

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

ORIGINAL

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER JENKINS LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201	
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F 000	INITIAL COMMENTS Surveyor: 32331 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 11/16/15 through 11/19/15. Jenkins Living Center was found not in compliance with the following requirements: F159, F176, F221, F280, F281, F323, F371, F373, and F441.	F 000	*Addendums noted with an asterisk per 12/31/15 per telephone with facility administrator JT/SDDOT/EL	
F 159 SS=D	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.	F 159	All resident funds and personal checks have been removed from the medication carts and have been placed in the resident fund account. No resident funds or personal checks will be stored on the nursing units. All residents in the facility could potentially be affected by this deficiency. The Director of Nursing and interdisciplinary team developed a policy on handling residents' funds and that information was shared with the nursing staff. JT/SDDOT/EL *OP JT/SDDOT/EL *for resident 2/26/30, 31/32 33/34 JT/SDDOT/EL 1/8/16	

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

Joseph M. Bullock

TITLE

Pres CEO

(X6) DATE

12-14-15

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.

DEC 16 2015
If continuation sheet Page 1 of 46
SD DOH L&C

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F 159	<p>Continued From page 1</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, and record review, the provider failed to account for for the funds and/or personal checks of six randomly sampled residents (26, 30, 31, 32, 33, and 34) kept in the medication rooms for six randomly sampled residents. Findings include:</p> <p>1a. Observation and interview on 11/18/15 at 9:30 a.m. on floor 2, unit 2 in the medication room with licensed practical nurse (LPN) M revealed: *There were five white letter sized envelopes in the locked drawer in the medication room with residents' names and dollar amounts written on the outsides. *Residents 26, 31, 32, 33, and 34 had personal funds in those envelopes with amounts from \$9.11 to \$105.00.</p>	F 159			

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F 159	<p>Continued From page 2</p> <p>-Resident 34 also had a wallet with one dollar and her driver's license in that drawer.</p> <p>*LPN M stated residents who wanted money to use on evenings or weekends had to keep it in the medication rooms, because the business office was closed during those times.</p> <p>*She also confirmed the money was not counted routinely.</p> <p>*The amount on the outside of the envelope was changed as the resident added or withdrew money.</p> <p>*Only the medication nurse on each unit had a key for the locked drawer in the medication room on the unit.</p> <p>b. Observation and interview on 11/18/15 at 10:20 a.m. on floor 2 in the memory care unit with LPN G revealed:</p> <p>*Resident 30 had two checkbooks locked in the drawer in the medication room.</p> <p>*LPN G stated the resident used the checks when family were present.</p> <p>c. Interview on 11/18/15 at 11:07 a.m. with accountant N revealed:</p> <p>*She knew there was money being kept on the nursing units.</p> <p>*She had nothing to do with the residents' money kept on the nursing units.</p> <p>*The money on the units would not be earning any interest.</p> <p>Interview on 11/18/15 at 1:20 p.m. with the director of nursing revealed she:</p> <p>*Was aware there were residents' funds and personal checks on the nursing units in the locked drawer in the medication rooms.</p> <p>*Knew the money was not routinely counted.</p> <p>*Agreed if an envelope was missing there would</p>	F 159			

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F 159	Continued From page 3 be no way of knowing the amount that had been in the envelope. *Agreed if checks were missing it would be difficult to identify which checks were gone. *Stated there was no policy or procedure on handing the residents' funds and personal checks on the nursing units.	F 159			
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Surveyor: 32332 Based on observation, record review, interview, and policy review, the provider failed to follow their policy to routinely assess the ability to self-administer their own medications for one of two sampled residents (5) who had physician's orders to self-administer medications. Findings include: Surveyor: 33488 1. Observations on 11/17/15 with resident 5 in her room revealed: *At 10:10 a.m., she was in the process of self-administering a nebulizer treatment (device used to administer medicine as a mist into the lungs). *At 10:25 a.m. the resident had finished her nebulizer treatment and had laid it in her lap.	F 176	An assessment has been completed on resident #5 for her ability to self-administer her nebulizer treatment after set-up. Any resident who self-administers medications could potentially be affected by this deficiency. The Director of Nursing reviewed and revised the policy and procedure for assessing residents' ability to self-administer medications to ensure that routine assessments are completed. All professional nurses and UAP's were re-educated by the Director of Nursing regarding the policy on December 16, 2015. The Director of Nursing, or her designee, will review self-administration assessments for 4 residents who self-administer medications weekly x4 and then monthly x3 to ensure that assessments are completed on a routine basis. Results of the audits will be reported by the Director of Nursing, or her designee, at monthly QAPI Committee meetings for a period of 3 months, with additional follow-up as recommended by the Committee.	1/8/16	

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F 176	<p>Continued From page 4</p> <p>*She was unable to shut the machine off or return the mask to the base on the bedside table, as she could not reach it due to her limited mobility.</p> <p>*At 10:30 a.m. licensed practical nurse (LPN) M entered the resident's room, removed the nebulizer from the resident's grasp, shut it off, placed it on the bedside table, and left the room.</p> <p>Surveyor: 32332</p> <p>2. Review of resident 5's medical record and the November 9 through 16, 2015 medication administration record (MAR) revealed:</p> <p>*A 10/30/14 physician's order "May self administer nebs [nebulizer] after set-up."</p> <p>*The medical record revealed a 10/27/14 medication self-administration assessment that indicated the resident was capable of self-administering the nebulizer medication appropriately.</p> <p>*No current self-administration assessments after 10/27/14 were found.</p> <p>*No indication in the medical record or the MAR when the resident was to have been assessed again.</p> <p>Interview on 11/18/15 at 5:00 p.m. with LPN Q revealed the nurses who gave resident 5 the nebulizer treatments were not responsible for assessing her ability to self-administer the medication. She stated registered nurse (RN) S would have assessed for her ability to self-administer her nebulizer medication.</p> <p>Interview on 11/19/15 at 9:00 a.m. with the director of nursing (DON) revealed RN S:</p> <p>*Assessed residents for their ability to self-administer medication.</p> <p>*He would have documented the assessment weekly on a medication administration form in</p>	F 176			

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F 176	Continued From page 5 those residents' rooms. Interview on 11/19/15 at 11:40 a.m. with the DON revealed: *She had visited with RN S. *She had been told he assessed residents who self-administered other medications, such as pills or insulin for their ability to self-administer those medications. *He had not assessed residents who self-administered nebulizer treatments. *He did not keep a medication record in resident 5's room to document self-administration abilities. Review of the provider's March 2009 Medication Self-Administration policy revealed: *The nurse would complete a weekly assessment on the resident's ability to self-administer medications. *That would then be documented on a MAR in the resident's room. *The old MAR would have been placed in the resident's chart and signed by the reviewing nurse.	F 176			
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, record review, and policy review, the provider failed to assess	F 221	No corrective action was required for resident #15 because the assessment had already been completed. All residents in the facility could potentially be affected by this deficiency. The Director of Nursing reviewed the restraint policy to ensure it addresses an assessment being completed prior to the use of what may be a restrictive device or restraint. The Director of Nursing, or her designee, will audit all residents with a restraint weekly x4	1/8/15	

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F 221	<p>Continued From page 6</p> <p>one of one sampled resident (15) prior to use of what may be a restrictive device or restraint. Findings include:</p> <p>1. Random observations and interview from 11/16/15 through 11/18/15 on the second floor memory care unit (MCU) of resident 15 revealed the following: *On 11/16/15: - At 1:58 p.m. she was in a Merry Walker (walker/chair combination with wheels used to aide in walking). Interview at that time with licensed practical nurse (LPN) G revealed "She was in the Merry Walker a lot but not at meal times." -At 4:35 p.m. she was in the Merry Walker in the dining room. -At 5:25 p.m. she was transferred from a chair into the Merry Walker. *On 11/17/15 and 11/18/15 throughout the day she was in the Merry Walker.</p> <p>Review of resident 15's medical record revealed: *She been admitted on 9/21/15. *She had diagnoses of Alzheimer's disease (memory loss) and cerebral vascular accident (stroke). *There was no documentation on admission she had used a Merry Walker.</p> <p>Review of resident 15's 9/27/15 Minimum Data Set (MDS) assessment revealed: *Her Brief Interview for Mental Status (BIMS) assessment was coded "00" indicating severe cognitive loss (memory impairment). *Physical restraints were coded "0" indicating not used.</p> <p>Review of resident 15's 10/14/15 care plan</p>	F 221	and then monthly x3 to ensure that an assessment was completed prior to use. Results of the audits will be reported by the Director of Nursing, or her designee, at monthly QAPI Committee meetings, with additional follow-up as recommended by the Committee.		

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F 221	<p>Continued From page 7</p> <p>revealed:</p> <p>*She used a front wheel walker with a gait belt (used to assist resident getting up and walking as a safety device) and assistance of one staff.</p> <p>*The short term care plan on 9/29/15 at 1400 (2:00 p.m.) revealed "May try meri-walker [Merry Walker] per [name] PT [physical therapist]. Does well. Addendum to meri-walker. Resident continuously gets up from w/c [wheelchair] and comes out walking per self-gait very wobbly and unsteady. Does well with meri-walker for ambulation [walking]."</p> <p>*On 11/5/15 at 1410 (2:10 p.m.) revealed "Assessment completed for Merry Walker. Fax req [request] for an order."</p> <p>*On 9/22/15 screen completed by PT F revealed: - "SBA [stand by assistance]. - FWW [front wheeled walker]. - 200' [two hundred feet]."</p> <p>*The 9/22/15 physician fax sent by the PT to the physician revealed "PT screen completed upon pt [patient] admit. No skilled PT needs noted with restorative program to be set up. Can standing PT orders to eval [evaluate] and treat upon admit be D/Ced [discontinued]?" Physician response was "OK."</p> <p>*The 9/30/15 physician's progress note revealed "Gets around in geri walker [another name for Merry Walker]."</p> <p>*The 11/5/15 physician's fax revealed: "Patient concern: May we have an order for res [resident] to use a Merry Walker ambulation device? R/T [related to] Alzheimer's." -The physician's response to the above was "yes."</p> <p>Review of the provider's 2014 Merry Walker Ambulation Device Assessment Form-2014 revealed:</p>	F 221			

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F 221	<p>Continued From page 8</p> <p>*The assessment had been completed by the director of nursing (DON) on 11/5/15.</p> <p>*"The Merry Walker is restraint free when the user is able to open and close the front gate independently.</p> <p>*It will be considered an enabler or justified restraint if the end user is unable to open and close the front gate and must be charted as such. -It may require a physician's order for use in some cases."</p> <p>Review of the 9/21/15 through 11/18/15 nurses notes regarding resident 15 revealed on:</p> <p>*9/21/15: Admitted to the facility. Was able to walk with her walker with assistance.</p> <p>*9/30/15: Had been examined by the attending physician. There was no documentation for the use of a Merry Walker.</p> <p>*10/01/15: "Wandering around unit in merry walker."</p> <p>*10/16/15: "Wanders around unit in merry walker."</p> <p>*11/5/15: "Purpose of note: Assessment for use. -Supportive device: Merry Walker. -Benefits/purpose: Enable ambulation, independently. Although it is coded as a restraint on the MDS per the RAI [resident assessment instrument] manual definition. -Actions: Res [resident] repositions self often in Merrywalker. -Plan: device appropriate Obtain consent Obtain physician's order."</p> <p>*There was no documentation the family had been notified of the Merry Walker.</p> <p>Observation and interview on 11/17/15 at 5:50 p.m. with LPN E and resident 15 revealed:</p> <p>*The resident was in the Merry Walker.</p> <p>*The surveyor requested to have the resident</p>	F 221			

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F 221	<p>Continued From page 9</p> <p>release the strap on the Merry Walker.</p> <p>*The resident was unable to release the strap on the Merry Walker.</p> <p>*LPN E confirmed the resident was unable to:</p> <ul style="list-style-type: none"> -Know how to release the straps on the Merry Walker. -Physically release the strap on the Merry Walker. <p>Interview on 11/18/15 at 2:00 p.m. with the DON regarding resident 15 revealed:</p> <p>*The Merry Walker formal assessment had not been completed until 11/5/15.</p> <p>*The consent had been mailed to the family after the Merry Walker had been initiated, and the formal assessment had been completed.</p> <p>*She had considered the Merry Walker a restraint.</p> <p>*The resident had not used the Merry Walker upon admission.</p> <p>*There had not been a formal assessment completed prior to the use of the Merry Walker.</p> <p>*She agreed:</p> <ul style="list-style-type: none"> -The resident was unable to open the strap on the Merry Walker. -They had not followed their policy to determine if the Merry Walker was an assistive device or restraint. <p>Interview on 11/18/15 at 3:05 p.m. with physical therapist F regarding resident 15 revealed:</p> <p>*He had completed a screening assessment for her upon admission.</p> <ul style="list-style-type: none"> -The screening assessment had not included the use of a Merry Walker. <p>*She had used a front wheel walker when she had been admitted.</p> <p>*He often received phone calls from one of the floors requesting permission for a resident to use a certain piece of equipment.</p>	F 221			

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F 221	Continued From page 10 *The use of the Merry Walker had been done through phone communication. *He had not completed a formal assessment for her to use the Merry Walker. Review of the provider's undated physical restraint policy revealed: *The resident has the right to be free of any physical restraints. *An assessment would be done by an RN (registered nurse)/LPN or therapy member prior to the use of the device to determine the effect the device had on the resident and if it was an assistive device or a restraint. *Equipment: Merry Walker. *Complete assessment prior to placement. Review of the provider's revised October 2015 Resident Centered Care Plan Facility Standards policy revealed: *Elements of the care plan included a short term care plan. *The care plan was to have been reviewed and/or revised after each assessment and PRN (when needed). *The short term care plan was to have been reviewed during that time and long term care issues carried forward to the long term care plan.	F 221			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280	Resident #12 has discharged from the facility. the care plan for resident #16 has been updated with interventions to address the identified problem. All residents in the facility could potentially be affected by this deficiency. The Director of Nursing reviewed the Resident Centered Care Plan Facility Standards to ensure	1/8/16	

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F 280	Continued From page 11 within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 A. Based on record review, interview, and policy review, the provider failed to accurately revise the care plan for one of one sampled resident (12) who had severe weight loss (weight loss of greater than five percent [%] in one month). Findings include: 1. Review of resident 12's complete medical record revealed: *She had been admitted on 9/25/15. *Her weight on the following dates was: -9/26/15: 105.0 pounds (lb). -10/1/15: 106.5 lb. -10/8/15: 102.5 lb. -10/15/15: 99.0 lb. -10/22/15: 95.0 lb. -10/29/15: 90.0 lb. -11/5/15: 85.5 lb. -11/12/15: 86.0 lb. -11/17/15: 90.9 lb. *She had lost a total of twenty-one pounds or	F 280	that resident care plans include measurable outcomes and identify interventions that are specific to the individual resident. <i>*All care plans are checked by the MDS coordinator quarterly or as scheduled with MDS completion.</i> The Director of Nursing, or her designee, will audit 4 care plans weekly x4 and then monthly x3 to ensure that care plans are revised to reflect current information about the residents, and that interventions are care planned. Results of the audits will be reported by the Director of Nursing, or her designee, at monthly QAPI Committee meetings for a period of 3 months, with additional follow-up as recommended by the Committee.	JIT/SD008/EL	

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F 280	<p>Continued From page 12</p> <p>19.7% of her total body weight from 10/1/15 to 11/5/15.</p> <p>*A weight loss of greater than 5% in one month was considered severe weight loss, according to the State Operations Manual Appendix PP-Guidance to Surveyors for Long Term Care Facilities (revised 10/9/15).</p> <p>Review of resident 12's 10/14/15 care plan revealed: *"Weight goal 1 - 2# [pounds] per month gain to 110-115#." *All staff were to have watched for any changes including weight loss.</p> <p>Review of resident 12's revised 11/12/15 short term care plan revealed no documentation regarding her weight loss.</p> <p>Interview on 11/16/15 at 5:50 p.m. with the registered dietitian (RD) regarding resident 12 revealed: *She had lost a significant amount of weight since her admission. *She was on scheduled nutritional supplements. *An appetite stimulant had been ordered and discontinued on 11/13/15 by her physician. -The family had declined the usage of the above appetite stimulant. *She was at nutritional risk.</p> <p>Review of the RD's fax on 11/12/15 to resident 12's physician revealed: *She had lost 21% of her body weight in one month. *She had a poor intake of foods and fluids. *She was on supplements three times per day. *An appetite stimulant had been recommended.</p>	F 280		

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F 280	<p>Continued From page 13</p> <p>Interview on 11/18/15 at 10:00 a.m. with the RD and on 11/18/15 at 10:35 a.m. with the director of nursing (DON) regarding resident 12's weight loss and care plan revealed:</p> <p>*Both stated the care plan needed to have been updated with the resident's current status.</p> <p>*Both confirmed the care plan had not been accurately revised and updated with her weight loss.</p> <p>*Each member of the care team was responsible for updating and revising the care plan as needed.</p> <p>Review of the provider's revised October 2015 Resident Centered Care Plan Facility Standards policy revealed:</p> <p>***"The care plan is reviewed and/or revised after each assessment and PRN [as needed]. The short term care plan is reviewed during this time and long term issues are carried forward to the long term care plan."</p> <p>*Each discipline (care team member) was responsible for updating the care plan as changes occurred between assessments.</p> <p>Surveyor: 33265</p> <p>B. Based on interview, record review, and policy review, the provider failed to identify interventions for inappropriate comments made to the nursing staff by 1 of 24 sampled residents (16). Findings include:</p> <p>1. Review of resident 16's complete medical record revealed:</p> <p>*He had been admitted on 5/28/15.</p> <p>*Admitting diagnoses included major neurocognitive disorder (disturbed thinking).</p> <p>*The physician had been notified on 10/22/15 by fax of the inappropriate comments to the nursing</p>	F 280			

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F 280	Continued From page 14 staff, and he had faxed and ordered a psychiatric consult on 10/26/15. *Neither the care plan nor the short term care plan identified interventions for dealing with the inappropriate comments to staff. Interview with the DON on 11/19/15 at 9:00 a.m. revealed she agreed there were no interventions on resident 16's care plan nor the short term care plan for dealing with the inappropriate comments to staff. Review of the provider's October 2015 Resident Centered Care Plan Facility Standards policy revealed: *Care plans were to include measurable outcomes and identify interventions that were specific to the individual resident. *The care plan was to be reviewed and/or revised after each assessment and as needed.	F 280			
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, record review, interview, and policy review, the provider failed to: *Verify medication dosages before administration for 2 of 29 residents (17 and 28) randomly observed medication administrations. *Ensure medications were administered in a sanitary manner during 1 of 28 residents (29) randomly observed medication administrations.	F 281	Resident #17 has discharged from the facility. The medication administration record was updated for resident #28. No corrective action was needed for resident #29. Expired medications were removed from the medication cart for residents #25 and 26. The medications with the damaged foil backings were removed from the medication cards for residents #25 and 27. All residents receiving medications could potentially be affected by this deficiency. The Director of Nursing reviewed and revised the Medication Administration policy to ensure that it addresses the need to match medication administration records with labels on all medi-	1/8/16	

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F 281	<p>Continued From page 15</p> <p>*Remove medications that were beyond the expiration date for 2 of 28 residents (25 and 26) randomly reviewed prn (take as needed) medication punch cards.</p> <p>*Ensure medications were stored in a sanitary manner for 2 of 28 residents (25 and 27) randomly reviewed prn medication punch cards.</p> <p>Findings include:</p> <p>1a. Observation on 11/18/15 at 7:28 a.m. of registered nurse (RN) K preparing an insulin injection for resident 17 revealed:</p> <p>*A 9/3/15 physician's order on the medication administration record (MAR) for insulin NPH (for diabetes) 18 units to have been given subcutaneous (SQ) (under the skin) daily in the morning.</p> <p>*RN K drew 18 units of insulin NPH from resident 17's insulin bottle.</p> <p>*That insulin bottle had been dispensed from the pharmacy on 10/25/15.</p> <p>*Instructions on the bottle label stated, "Inject 15 units SQ every morning."</p> <p>*There had been no documentation or label on the bottle to indicate medication orders had been changed.</p> <p>Interview at that time with RN K revealed:</p> <p>*She was aware the insulin orders had been increased to 18 units.</p> <p>*The insulin orders on the MAR had not matched the instructions on the bottle.</p> <p>*The nurse receiving the bottle should have added a sticker to the bottle to indicate the orders had changed.</p> <p>*The pharmacy had sent another bottle with the previous insulin dose several weeks after the order had changed.</p>	F 281	<p>cations; that medications are stored in a sanitary manner; and that expiration dates continue to be checked prior to administration of any medication. All professional nurses and UAP's were re-educated regarding the policy by the Director of Nursing on December 16, 2015.*</p> <p>The Director of Nursing, or her designee, will audit a medication pass weekly x4 and then monthly x3 to ensure medication administration records match the medication labels; medications are handled and stored in a sanitary manner; and expiration dates are checked prior to administration. Results of the audits will be reported by The Director of Nursing, or her designee, at monthly QAPI Committee meetings for a period of 3 months, with additional follow-up as recommended by the Committee.</p> <p>→ Nursing staff and pharmacy check all medication carts' medications for outdated medications and for any medication cards that have taped medication on them. JT/SPDOH/EL</p>		

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F 281	<p>Continued From page 16</p> <p>Interview on 11/19/15 at 9:00 a.m. with the director of nursing (DON) revealed: *Nursing staff should have placed an order change sticker on the insulin bottle to inform staff of changes. *Nursing staff should have notified the pharmacy of order changes if the pharmacy had not been aware of them.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo, 2013, p. 583, revealed the steps to take to prevent medication errors included to read labels at least three times comparing the MAR and the label before administering the medication.</p> <p>Surveyor: 33265 b. Observation and record review on 11/17/15 at 7:35 a.m. with licensed practical nurse (LPN) L during medication pass revealed: *Resident 28 had an order dated 9/25/15 for a supplement with calcium 600 milligrams (mg) and vitamin D 125 units. *The electronic MAR listed calcium 600 mg and vitamin D 125 units. *The label on the medication punch card listed calcium 600 mg and vitamin D 200 units tablet. *LPN L administered the calcium 600 mg and vitamin D 200 units tablet. *LPN L had not noticed the different amounts of vitamin D units that were listed.</p> <p>Further interview on 11/17/15 at 10:45 a.m. with LPN L revealed she: *Had called the pharmacy and inquired about the differences in the amount of vitamin D. *Pharmacy had told her the supplement was not available with only 125 units of vitamin D and the</p>	F 281		

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F 281	<p>Continued From page 17</p> <p>pharmacy had contacted the physician on 9/25/15 to clarify the amount.</p> <p>-The physician had changed the order to 200 units of vitamin D that was available.</p> <p>*No copy of the above fax had been found in the medical record.</p> <p>*LPN L requested and received a copy of the fax from the pharmacy.</p> <p>Interview on 11/19/15 at 9:00 a.m. with the DON regarding the above medication administration revealed she agreed:</p> <p>*LPN L should have compared the MAR order to the label on the medication punch card.</p> <p>*She should have noticed the difference.</p> <p>*She should have called the physician for clarification.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo, 2013, p. 583, revealed the steps to take to prevent medication errors included to read labels at least three times comparing the MAR and the label before administering the medication.</p> <p>2. Observation and interview on 11/17/15 at 8:07 a.m. with RN K revealed she:</p> <p>*Administered an aspirin tablet to resident 29 after using her finger to get the tablet out of the container.</p> <p>*Realized what she had done and said "Habit."</p> <p>Interview on 11/19/15 at 9:00 a.m. with the DON revealed she agreed the medication should not have been touched by bare fingers.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St.</p>	F 281			

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F 281	<p>Continued From page 18</p> <p>Louis, Mo, 2013, p. 613, revealed the person administering medication should not touch the medication with their fingers.</p> <p>3. Observation, record review, and interview on 11/18/15 at 10:10 a.m. with LPN M revealed: *Resident 26 had an order for a medication to be given every four to six hours as needed for pain. The punch card containing that medication listed the expiration date as 10/23/15. *Resident 25 had an order for a medication to be given every six hours as needed for anxiety. The punch card containing that medication listed the expiration date as 10/31/15. *LPN M stated both medications should have been pulled from the medication cart at the time they had expired.</p> <p>Interview on 11/19/15 at 9:00 a.m. with the DON revealed she agreed the medication punch cards that had expired should have been removed from the cart.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo, 2013, p. 612, revealed medications should be checked for expiration dates and if expired returned to the pharmacy.</p> <p>4. Observation and interview on 11/18/15 at 10:10 a.m. with LPN M revealed: *Resident 25 had a medication for anxiety ordered on a prn basis. -The punch card had fourteen doses remaining. -One of those doses no longer had a sealed foil backing. *Resident 27 had a medication for anxiety ordered on a prn basis. -The punch card had fifteen doses remaining.</p>	F 281			

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F 281	Continued From page 19 -One of those doses no longer had a sealed foil backing. *The medications should have been removed and destroyed once the sealed foil backing was no longer sealed. Interview on 11/19/15 at 9:00 a.m. with the DON revealed she agreed the medication should have been destroyed when the foil backing was no longer sealed. Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo, 2013, p. 613, revealed the sealed wrapper holding a medication in place maintained cleanliness of the medication.	F 281	→ resident 8's screen has been put in the window and the window cranks have been removed in the memory care units including rooms 272, 280, 288, and 290. JT/SDDO/H/EL		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 A. Based on observation, interview, product information review, and policy review, the provider failed to ensure hazardous chemicals were stored in a secured locked up manner to protect: *Residents with cognitive impairment (decline in brain functioning) in one of three memory care	F 323	All identified unsecured chemicals were removed immediately and secured per policy. Resident #11 has been assessed for safe transfers without the use of the shin strap on the standing lift. All window cranks were removed from windows in the memory care units, and all window screens were put in place. The 5-gallon Lysol containers have been identified with appropriate labels. All residents in the facility could potentially be affected by this deficiency. The Director of Environmental Services reviewed and revised the policy for chemical storage and proper labeling. The Director of Nursing reviewed the policy for standing mechanical lifts to ensure that an assessment is done if a resident either chooses to, or is unable to, use all of the straps as they are intended. The Director of Environmental Services created a policy regarding	12/16/15	

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F 323	<p>Continued From page 20 units (Wrage). *All residents in one of one activity area (Main Street). Findings include:</p> <p>1. Observation on 11/18/15 at 8:15 a.m. of the dining room/kitchen area in the Wrage memory care unit revealed an eight ounce bottle of Miracle Gro liquid cactus plant food fertilizer stored in an unlocked kitchen cupboard. The bottle had been placed in a bread pan. The pan had sat beside several unopened individual containers of applesauce.</p> <p>Review of the Miracle Gro Liquid Cactus Plant Food August 2010 Material Safety Data Sheet revealed: **"Keep out of reach of children." **"May cause irritation of respiratory [breathing] tract." **"Contact with eyes may cause irritation." *A physician or poison control center was to have been contacted for advice if the liquid fertilizer had been swallowed, inhaled, or came into contact with the eyes or skin.</p> <p>Interview on 11/18/15 at 11:25 a.m. with licensed practical nurse (LPN) T revealed the Miracle Gro should have been stored securely out of reach of the residents and away from food items.</p> <p>Observation on 11/18/15 at 2:15 p.m. of an isolation cart (used to store supplies for residents with an infection) located in the hallway of the Wrage memory care unit revealed an unsecured spray bottle of Virasept disinfectant (kills germs) in an open drawer.</p> <p>Review of the above bottle revealed precautions</p>	F 323	<p>window cranks and screens. All nursing staff were re-educated by the Director of Nursing regarding the policy for standing lifts and the need for assessments on 12/16/15. All Environmental Services staff were re-educated by the Environmental Services Director at a departmental meeting on 12/16/15 regarding proper labeling and storage of chemicals, and also the use of window cranks and screens in memory care units. Other departmental staff will be educated on resident safety and accident prevention through the facility's in-house newsletter. 2015. JTTISDDO/HJEL by December 17,</p> <p>The Director of Environmental Services, or his designee, will audit areas of the building weekly x4 and then monthly x3 to ensure that chemicals are stored and labeled properly, and that window screens are in place and window cranks removed in memory care units.</p> <p>The Director of Nursing, or her designee, will audit 4 residents who use a standing lift weekly x4 and then monthly x3 to ensure that the lifts are used as intended, and that assessments are completed for those who choose not to, or are unable to, use all of the straps as they are intended. Results of the audits will be reported by the Director of Environmental Services and the Director of Nursing, or their designees, at monthly QAPI Committee meetings for a period of 3 months, with additional follow-up as recommended by the Committee.</p>		

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F 323	<p>Continued From page 21</p> <p>"Danger. Causes serious eye damage." If the disinfectant got into the eyes they were to have been rinsed for several minutes and "Immediately call a poison control center or doctor/physician."</p> <p>Interview with certified nursing assistant (CNA) U at that time revealed chemicals were not to have been left unsecured in resident areas.</p> <p>Interview on 11/19/15 at 9:00 a.m. with the director of nursing (DON) regarding the Miracle Gro and Virasept revealed her expectations were chemicals were to have been secured in resident areas.</p> <p>Surveyor: 32331 2. Observation on 11/16/15 at 2:00 p.m. underneath a handsink in an unlocked cabinet next to the coffee machine in the activity room (Main Street) revealed: *One Lysol No Rinse Sanitizer spray bottle approximately one-half full. *Caution warnings on the chemical's label stated it: -Was hazardous to humans and domestic pets. -Could cause eye damage. -Could cause skin burns. -Was harmful if swallowed. -Was to be kept out of the reach of children. *At the time of the observation the activity room had multiple residents in the area.</p> <p>Interview on 11/18/15 at 11:10 a.m. with activity coordinator C and on 11/18/15 at 3:20 p.m. with the director of environmental services regarding the above spray bottle in the unlocked cabinet in the above activity room revealed: *That room was available for use by all residents in the facility.</p>	F 323			

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F 323	<p>Continued From page 22</p> <p>*Both agreed the chemical should have been secured away from residents access. *Both agreed the chemical needed to have been in a secured area.</p> <p>Review of the provider's undated Chemical Storage policy revealed chemicals and other items labeled with "keep out of reach of children" would have been kept in a locked cabinet or area to minimize risk of accidental ingestion.</p> <p>Surveyor: 32332 B. Based on observation, record review, interview, and policy review, the provider failed to assess the safe use of a stand lift (mechanically equipment used to transfer the resident to a standing position) for one of four sampled residents (11) who used that lift. Findings include:</p> <p>1. Review of resident 11's medical record revealed: *She had a history of falls. *Her weight was over three hundred pounds. *She used an EZ Way stand (mechanical lift) to transfer between surfaces with extensive physical assistance from staff. *A 7/14/15 note from physical therapist (PT) F stated "Resident requests to restart EZ Lift for safety and ease following procedure."</p> <p>Observation on 11/17/15 at 8:15 a.m. of CNA P transferring resident 11 with an EZ Way stand lift off the toilet revealed: *CNA P placed her feet on the foot plate of the stand lift and applied the lift harness around the resident's back. She secured the harness to the lift. *CNA P began applying the shin strap around the resident's legs, but the strap was too short to</p>	F 323			

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F 323	<p>Continued From page 23</p> <p>reach around her legs.</p> <p>*The resident stated she did not use the shin strap, because it did not fit around her legs.</p> <p>*CNA P applied a gait belt around the resident's waist and pushed the lift button to lift the resident into a standing position.</p> <p>*The lift harness buckle sat loosely around the resident's chest area.</p> <p>*CNA P applied a brief (disposable underwear) to her bottom and secured it around her waist.</p> <p>*The resident wanted to be sure the harness would not be in the way of the brief application.</p> <p>*She transferred her into her chair.</p> <p>Interview at that time with CNA P revealed:</p> <p>*She rarely transferred resident 11, because she worked the night shift.</p> <p>*She was aware the shin belt did not fit around her legs.</p> <p>*Staff used a gait belt around her waist for safety if the resident had begun to fall.</p> <p>Interview on 11/18/15 at 7:00 a.m. with resident 11 regarding her use of the stand lift revealed:</p> <p>*None of the provider's stand lifts had a shin strap long enough to go around her legs.</p> <p>*The staff used a gait belt around her waist for safety.</p> <p>*She had to use a full mechanical lift (uses a sling to lift the resident from one place to another) in the past but did not want to use that.</p> <p>*The EZ Way allowed her to stand for transfers.</p> <p>Interview on 11/18/15 at 2:00 p.m. with LPN V regarding assessing resident 11 for safe transfers revealed:</p> <p>*She had not known if the resident had been assessed for safe transfers without the use of the shin strap.</p>	F 323			

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F 323	<p>Continued From page 24</p> <p>*She stated the resident was asked by staff members if she wanted to use the EZ Way without the shin strap. *The resident wanted to use it without the strap.</p> <p>Interview on 11/18/15 at 2:25 p.m. with CNA B regarding transferring resident 11 without a shin strap revealed: *She had not heard anything about how the staff should use the lift without a shin strap. *She would not have known who to ask about the safety of the sling without a strap. *She had not heard if PT had reviewed the EZ Way for safe transfers.</p> <p>Interview on 11/19/15 at 8:20 a.m. with PT F regarding assessing resident 11's use of the EZ Way lift revealed: *He had not assessed residents to ensure the lifts were safe for use. *The nursing staff on each unit assessed for safety of the lifts for each resident. *He had not known the shin strap had not been used for resident 11. *If he had known the shin strap had not fit he would have contacted the lift manufacturer to get a strap for the legs. *It was the provider's protocol the shin strap was used for all residents.</p> <p>Interview on 11/19/15 at 9:00 a.m. with the DON regarding resident 11 revealed: *She had been aware the resident's shin strap had not fit around her legs. *She had contacted the manufacturer for a longer strap, but the manufacturer did not make larger straps. *She had not documented her assessment of the EZ Way lift or the phone call to the manufacturer.</p>	F 323		

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F 323	<p>Continued From page 25</p> <p>*The provider had trained staff to use all straps on all of the lifts.</p> <p>*The staff had been instructed to use the gait belt around resident 11's waist for extra safety. It was to have been used if the resident had begun to fall.</p> <p>Review of the provider's March 2009 stand lift policy was the EZ Way Stand Operator's Instructions which revealed:</p> <p>**"As patients [residents] do vary in size, shape, weight and temperament, these conditions must be taken into consideration when deciding if the EZ Way stand is suitable for their needs."</p> <p>**"Please make sure the accessories used with each stand are appropriate for both the patient and the transferring situation and call EZ Way if you have any questions."</p> <p>**"Use of Shin Pad Strap: If a caregiver deems [determines] it necessary to keep a patient's shins or feet on the foot plate, secure the shin strap around the patient's legs."</p> <p>Surveyor: 29354</p> <p>C. Based on observation, interview, and record review, the provider failed to assess for the safety of one of three sampled residents (8), four of eleven rooms (272, 280, 288, and 290), and one of one activity area in one of three secured memory care units (MCU) (second south). Findings include:</p> <p>1. Observation and interview on 11/16/15 at 4:30 p.m. in resident 8's room revealed:</p> <p>*He had been walking with a front wheeled walker and had sat down on his bed.</p> <p>*He was unable to recall the correct date, place, or time.</p> <p>*Across the room by his roommate's bed was a</p>	F 323			

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F 323	<p>Continued From page 26</p> <p>window screen positioned against the wall. *The left side of the window did not have a screen. *The right side of the window had a screen and a window crank.</p> <p>Observation and interview on 11/16/15 at 4:50 p.m. with CNA H in resident 8's room revealed: *A screen had been placed against resident 8's roommate's wall. *There was not a screen on the left side of the window or a window crank. *On the right side of the window there was a screen. *There was a hand crank on the right side of the window. *The windows opened up to the outside. *The room was on the second floor. *The CNA confirmed the above.</p> <p>Review of resident 8's medical record revealed: *A 1/20/12 admission date. *Diagnosis of Alzheimer's disease (memory loss). *The quarterly 9/2/15 Minimum Data Set (MDS) assessment revealed: -He required limited assistance with ambulation. -A Brief Interview for Mental Status (BIMS) with a score of seven indicated moderate confusion (memory impairment). *He was a high fall risk. *The 11/12/15 care plan stated he was on a secured unit due to wandering and periods of confusion.</p> <p>Interview on 11/16/15 at 4:57 p.m. with LPN E revealed: *The staff were told not to open the windows. *She did not know why the screen was off resident 8's window.</p>	F 323			

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F 323	<p>Continued From page 27</p> <p>*Agreed the hand crank was on resident 8's side of the window.</p> <p>Interview on 11/16/15 at 5:32 p.m. with the DON regarding window hand cranks on the second floor MCU revealed:</p> <p>*Some of the windows had cranks and some did not.</p> <p>*She was not sure why they did or did not have window cranks.</p> <p>*The director of environmental services would know why some windows had window cranks and some did not.</p> <p>*Residents had been able to open windows.</p> <p>*The residents on the MCU had cognitive impairment.</p> <p>Observation on 11/16/15 at 5:45 p.m. of the second floor MCU revealed four resident rooms (272, 280, 288, and 290) had cranks on the windows and one activity room had a window crank.</p> <p>Interview on 11/16/15 at 5:50 p.m. with the DON revealed she did not have a policy for window cranks for the second floor MCU.</p> <p>Interview on 11/17/15 at 7:28 a.m. with the director of environmental services regarding resident 8's window, window screen, and other window cranks revealed:</p> <p>*The residents could have cranks on their windows.</p> <p>*If a resident was safe to open the window they could have a window crank.</p> <p>*The windows could be opened in the spring and in the fall.</p> <p>*He was not sure if they had a policy for window cranks for the MCU rooms.</p>	F 323			

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F 323	<p>Continued From page 28</p> <p>*He thought the residents might be assessed for safety, but that would have been a nursing issue.</p> <p>Interview on 11/17/15 at 9:20 a.m. with the DON regarding window cranks on the second floor MCU revealed: *She had spoken with the environmental services director. *They did not have a policy for window cranks on the three MCUs. *They had not done any assessments for residents who resided on the MCUs for safety to have window cranks. *She confirmed they should not have cranks on the windows on the MCUs.</p> <p>Interview on 11/19/15 at 8:15 a.m. with the director of environmental services regarding the MCU window cranks revealed: *They had always left the window cranks on the windows. *The screens on the first floor MCU were secured and needed tools to be removed. *The screens on the second and third floor MCUs were able to be removed.</p> <p>Surveyor: 32331 D. Based on observation, interview, and policy review, the provider failed to maintain proper labeling of a chemical in one of one kitchen janitorial closet in the main kitchen. Findings include:</p> <p>1. Observation on 11/16/15 at 1:35 p.m. and on 11/17/15 at 10:50 a.m. in the kitchen janitorial closet in the main kitchen revealed: *A five-gallon container located on a shelf. -The container was approximately one-eighth full with a clear liquid.</p>	F 323		

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F 323	Continued From page 29 -A spigot (a valve controlling the release of a liquid) was attached to the end of the container. *A handwritten label was attached to the above container with the words "Lysol Sanitizer" (kills germs). *The container had not been properly labeled with the contents and any warnings for its use. Interview on 11/18/15 at 9:45 a.m. with the director of environmental services and certified dietary manager D in the kitchen janitorial closet in the main kitchen regarding the above container revealed: *The five-gallon container contained Lysol No Rinse Sanitizer. *The container had been mixed with water and a gallon of concentrated sanitizer that had been ordered by housekeeping. *The sanitizer was always mixed by dietary staff into a five-gallon container. *Staff then used the spigot on the side of the container for dispensing into spray bottles for use in the kitchen. *Both agreed the container had needed more information on the label. *Both agreed the container should have been properly labeled with the contents and any warnings for its use. Review of the provider's undated Chemical Labels policy revealed all chemicals were to have been stored in containers with manufacturer's label.	F 323	containers. The Registered Dietitian revised the policy for storage and handling of clean equipment and utensils to include scoops used for the thickening product. The refrigerator in the Main Street area has been cleaned and will be added to the preventative maintenance schedule. All residents in the facility could potentially be affected by this deficiency. Dietary staff members were re-educated by the Registered Dietitian regarding the survey findings, as well as policy changes, on 12/8/15. The Director of Environmental Services re-educated all Environmental Services staff on 12/16/15 regarding cleaning of fans in the walk-in cooler, and cleaning of the Main Street refrigerator. The Registered Dietitian, or her designee, will perform audits regarding the storage and handling of clean equipment and utensils weekly x4 and then monthly x3 to ensure sanitary conditions. The Director of Environmental Services will perform audits of the walk-in cooler and Main Street refrigerator monthly x3 to ensure that these items are being cleaned properly. Results of the audits will be reported by the Registered Dietitian and Environmental Services Director, or their designees, at monthly QAPI Committee meetings for a period of 3 months, with additional follow-up as recommended by the Committee.		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371	New cabinets have been purchased for the main kitchen and will be installed by the completion date. Fans in the walk-in cooler have been cleaned. Scoops were removed from thickener containers and placed in separate	1/8/16	

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F 371	<p>Continued From page 30</p> <p>considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332</p> <p>Surveyor: 32331 Based on observation, interview, record review, and policy review, the provider failed to ensure sanitary conditions were maintained for: *Two of two fans in the main kitchen's walk-in refrigerator. *Eight of ten cupboard shelves in the main kitchen containing food, supplies, equipment, and dishes. *Thick & Easy (food and beverage thickener) powder scoops had been stored properly in five areas (main kitchen, third floor assisted dining room, second floor kitchen, third floor kitchen, and second floor lounge cupboard area). *One of one refrigerator in the activity area (Main Street). Findings include:</p> <p>1. Observation on 11/16/15 at 1:12 p.m. through 2:00 p.m. of the main kitchen and the activity area (Main Street) revealed: *Two of two Bohn fan covers in the walk-in refrigerator in the main kitchen contained a moderate build-up of brown, gray, and black spots on them.</p>	F 371	<p>containers. The Registered Dietitian revised the policy for storage and handling of clean equipment and utensils to include scoops used for the thickening product. The refrigerator in the Main Street area has been cleaned and will be added to the preventative maintenance schedule.</p> <p>All residents in the facility could potentially be affected by this deficiency.</p> <p>Dietary staff members were re-educated by the Registered Dietitian regarding the survey findings, as well as policy changes, on 12/8/15. The Director of Environmental Services re-educated all Environmental Services staff on 12/16/15 regarding cleaning of fans in the walk-in cooler, and cleaning of the Main Street refrigerator.</p> <p>The Registered Dietitian, or her designee, will perform audits regarding the storage and handling of clean equipment and utensils weekly x4 and then monthly x3 to ensure sanitary conditions. The Director of Environmental Services will perform audits of the walk-in cooler and Main Street refrigerator monthly x3 to ensure that these items are being cleaned properly. Results of the audits will be reported by the Registered Dietitian and Environmental Services Director, or their designees, at monthly QAPI Committee meetings for a period of 3 months, with additional follow-up as recommended by the Committee.</p>		

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F 371	<p>Continued From page 31</p> <ul style="list-style-type: none"> -Those fans were blowing over two carts containing food that were being stored there. *Eight of ten cupboard shelves located above food production areas in the main kitchen that contained food, supplies, equipment, and dishes had chipped, peeled, cracked, and unfinished areas on the shelves. -Each of those above shelves contained areas making them uncleanable surfaces. *One plastic container marked Thick & Easy with approximately three-fourth full was in the main kitchen. -In the above container there was one scoop with the handle covered by the thickening product. *One White/Westinghouse refrigerator in the activity area (Main Street) contained a large amount of tan, white, and brown crumbs in the freezer and refrigerator areas. -In the above refrigerator's freezer section there was approximately a two inch round, brown-colored frozen liquid. -That above frozen liquid was located on the bottom of the freezer. <p>2. Interview on 11/18/15 at 9:45 a.m. with the environmental services director and certified dietary manager (CDM) D in the main kitchen revealed:</p> <ul style="list-style-type: none"> *The environmental services director stated his department was responsible for cleaning the refrigeration unit fans. *The environmental services director stated he did not have the fans in the walk-in refrigerator on a cleaning schedule. *Both agreed fans in the walk-in refrigerator needed to have been cleaned. <p>Review of the provider's November 2015 Cleaning the Cooler and Freezer Condenser</p>	F 371			

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F 371	<p>Continued From page 32</p> <p>Fans policy revealed: *Cleaning of the fans was to have been done on a quarterly basis or more often if needed. *Maintenance was to have shut down and dismantled the fans. *Dietary was to have cleaned the fans and fan covers. *Maintenance was to have replaced the covers and restarted the fan units.</p> <p>3. Interview on 11/18/15 at 9:45 a.m. with the environmental services director and CDM D in the main kitchen revealed both agreed: *Eight cupboard shelves containing food, supplies, equipment, and dishes contained chipped, peeled, cracked, and unfinished areas on the shelves making them uncleanable surfaces.</p> <p>Review of the provider's revised November 2015 Storage and Handling of Clean Equipment and Utensils policy revealed cleaned equipment was to have been stored by staff to prevent contamination.</p> <p>Review of the provider's revised November 2015 Food Storage policy revealed food was to have been stored by methods designed to prevent contamination.</p> <p>4a. Observation on 11/16/15 at 5:15 p.m. with dietary assistant A in the third floor kitchen revealed: *One Thick & Easy container approximately one-half full located on a food preparation counter. -Two scoops were observed inside the container with the handles covered by the thickening product.</p>	F 371			

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F 371	<p>Continued From page 33</p> <p>*Dietary assistant A took one of the scoops out of the container and thickened a milk for an unknown resident. -After she thickened the milk she placed the scoop back into the container -The scoop handle was touching the product inside the container.</p> <p>b. Observation on 11/17/15 at 11:10 a.m. in the second floor kitchen revealed: *One Thick & Easy container approximately one-half full located on top of the microwave. -One scoop was found inside the container with the handle covered by the thickening product.</p> <p>c. Observation on 11/17/15 at 3:00 p.m. with nurse aide in training B on the third floor assisted dining room revealed: *One Thick & Easy container approximately one-half full located on top of a tabletop. -One scoop was found inside the container with the handle covered by the thickening product. *Nurse aide in training B took the scoop out of the container and thickened a water for an unknown resident. -After she thickened the water she placed the scoop back into the container and placed the container into a cupboard in the dining room. -The scoop handle was touching the product inside the container.</p> <p>Surveyor: 32332</p> <p>d. Observation on 11/18/15 at 8:30 a.m. in the second floor lounge cupboard revealed a container of Thick & Easy food thickening powder. The scoop used to measure out the thickener had been placed inside the container directly in the thickening powder.</p>	F 371			

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F 371	<p>Continued From page 34</p> <p>Surveyor: 32331</p> <p>e. Review of the provider's revised November 2015 Food Storage policy revealed: *Food was to have been stored by methods designed to prevent contamination. *Scoops were not to have been stored in food containers and were to have been kept covered in a protected area near the containers.</p> <p>5. Interview on 11/18/15 at 11:10 a.m. with activity coordinator C regarding cleaning of the refrigerator in the activity area (Main Street) revealed she: *Was unsure who was to have cleaned the refrigerator. *Had last cleaned it about two months ago. *Had no documentation regarding a cleaning schedule for it.</p> <p>Interview on 11/18/15 at 2:45 p.m. with the registered dietitian regarding the fans in the walk-in refrigerator, cupboard shelves in the main kitchen, scoops in the Thick & Easy containers, and the refrigerator in the activity area (Main Street) revealed she agreed all the above areas needed to have been kept clean and sanitary.</p> <p>Interview on 11/18/15 at 3:20 p.m. with the environmental services director regarding the refrigerator in the activity area (Main Street) revealed he: *Stated the refrigerator had not been on an assigned cleaning schedule. *Confirmed the refrigerator had not been cleaned.</p> <p>Review of the provider's revised November 2015 Food Storage policy revealed: *Food was to have been stored by methods designed to prevent contamination.</p>	F 371			

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F 371	Continued From page 35 *All refrigerator units were to have been kept clean at all times. Review of the provider's untitled and undated cleaning schedule for the refrigerators revealed no documentation for a cleaning schedule for the refrigerator located in the activity area on Main Street. Review of the provider's 12/11/14 Refrigerator policy revealed housekeeping was to have cleaned all other refrigerators not assigned.	F 371	<p>→ The SLP or designee will ensure ongoing reviews to ensure paid feeding staff are not working with residents with a complicated feeding program. JT/SDDO/H/E/L</p>		
F 373 SS=D	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.	F 373		Resident #5 has been removed from the list of residents approved to be assisted by paid feeding assistants. All residents who require assistance with eating could potentially be affected by this deficiency. The Director of Nursing and Speech Language Pathologist reviewed the policy for paid feeding assistants to ensure that residents are assessed routinely and removed from the approved list if they exhibit complicated feeding problems. The Speech Language Pathologist will audit the the approved list of residents who qualify to be fed by paid feeding assistants weekly x4 and monthly x3 to ensure that all residents on the approved list are still safe for help from paid feeding assistants. Results of the audits will be reported by the Speech Language Pathologist, or her designee, at monthly QAPI Committee meetings for a period of 3 months, with additional follow-up as recommended by the Committee.*	1/8/16

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F 373	<p>Continued From page 36</p> <p>The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care.</p> <p>NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160:</p> <ul style="list-style-type: none"> o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following: <ul style="list-style-type: none"> Feeding techniques. Assistance with feeding and hydration. Communication and interpersonal skills. Appropriate responses to resident behavior. Safety and emergency procedures, including the Heimlich maneuver. Infection control. Resident rights. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse. <p>A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, record review, interview, and policy review, the provider failed to ensure qualified staff were used to assist one of six</p>	F 373			

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F 373	<p>Continued From page 37</p> <p>sampled residents (5) who had difficulties with eating. Findings include:</p> <p>1. Observation on 11/17/15 at 7:25 a.m. of resident 5 in the second floor dining room revealed:</p> <ul style="list-style-type: none"> *She was sitting at a supervised eating table. *She used a straw to drink nectar-thickened liquids. *Feeding assistant W was assisting resident 5. -She was spooning oatmeal into the resident's mouth. -The resident exhibited quiet throat-clearing during that breakfast meal. <p>Review of resident 5's medical record revealed:</p> <ul style="list-style-type: none"> *She had a diagnosis of dysphagia (difficulty swallowing). *Her diet consisted of regular food with a fifteen-hundred cubic centimeter (cc) fluid-restriction. *Her fluids were nectar-thickened due to her swallowing problems. *A 8/26/15 speech language pathologist (SLP) evaluation completed by SLP X had indicated: -The resident had been evaluated by SLP X due to difficulty with swallowing. -Resident 5 had a history of coughing/choking incidents. -She had past episodes in the dining room with "weak prolonged coughing to the point of turning red." <p>Interview on 11/18/15 at 5:00 p.m. with registered nurse (RN) Y, who was in charge of training the paid feeding assistants revealed:</p> <ul style="list-style-type: none"> *Her role was to train the feeding assistants. *She gave an updated list of residents her assistants were feeding monthly to the SLP. 	F 373			

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F 373	<p>Continued From page 38</p> <p>*The SLP reviewed the list monthly to assess if the feeding assistants were qualified to feed those residents.</p> <p>*The SLP had approved a feeding assistant to assist with feeding resident 5.</p> <p>Interview on 11/18/15 at 5:20 p.m. and on 11/19/15 at 9:25 a.m. with SLP X regarding feeding assistant W assisting resident 5 with eating revealed:</p> <p>*She agreed the resident had swallowing problems but had wanted her to remain as independent as possible with eating.</p> <p>*She agreed a feeding assistant was not qualified to assist her with eating.</p> <p>Interview on 11/19/15 at 9:00 a.m. with the director of nursing regarding feeding assistants helping resident 5 revealed she agreed a feeding assistant was not qualified to feed her.</p> <p>Review of the provider's March 2015 Assisted Feeding Program Guidelines and Curriculum for Nurses, Aides, Feeding Assistants policy revealed:</p> <p>*Feeding assistants were not allowed to feed any residents who had complicated feeding problems such as:</p> <ul style="list-style-type: none"> -Difficulty swallowing. -High risk for choking related to chewing or swallowing. <p>*Certified nursing assistants would assist with feeding those residents with more complicated feeding problems.</p>	F 373			
F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an</p>	F 441	<p>No corrective action was needed with the findings for resident #5. All oxygen concentrator filters have been cleaned. All expired eye saline solutions have been replaced.*</p>	1/8/16	

→ Resident 5's catheter irrigation and care and her nebulizer equipment cleaning have been followed up on and corrected.
JT/SDDOHT/EL

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F 441	<p>Continued From page 39</p> <p>Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332</p>	F 441	<p>All residents and staff in the facility could potentially be affected by this deficiency.</p> <p>The Director of Nursing and Infection Control Nurse reviewed and revised the policies regarding the following areas: disinfecting shower stalls after showering a resident with Clostridium difficile; catheter irrigation; catheter care; nebulizer administration; cleaning of oxygen concentrator filters; and eye saline storage. These policies were reviewed to ensure that preventative measures are taken to prevent the transfer of organisms, nebulizer chambers are air dried between use, oxygen filters are kept clean, and eye saline solutions are replaced prior to expiration. All nursing staff were re-educated by the Director of Nursing regarding the above policies on December 16, 2015. The Director of Environmental Services will maintain a log of expiration dates of eye saline solutions at each eye washing station location, and replace solutions prior to expiration.</p> <p>The Infection Control Nurse, or her designee, will audit disinfection of the shower stalls after showering residents with C-diff if there are any active cases, catheter care/catheter irrigation for 4 residents, nebulizer administration for 4 residents, and 4 oxygen concentrator filters weekly x4 and then monthly x3 to ensure that barriers are used when indicated, gloves are changed appropriately, nebulizer chambers are allowed to air dry between use, and oxygen filters are kept clean. Results of the audits will be reported by The Director of Nursing, or her designee, at monthly QAPI Committee meetings for a period of 3 months, with follow-up as recommended by the Committee.</p>		

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F 441	<p>Continued From page 40</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure:</p> <ul style="list-style-type: none"> *A system was in place for the disinfecting of all shower stalls after showering a resident with clostridium difficile (C-diff) (a highly infectious organism). *Proper sanitation for: <ul style="list-style-type: none"> -One of one resident (5) receiving a catheter irrigation. -One of two residents (5) receiving urinary catheter care. -Cleaning and storage of nebulizer equipment (used for inhaling medication into the lungs) after resident 5's use for three of four observations. -Three of six randomly observed oxygen concentrator filters. -Maintaining eye saline solution for emergency eye flushes within the expiration date for one of three memory care units (Wrage). <p>Findings include:</p> <p>1. Observation and interview on 11/17/15 at 8:45 a.m. in the second floor tub room with certified nursing assistant (CNA)/bath aide O regarding how to bathe a resident with C-diff revealed:</p> <ul style="list-style-type: none"> *All residents with C-diff were showered in the tub room/shower stall. *They were given the last shower of the day. *After the CNA/bath aide completed the shower the housekeeper would clean the shower stall with Virasept disinfectant (kills germs). <p>Interview on 11/17/15 at 11:15 a.m. with housekeeper R on the second floor revealed when asked how she cleaned the shower stall after a resident with C-diff had showered she stated:</p> <ul style="list-style-type: none"> *Housekeepers did not clean shower stalls. *The bath aides were responsible for cleaning the 	F 441			

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F 441	<p>Continued From page 41</p> <p>shower stall after the resident had showered. *Housekeepers cleaned only the toilets, sinks, and floors of the tub rooms.</p> <p>Interview on 11/17/15 at 12:00 noon with CNA/bath aide Z in the third floor tub room regarding how to clean the shower after showering a resident with C-diff revealed: *She cleaned the shower stall walls using Virasept disinfectant. *The housekeeper came later to clean the sink, toilet, and floor.</p> <p>Interview on 11/18/15 at 8:45 a.m. with CNA/bath aide U in the Wrage memory care unit revealed when asked how to clean the shower stall after bathing a resident with C-diff revealed: *She used Virasept disinfectant to clean the stall. *The housekeeper cleaned the rest of the bathroom.</p> <p>Interview on 11/18/15 at 4:30 p.m. with the infection control nurse revealed her expectation was the housekeeper would clean the shower stall after the CNA/bath aide had completed showering a resident with C-diff.</p> <p>Interview on 11/19/15 at 9:00 a.m. with the director of nursing (DON) revealed: *Her expectation was the housekeeper would clean the shower stall after the CNA/bath aide had completed showering a resident with C-diff. *She was not aware the provider's C-diff policy had not established who was responsible for disinfecting of all shower stalls after showering a resident with C-diff.</p> <p>Review of the provider's 2010 Guidelines for Clostridium Difficile Associated Disease policy</p>	F 441		

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F 441	<p>Continued From page 42 revealed:</p> <ul style="list-style-type: none"> *The purpose was to provide guidelines for prevention and control of C-diff. *There was no instructions on bathing/showering a resident with C. diff. or who was responsible for cleaning the environment. <p>2. Observation on 11/17/15 at 9:00 a.m. of licensed practical nurse (LPN) M performing a Foley catheter (tube in the bladder to drain urine) irrigation with resident 5 revealed she:</p> <ul style="list-style-type: none"> *Opened the irrigation tray and disposed of the barrier included in the container. *Placed all irrigation equipment on the resident's bedside table without placing a barrier between the table and the equipment. *Performed the irrigation per physician's orders. *Placed two soiled towels on the floor with no barrier between the soiled towels and the floor. <p>Interview on 11/18/15 at 4:30 p.m. with the infection control nurse regarding catheter irrigations revealed her expectation was the nurse would have always placed a barrier:</p> <ul style="list-style-type: none"> *Between clean equipment and the resident's environment. *Between soiled linen and the floor. <p>3. Observation on 11/18/15 at 7:10 a.m. of CNA Q performing Foley catheter and perineal (private area) care for resident 5 revealed she:</p> <ul style="list-style-type: none"> *Cleansed her hands and applied gloves to prepare the needed equipment. *Removed those gloves, cleansed her hands again, and applied new gloves to clean around the catheter and groin areas. *With those same gloves on she: <ul style="list-style-type: none"> -Removed a pillow from the bed. -Adjusted the sheets and bed cover. 	F 441			

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F 441	<p>Continued From page 43</p> <p>-Prepared washcloths and cleansed the resident's buttocks.</p> <p>Interview on 11/18/15 at 4:30 p.m. with the infection control nurse revealed her expectation was the CNA would have removed soiled gloves before touching the resident's bed linen.</p> <p>Review of the provider's February 2009 Foley Catheter management policy revealed the policy had not included prevention of cross-contamination with soiled gloves.</p> <p>4. Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., Elsevier, St. Louis, Mo., 2013 revealed on page 410: *"Base efforts to minimize the onset and spread of infection on the principles of aseptic technique." *Medical asepsis included procedures for reducing the number of disease-producing organisms present. *Preventing the transfer of organisms using preventative measures included hand hygiene and barrier techniques.</p> <p>5. Observations of resident 5's nebulizer machine revealed: *On 11/16/15 at 1:45 p.m. the nebulizer chamber (used to hold liquid medication) was attached to the machine and contained liquid droplets. The chamber was also found attached to the machine and contained liquid droplets on: *11/17/15 at 9:15 a.m. *11/18/15 at 11:45 a.m. *11/19/15 at 7:35 a.m.</p> <p>Interview on 11/18/15 at 11:50 a.m. with LPN M revealed:</p>	F 441			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER JENKINS LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 44</p> <p>*The nebulizer chambers were cleaned daily by the night shift.</p> <p>*The outside of the chambers were wiped off if there was something on them, but the chambers were not rinsed or left open after use.</p> <p>Interview on 11/18/15 at 8:40 a.m. with registered nurse (RN) K revealed she rinsed nebulizer chambers after each use and left them to air dry.</p> <p>Interview on 11/18/15 at 4:30 p.m. with the infection control nurse revealed:</p> <p>*The night nurse cleaned the nebulizer chambers daily with vinegar.</p> <p>*The nebulizer chambers were disposed and replaced weekly.</p> <p>*She was unsure if the chambers should have been rinsed or opened to air dry.</p> <p>Review of the provider's June 2011 Nebulizer Sanitation policy revealed:</p> <p>*The resident would be protected by minimizing the potential for bacterial growth in the nebulizer set.</p> <p>*Nurses were to have soaked the nebulizer setup (chamber) in a vinegar solution every HS (bedtime) for twenty minutes.</p> <p>*The nebulizer set-up (chamber) was to have been replaced every Monday.</p> <p>Review of Apic Text of Infection Control and Epidemiology, 3rd Ed., Association for Professionals in Infection Control and Epidemiology, Inc., Washington, DC, 2009, page 63-3, revealed "Between treatments of the same patient [resident], small-volume nebulizers should be disinfected, rinsed with sterile water or pasteurized water, or air dried."</p>	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER JENKINS LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 45</p> <p>6. Observations from 11/16/15 through 11/19/15 revealed three randomly observed oxygen concentrators with brown dusty filters. Locations of the concentrators were: *One soiled concentrator filter located in the Wrage dining room. *Two soiled concentrator filters located in the third floor unit two.</p> <p>Interview on 11/18/15 at 4:30 p.m. with the infection control nurse revealed her expectation was the oxygen concentrator filters would have been cleaned regularly.</p> <p>Review of the provider's May 2014 Oxygen Concentrator policy revealed: *Outside air filters were to have been cleaned by using water as needed. *There was no set schedule for cleaning the filters. *The durable medical equipment supplier would monitor and maintain the equipment.</p> <p>7. Observation on 11/18/15 at 8:45 a.m. of the soiled utility room on the Wrage memory care unit revealed an emergency eye-wash station on the wall. The bottle of Eye-Lert Buffered eye flush was marked with a May 2014 expiration date.</p> <p>Interview on 11/19/15 at 9:00 a.m. with the DON revealed her expectation was the eye-flush equipment should have been maintained with fresh (not outdated) supplies.</p>	F 441			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2015
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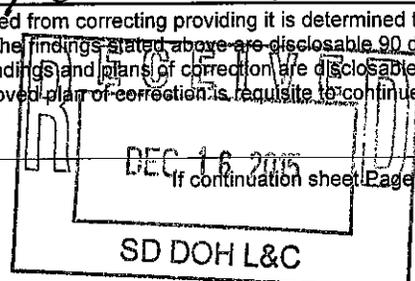
NAME OF PROVIDER OR SUPPLIER JENKINS LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 11/18/15. Jenkins Living Center (building 01) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 11/19/15 upon correction of the deficiencies identified below.</p> <p>Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
K 034 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4</p> <p>This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and record review, the provider failed to provide conforming exit stairs for one of three exit stairs (west stair) that did not have a landing. Findings include:</p> <p>1. Observation at 9:00 a.m. on 11/18/15 revealed the west stair connecting the first and second level was not provided with a landing at the</p>	K 034		"F"

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Joseph M. Kullback</i>	TITLE <i>Pres/CEO</i>	(X6) DATE <i>12-14-15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
NAME OF PROVIDER OR SUPPLIER JENKINS LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 034	Continued From page 1 second level. Record review of previous survey data confirmed the landing was not provided at the second level. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct the deficiency identified in K000.	K 034			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2015
NAME OF PROVIDER OR SUPPLIER JENKINS LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 11/18/15. Jenkins Living Center (Building 02) 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 11/19/15 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 034 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and record review, the provider failed to ensure conforming exit stairs for two of two stairs (east and west stairs) were not conforming. Findings include: 1. Observation at 10:00 a.m. on 11/18/15 revealed the door swinging into the second floor west stair enclosure reduced the landing to 21	K 034		F

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

John M. Bullock

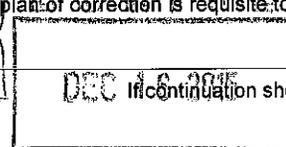
TITLE

Pres/CEO

(X6) DATE

12-14-15

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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NAME OF PROVIDER OR SUPPLIER JENKINS LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 034	Continued From page 1 inches. Observation at 10:30 a.m. on 11/18/15 also revealed the door swinging into the second floor east stair enclosure reduced the landing to 11 inches. Document review of previous survey data confirmed the condition. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct the deficiency identified in K000.	K 034			

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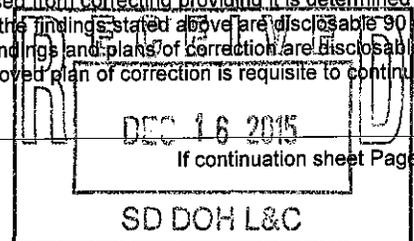
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 03 B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2015
NAME OF PROVIDER OR SUPPLIER JENKINS LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 11/18/15. Jenkins Living Center (Building 03) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Forch M. Duboma* TITLE: *Pres/CEO* (X6) DATE: *12-14-15*

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - BUILDING 04 B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
NAME OF PROVIDER OR SUPPLIER JENKINS LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 11/18/15. Jenkins Living Center (building 04) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *John M. Wilkman* TITLE: *Pres/CEO* (X6) DATE: *12-14-15*

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DEC 16 2015
If continuation sheet Page 1 of 1
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING 05 - BUILDING 05 B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2015
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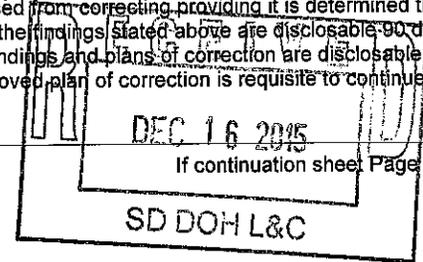
NAME OF PROVIDER OR SUPPLIER JENKINS LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code(LSC) (2000 new health care occupancy) was conducted on 11/18/15. Jenkins Living Center (building 05) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Josh M. Williams</i>	TITLE <i>Pres/CEO</i>	(X6) DATE <i>12-14-15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2015
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NAME OF PROVIDER OR SUPPLIER JENKIN'S LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 215 S MAPLE ST WATERTOWN, SD 57201
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement Surveyor: 32331 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, requirements for nursing facilities, was conducted from 11/16/15 through 11/19/15. Jenkins Living Center was found not in compliance with the following requirement: S236.	S 000		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;	S 236	No corrective action was required for certified nurse aide J as the TB testing had already been completed. All new employees could potentially be affected by this deficiency. The Infection Control Nurse reviewed and revised the policy for TB testing for all new employees to ensure that it includes the required 14-day timeframe from start to completion. The Infection Control Nurse, or her designee, will audit up to 4 new hires weekly x4 and then monthly x3 to ensure the two-step TB test is completed within 14 days of hire. Results of the audits will be reported by the Director of Nursing, or her designee, at monthly QAPI Committee meetings for a period of 3 months, with follow-up as recommended by the Committee.	1/8/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *John M. Williams* TITLE: *Pres/CEO* (X6) DATE: *12-14-15*

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2015
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NAME OF PROVIDER OR SUPPLIER JENKIN'S LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 215 S MAPLE ST WATERTOWN, SD 57201
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 236	<p>Continued From page 1</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 33488 Based on employee record review and policy review, the provider failed to ensure one of five sampled employees (J) had been given a two-step tuberculosis (TB) (highly contagious lung disease) screening test within fourteen days of being hired. Findings include:</p> <p>1. Review of the employee records for certified nurse aide J revealed: *She was hired on 3/24/15. *Her first TB test was administered on 3/25/15. *Her second TB test was not administered until 4/9/15, sixteen days after her date of hire.</p> <p>Interview on 11/18/15 at 2:40 p.m. with the director of nursing regarding employee J and her TB test revealed it was her expectation employees received their two-step TB test within fourteen days of employment.</p> <p>Review of the provider's January 2003, TB Testing Requirements for Employees policy revealed: *New employees must receive a two-step TB test. *No mention of the required fourteen day timeframe from start to completion.</p>	S 236		