 mg at bedtime to help control agitation. He is once again due for your assessment of dosage reduction potential. Would it be possible to try a very slight reduction, such as continuing 25 mg on 6 [six] nights a week and give 12.5 mg on 1 [one] night a week?"</p> <p>-The physician declined the recommendation stating "Agitated features with dementia, improved but still present."</p> <p>-The physician had not defined what was meant by agitated features.</p> <p>Review of resident 8's 3/16/15 care plan revealed it had not addressed the ongoing monitoring of specific target behaviors; documentation of 1) A DANGER to self or others 2) desired outcome(s) 3) the efficacy of individualized, non-pharmacological approaches and 4) potential adverse consequences."</p> <p>Interviews on 5/5/15 at 5:00 p.m. and on 5/7/15 at 7:50 a.m. with registered nurse P regarding</p>	F 329			

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F 329	<p>Continued From page 35 resident 8 revealed: *He had recently been in the hospital for treatment of a urinary tract infection (UTI) and had not been the same since his return. *He was sleeping more. *He frequently refused care, such as changing his clothes and taking his medications. *She confirmed in January 2014 when he was started on the antipsychotic, he was also being treated for a UTI. *She agreed an increase in behaviors could have been related to the UTI. *He had never physically threatened a staff person or a resident. *He responded better to staff that he was familiar with, and noted with all the changes in the secured unit they had more difficulties with him refusing care when he did not know the staff. *He really liked one of the certified nursing assistants, because she had worked there a long time and knew how to work with him. *She agreed agitated could have been interpreted differently by different staff. *She agreed some of his agitation could have been caused by all the changes in the secured unit with staffing.</p> <p>Interview on 5/6/15 at 10:40 a.m. with social worker S regarding resident 8 revealed she: *Was aware he refused medications and care at times. *Felt it had to do with the changes in staff in the secured unit. *Agreed the behaviors he presented did not present a danger to himself or others. *Knew there were things staff did with the resident that were successful in managing his behaviors, but they had not been specifically addressed on the care plan.</p>	F 329			

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F 329	<p>Continued From page 36</p> <p>*Relied on the pharmacist to advocate for residents to have dose reductions with their psychotropic medications.</p> <p>Surveyor: 32335</p> <p>2. Review of resident 13's medical record revealed:</p> <p>*She had been admitted into a behavioral health center on 7/18/14 due to increased agitation and aggression.</p> <p>*She was discharged back to the facility on 7/31/14.</p> <p>*Her discharge diagnosis from the behavioral health center had been dementia of the Alzheimer type with behavioral disturbances.</p> <p>*She had been discharged on the following medications:</p> <ul style="list-style-type: none"> -Zyprexa (used to treat the symptoms of psychotic conditions) 5 mg TID (three times a day) which had been started there. -Zoloft (used to treat depression, obsessive-compulsive disorder and panic and anxiety disorders) 100 mg per day which had been increased during her stay. -Ativan (used to treat anxiety disorders or anxiety associated with depression) 0.5 mg TID. -Depakote Sprinkles (used to treat various types of seizure disorders and manic episodes related to manic depression) 250 mg TID which had been started during her stay. <p>Review of resident 13's mood/behavioral documentation provided by the facility revealed:</p> <p>*From 8/3/14 through 8/28/14 she remained anxious, demanding, and moody.</p> <p>*From 8/28/14 through 2/13/15 there was no documentation provided regarding her mood and behaviors.</p>	F 329			

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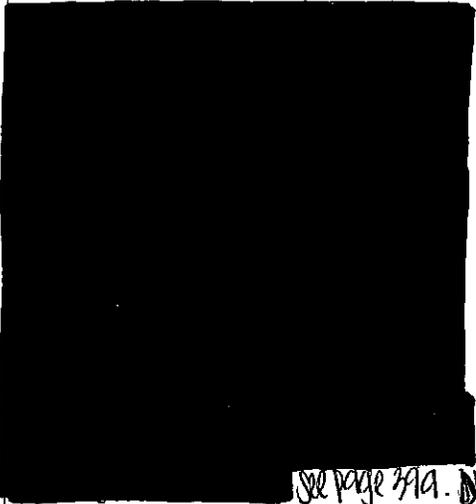
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F 329	<p>Continued From page 37</p> <p>*The electronic medication record information they provided indicated from 11/18/14 through 2/25/15 Ativan prn had been given sixteen times for anxiety.</p> <p>*There had been no other mood and behavior documentation provided to this surveyor prior to leaving the facility.</p> <p>Interview on 5/7/15 from 8:00 a.m. through 8:50 a.m. with the administrator, executive director, assistant director of nursing F, and the director of nursing (DON) regarding resident 13 revealed the justification for the use of Zyprexa had been for Alzheimer's with delusional behavior.</p> <p>Review of the Todd P. Semla et al., Geriatric Dosage Handbook, 16th ed., Lexi-Comp, Ohio, 2011, p. 1276, revealed Olanzapine (Zyprexa) had the following warning: elderly patients with dementia-related psychosis treated with antipsychotics were at an increased risk of death.</p> <p>Review of resident 13's 1/9/15 pharmacy consultation report revealed there had been a recommendation to reduce the Depakote Sprinkles, Zoloft, and Zyprexa. The doctor declined the recommendation stating "Patient currently exhibiting lots of anxiety symptoms, would like to keep meds [medications] as is."</p> <p>Review of the provider's February 2013 psychopharmacological (used for mood and behavior) medications and sedative/hypnotics policy revealed: *"The resident will be free from any chemical restraint [medications] imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms. *Residents who use antipsychotic drugs receive</p>	F 329		
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F 329	Continued From page 38	F 329			
F 431 SS=E	gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs." 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, 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.	F 431 X	F 431 Drug Records, Label/Store Drugs & Biologicals  <i>See page 39A. N. SCHIMM</i> All eye drops, insulin pens, and other medications packaged in containers other than bubble packs will be dated when first opened and used. If the medication has specific instructions as to expiration from the manufacturer that date will also be included. Fentanyl patches will be destroyed when they are changed per order via sewer with 2 nurses witnessing this. Every shift the nurse or UAP will document that the patch is in place.		

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F 329	Continued From page 38 gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs."	F 329	* All multidose medications in the medication cart and refrigerator will be reviewed for appropriate dating. if the bottles or containers are not dated, the medication will be destroyed and new medication will be ordered. These new bottles or containers will be dated appropriately when they are ordered. DK/SDDOH/MF		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, 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.	F 431			

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F 431	<p>Continued From page 39</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation during random medication cart audits, interviews, manufacturer's guideline review, and policy review, the provider failed to: *Appropriately label eye drops with an opened date and an expiration date on bottles that required dating on randomly selected eye drop medications in six of six medication carts (dementia care unit, the 200 wing and the 400 wings). *Appropriately label diabetic insulin pens with an open and a used by date on randomly selected insulin medications in six of six medication carts located on the dementia care unit, the 200 wing and the 400 wings. *Appropriately dispose of all Fentanyl patches (a skin patch of narcotic pain medication) that limited access from unauthorized staff. *Appropriately label inhaled medications with an opened date on one of one randomly selected inhaled medication (rehabilitation wing medication cart). Findings include:</p> <p>1. Observations on 5/6/15 from 10:00 a.m. through 3:00 p.m. of six randomly selected medication carts located on the dementia unit, the 200 wing, and the 400 wings revealed: *Numerous eye drop medications belonging to various residents with no opened dates or expiration dates written on the bottle or container as required by the pharmacy or manufacturer. *Those eye drop medications included Vigamox (antibacterial medication), Latanoprost (glaucoma medication), Visine, and Artificial tears (lubricant</p>	F 431	<p>All nurses and UAPs will be educated on the policy Transdermal Patch Application I.I.M.8z in the nursing manual by June 3rd to review and on June 10th and June 11th there will be live meeting by the DNS regarding the need to date bottles, insulin pens, eye drops, and inhalers when they are opened. An expiration date will be added per manufacturer guidelines. The destruction of Fentanyl patches via sewer with 2 nurses witnessing will be reviewed. The DNS will educate on the need to document that a Fentanyl patch is in place daily. The Night Charge Nurse will audit medication carts to assure all eye drops, insulin pens, inhalers, and other medications not in bubble packs are dated with open dates and expiration dates per manufacturer recommendation. The ADONs will monitor for initials on the e-MAR that Fentanyl patches are in place and that the destruction was done properly and witnessed by 2 nurses when the patch was changed. These audits will be done weekly X4 and then monthly x 3, the ADONs will report these audit findings to the QAPI committee monthly and the committee will determine if further auditing is needed.</p>	6-26-15

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 3901 S MARION RD 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 431	<p>Continued From page 40 drops).</p> <p>*Numerous diabetic insulin pens belonging to various residents with no opened dates or use by dates written on the pen as required by the pharmacy or manufacturer.</p> <p>*Those diabetic insulin pen medications included Novolog (a rapid-acting insulin), Lantus (a long-acting insulin), and Levemir (a long-acting insulin).</p> <p>2. Observations and interviews on 5/6/15 from 10:00 a.m. through 3:00 p.m. with medication aide H who was in charge of medication administration in the dementia care unit that day revealed she was:</p> <p>*Unaware of the randomly selected eye medications belonging to residents in the dementia care unit were not labeled with opened or expiration dates.</p> <p>*Unaware of the randomly selected insulin pens belonging to residents in the dementia care unit were not labeled with opened or expiration dates.</p> <p>*Unsure why they had not been labeled appropriately.</p> <p>3. Observations and interviews on 5/6/15 from 10:00 a.m. through 3:00 p.m. with registered nurses (RNs) I and C who were in charge of medication administration on the 200 wing that day revealed they were:</p> <p>*Unaware of the randomly selected eye medications belonging to residents in the 200 wing had not been labeled with opened or expiration dates.</p> <p>*Unsure of any policy regarding the destruction of Fentanyl patches.</p> <p>*Placing used Fentanyl patches in the sharps containers (disposal for dirty needles and syringes).</p>	F 431			

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F 431	Continued From page 41 4. Observations and interviews on 5/6/15 from 10:00 a.m. through 3:00 p.m. with licensed practical nurses (LPN) J and G were: *Unaware of the randomly selected eye medications belonging to residents in the 400 wing had not been labeled with opened or expiration dates. *Unsure of any policy regarding the destruction of Fentanyl patches. *Placing used Fentanyl patches in unsecured garbage cans. Review of the current manufacturer's guidelines for the medications listed below, accessed on 5/11/15 at www.drugs.com regarding opened and used-by dates as follows: *Vigamox: the use by date should be twenty-eight days after opening the bottle. *Latanoprost: the expiration date should be no longer than six weeks after the bottle was opened. *Visine: discard four weeks after opening or if cloudy or yellow. *Artificial tears: the use by date should be twenty-eight days after opening the bottle. Review of the current manufacturer's guidelines for the medications listed below, accessed on 5/11/15 at www.novolog.com; www.lantus.com; and www.levemir.com regarding opened and use-by dates were as follows: *Novolog: discard after forty-two days after first use. *Lantus: discard twenty-eight days after first use. *Levemir: discard forty-two days after first use. Review of the provider's June 2014 Acquisition, Receiving, Dispensing, and storage of	F 431			

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F 431	Continued From page 42 medications policy revealed: *All medications must be labeled with the expiration date and accessory instructions. *Controlled substances would be reconciled at least daily through appropriate records of receipt and disposition. Surveyor: 33265 5. Observation on 5/7/15 at 3:40 p.m. with registered nurse (RN) R concerning the documentation of opened dates on medication packages in the rehabilitation wing medication cart revealed: *Resident 29 had a physician's order for Advair diskus (inhaled medication). *The box the inhaler diskus were in had a preprinted label on it with "Open Date" printed on it. *No date had been written in the space, but the inhaler was being used. *RN R stated the diskus had been ordered from the pharmacy and sent from the pharmacy on 4/17/15 and had been first used at bedtime that same day 4/17/15.	F 431			
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	F 441	F 441 Infection Control, Prevent Spread, Linens Unable to go back and sanitize the glucometers. All glucometers will be cleaned with a Super Sani Cloth after each use; the glucometer will be wrapped in the Sani Cloth for a full 2 minutes and allowed to air dry before placing back in a container.		

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F 441	<p>Continued From page 43 in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to 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: 33265 Based on observation, interview, record review, and policy review, the provider failed to ensure the glucometers (device for testing blood sugar levels) were cleaned according to the manufacturer's instructions for two of three residents (26 and 27) observed blood glucose measurements. Findings include:</p> <p>1. Observation on 5/5/15 at 11:40 a.m. with</p>	F 441	<p>The DNS will educate all nurses and UAPs on the proper sanitation of the glucometer after each use on Nurses Meeting June 10 and UAP meeting June 11, 2015.</p> <p>The Staff Development or designee will monitor how staff sanitize the glucometers after each use on each medication cart weekly X4 and then monthly X3. Staff Development or designee will report audit findings to the QAPI committee monthly and the committee will determine if further auditing is needed.</p>	6-26-15	

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F 441	<p>Continued From page 44</p> <p>registered nurse (RN) C doing resident 26's blood glucose measurement revealed: *After the test was done RN C took a Super Sani cloth (presoaked cloth wipe to clean and disinfect) and wiped down the glucometer for six seconds. *She then laid the cleaned glucometer on top of a second glucometer in a three compartment container. *She put the container with glucometers and supplies away inside of the medication cart.</p> <p>2. Observation on 5/7/15 at 7:15 a.m. with RN D doing resident 27's blood glucose test revealed: *After the test was done, RN D took a Super Sani cloth (presoaked cloth wipe to clean and disinfect) and wiped down the glucometer for seven seconds. *She then laid the cleaned glucometer in the empty compartment in a three compartment container. *She put the container with glucometers and supplies away inside of the medication cart.</p> <p>3. Interview on 5/7/15 at 8:55 a.m. with the director of nursing (DON), the administrator, and the corporate executive director concerning the cleaning of the glucometers revealed: *The DON agreed the cleaning and disinfecting observed was not what should have been done according to the manufacturer's instructions. *The surface should have been kept wet with the solution on the Super Sani cloth for two minutes.</p> <p>Review of the provider's November 2013 Blood Glucose Monitoring procedure revealed: *The manufacturer's instructions for the specific device should be followed for performing the test and preventative maintenance.</p>	F 441			

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F 441	Continued From page 45 *The device should have been cleaned and disinfected between each resident. Review of the undated Assure Platinum User Instruction Manual revealed: *Cleaning and disinfecting could be completed using a commercially available product. *To use a commercial wipe they were to remove from container and follow product label instructions. Review of the undated Super Sani Cloth label revealed the device was to be kept wet with the solution on the cloth for a full two minutes and then allowed to air dry.	F 441			

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 3901 S MARION RD SIOUX FALLS, SD 57106	
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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 5/6/15. Good Samaritan Society Sioux Falls Village was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 5/6/15 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiency identified at K044 and K144 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 032 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and record review, the provider failed to maintain two conforming exits from the basement. Findings include:	K 032		

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TITLE

(X6) DATE

Alexis O'Neil

Administrator

5-29-15

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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SD DOH L&C

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K 032	Continued From page 1 1. Observation at 11:00 a.m. on 5/6/15 revealed the basement level was not provided with conforming exits. One exit was through the boiler room (hazardous area), and the other discharged into the main level kitchen area. Review of previous survey data confirmed those conditions. This deficiency would not affect any resident smoke compartments. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K 032	POC K032 NFPA 101 Life Safety Code Standard	F
K 033 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and record review, the provider failed to maintain a continuous one hour fire resistive path of escape from the basement to the exterior of the building. Findings include: 1. Observation at 11:10 a.m. on 5/6/15 revealed the basement stairway discharged into the main level in the area of the kitchen. A one hour fire resistive path of escape was not maintained to	K 033		

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K 044	Continued From page 3	K 044		
K 144 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and interview, the provider failed to install a remote stop button outside the room housing the generator for one of one generator. Findings include:</p> <p>1. Observation at 9:00 a.m. on 5/6/15 revealed there was not an emergency stop button installed for the generator. Interview with the maintenance supervisor at the time of the observation revealed he was aware of the remote stop requirement for the generator. He thought it was just a suggested regulation.</p> <p>All Level 2 installations shall have a remote manual stop station of a type similar to a break-glass station located outside the room housing the prime mover or located elsewhere on the premises where the prime mover is located outside the building (National Fire Protection</p>	K 144	<p>K 144 NFPA 101 Life Safety Code Standard</p> <p>Emergency stop for generator was installed on May 28, 2015.</p> <p>Education on the use of the emergency generator stop will be held on June 4, 2015 with environmental services team and at the nurses meeting on June 10, 2015.</p> <p>Administrator will audit that the work is completed and training has been completed and will report to the QAPI committee.</p>	6-26-15

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K 144	Continued From page 4 Association 110, Chapter 3-5.5.6, 1999 Edition). See attachment number 1. The deficiency affected a single location required to be equipped with remote emergency stops.	K 144			

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS VII		STREET ADDRESS, CITY, STATE, ZIP CODE 3901 S MARION ROAD SIOUX FALLS, SD 57106		
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S 000	Initial Comments Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 5/5/15 through 5/7/15. Good Samaritan Society Sioux Falls Village was found not in compliance with the following requirement: S253.	S 000		
S 253	44:04:04:11.01 SECURED UNITS Each facility with secured units must comply with the following provisions: (1) A physician's orders for confinement that includes medical symptoms that warrant seclusion or placement must be documented in the...resident's chart and must be reviewed periodically by the physician; (2) Therapeutic programming must be provided and must be documented in the overall plan of care; (3) Confinement may not be used as a punishment or for the convenience of the staff; (4) Confinement and its necessity must be based on a comprehensive assessment of the...resident's physical and cognitive and psychosocial needs, and the risks and benefits of this confinement must be communicated to the...resident's family; (5) Locked doors must conform to Sections 18.2.2.4 and 19.2.2.4 of NFPA 101 Life Safety Code, 2000 edition; and (6) Staff assigned to the secured unit must have specific training regarding the unique needs of...residents in that unit. At least one caregiver must be on duty on the secured nursing unit at all times.	S 253	S 253 44:04:04:11.01 Secured Units Unable to change the events for residents in the SCU on 5/5 and 5/6/2015. The living room has been rearranged to promote better interaction for the residents, this will continue to be reevaluated. Resident 7's care plan has been updated to reflect the need for consistent seating in the dining room and assistance provided through the meal. All staff assigned to work in the SCU will be provided specific training prior to working in the unit and additional in-service education while working in the unit quarterly. Training will include CMS Hand in Hand training, staff will also utilize the Learning Center's trainings on dementia and Alzheimers. To get current staff into compliance, online learning course Providing High Quality Dementia Care - An Overview will be completed by June 12, 2015. The CMS Hand in Hand training program will be taught in its entirety to staff consistently assigned to work in the special care unit as well as those that typically float to cover the unit.	

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(X6) DATE

STATE FORM

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P5CM11

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S 253	Continued From page 1 This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 26180 Based on observation, record review, interview, and policy review, in the secured unit the provider failed to ensure: *Staff assigned to the unit had specific training regarding the needs of the residents in the unit. *Therapeutic programming was being provided. Findings include: 1. Observations on 5/5/15 in the secured unit revealed: *There were fifteen residents in the unit, and they all had a diagnosis of Alzheimer's/dementia (memory loss and confusion). *The unit was staffed with a certified nursing assistant (CNA) and an unlicensed assisted personnel (UAP)/medication aide (MA). -A registered nurse was also assigned to the unit, but she was only on the unit as needed or when she was called. *At 10:30 a.m.-Ten residents were sitting in the various chairs in the TV room/dining room. -Four of them were sleeping. -Resident 7 was folding wash cloths at a table. -Resident 8 was asleep at a table and continued to sleep throughout the morning. -The Price is Right was on the TV. -The chairs were positioned so that the residents faced each other, rather than facing the TV. *At 10:45 a.m. Certified nursing assistant (CNA) Q put a DVD on which was a black and white movie, and without saying a word or introducing the movie started it. -The same residents continued to sleep. *At 12:20 p.m. Lunch was served. *At 1:30 p.m. Most residents went to their rooms and were napping. -A music video of Irish dancers and singers was	S 253	This training will be held one hour a week beginning the week of June 22nd and continuing for six weeks. Alzheimers/Dementia will be added as a standing agenda item on regularly scheduled nursing & CNA meetings. CMS Hand in Hand training will also be incorporated into general orientation. Our goal is to have consistent staff per our Special Care Unit Staffing Guidelines IV.A. Therapeutic Programing will be set up by the social service and activities department following GSS SCU manual. This programing will encourage and stimulate physical movement, reduce undesirable behaviors, decrease anxiety and noise, increase better sleeping habits, decrease physical and chemical restraints. Staff will utilize tools such as the Sample Daily Programming/ Activity Schedule- GSS VI.B1 and the Special Care Unit Daily Program Description, GSS VI.B2, resident interest and preferences to develop the therapeutic programming schedule. The activity coordinator will monitor the SCU with observation and record review of how this programming is being managed.	

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10680	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/07/2015
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS VII		STREET ADDRESS, CITY, STATE, ZIP CODE 3901 S MARION ROAD 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 253	<p>Continued From page 2</p> <p>playing on the TV. There were no residents watching it.</p> <p>-Resident 7 was asleep on her bed and stayed there until 6:00 p.m. when they got her up for supper.</p> <p>-Resident 8 was asleep in his recliner and stayed there until after 5:00 p.m. when a family member came to visit.</p> <p>Interview at various times on 5/5/15 with CNA Q and MA N revealed:</p> <p>*Resident 7 was very hard of hearing, had been more anxious lately, and had very poor vision.</p> <p>*They had recently made changes with staff in the secured unit. The new staff had not been working there a long time.</p> <p>-The changes had taken place the end of February 2015.</p> <p>*They did not have a schedule of therapeutic programs they followed in the unit.</p> <p>*They used to have a schedule of programs they followed, but it was gone now.</p> <p>-CNA Q was not sure what had happened to it.</p> <p>Observation on 5/5/15 at 3:15 p.m. revealed an unidentified CNA came on duty. Interview at that time revealed she worked for a temporary staffing agency and had never worked for this provider before. She had received a brief report when she reported for duty, but she did not know the residents and had not received any dementia specific training from this provider prior to the start of her shift.</p> <p>Observation of resident 7 on 5/5/15 at the supper table revealed:</p> <p>*She was seated at a table with three women who ate independently.</p> <p>*Her supper was set before her by MA N without any orientation to what she was being served.</p>	S 253	<p>The Staff Development Coordinator will review when SCU staff have completed the specific learning requirements. The ADON will observe meal times to assure residents are receiving the needed assistance. These audits will be done weekly X4 and then monthly X3, each audit will be reported to the QAPI committee monthly by the activity coordinator, SDC, and ADON, the committee will determine if further auditing is needed.</p>	6-26-15

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S 253	<p>Continued From page 3</p> <p>*The resident hesitantly began to eat carefully placing her eating utensil until she felt like it had food on it. *After about twenty-five minutes of eating the surveyor asked her how she was doing, and she said she did not know what she was doing.</p> <p>Interview of MA H on 5/6/15 at 7:30 a.m. revealed she: *Had worked in the secured unit since February 2015. *Had not received training before she started working there. *Thought working in the unit could have gone better if they had received training to work with the residents.</p> <p>Observation on 5/6/15 at breakfast revealed: *Resident 7 was seated at a different table. *A CNA assisted her with telling her where her food was at on her plate. *They did not give her all of her food at once to prevent overwhelming her.</p> <p>Interview of MA H on 5/6/15 at 8:30 a.m. regarding resident 7 revealed she was always supposed to sit at the table she was currently at. She needed assistance and encouragement to eat. She was unsure why she would not have sat there the evening before.</p> <p>Interview on 5/6/15 at 9:00 a.m. with CNA X revealed: *She had worked there many years and consistently worked in the secured unit. *There had been a lot of changes with staffing in the past two months. *Their residents required a lot more care, and programming of activities was not occurring as it had in the past.</p>	S 253	

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S 253	<p>Continued From page 4</p> <p>*They had a schedule of programs, but they were unable to follow it anymore. -She was trying to make management aware of the challenges they were having now in the secured unit. *Staff had not received training on dementia (memory loss) and meeting those residents needs before the changes all took place. -She was trying to train as they went along now. *They were supposed to have exercises at 10:00 a.m. However staff were not having it anymore because the staff met for a brief review at that time now. *She confirmed knowing the residents and consistency with staffing was important in the secured unit.</p> <p>Review of the secured unit's programming schedule revealed there was to have been a schedule throughout the day. Observation on 5/5/15 and 5/6/15 revealed the only programs that occurred were the Devotions and Coffee time.</p> <p>Interview on 5/6/15 at 9:30 a.m. with the activity director revealed: *She confirmed staff had not received sufficient training in the secured unit before all the changes had occurred. *They had planned to train staff but had not gotten it done. *She was aware programming was not occurring as it should have been. -It was difficult to get CNAs to cross over and do the recreational programming in addition to the daily care. *It was difficult to monitor if activities were occurring. *Activities were not getting documented. *Review of resident 7's care plan and activity</p>	S 253		

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S 253	<p>Continued From page 5</p> <p>documentation revealed she had not participated in programming that was part of her plan. *Review of resident 8's care plan and activity documentation revealed he had not participated in programming that was part of his plan.</p> <p>Interview on 5/5/15 at 5:45 p.m. with the executive director revealed they had identified that staff training in the secured unit had not occurred. They were currently putting a plan in place to do that.</p> <p>Review of the provider's June 2012 Activity program policy revealed: "The center will provide a program of activities in compliance (met guidelines) with all applicable state and federal regulations in addition to the Society's mission, vision, and strategic direction."</p> <p>Review of the provider's August 2012 therapeutic programming objectives policy revealed "The person with a cognitive impairment requires specialized programmatic interventions. Activities for persons with dementia should be chosen for their therapeutic value. Daily programming should relate to the person's past life experiences, as well as current strengths. These should be meaningful, stimulating, appropriate, and provided in a dignified manner. Structured programming should be offered 10 hours per day."</p> <p>Review of the provider's June 2012 guidelines in programming for the special care unit resident revealed "Provide consistency and routine with daily programs."</p> <p>Review of the provider's August 2012 staff training policy revealed: **All staff assigned to the special care [secured]</p>	S 253		

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S 253	Continued From page 6 unit will receive training before working on the unit and additional in-service education while working on the unit. *Special care unit staff will receive quarterly scheduled in-service education to: -Review information learned during initial training. -Keep abreast of new information regarding Alzheimer's disease and other dementias. -Improve skills training regarding caring for residents with Alzheimer's disease and other dementias."	S 253			