

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

ORIGINAL

PRINTED: 08/23/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/11/2016
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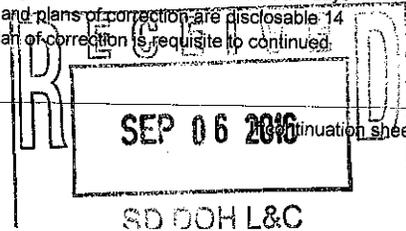
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MOBRIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 4TH AVENUE EAST POST OFFICE BOX 937 MOBRIDGE, SD 57601
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F 000	<p><i>*Addendums noted with an asterisk per 9/15/16 per telephone with facility administrator. JK/SDDOHHJEL</i></p> <p>INITIAL COMMENTS Surveyor: 32355 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/9/16 through 8/11/16. Golden LivingCenter-Mobridge was found not in compliance with the following requirement(s): F221, F240, F250, F281, F323, and F441.</p>	F 000	<p>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of an agreement with the facts and conclusions set forth in the survey report. Our Plan of Correction is prepared and executed as a means to continually improve the quality of and to comply with all the applicable state and federal requirements.</p>	
F 221 SS=E	<p>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/9/16 through 8/11/16. Areas surveyed included abuse, neglect, staffing, policies and procedures. Golden LivingCenter-Mobridge was found in compliance.</p> <p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, and interview, the provider failed to assess the use of recliners as a restraint for two of two randomly observed residents (2 and 28) residing in the advanced Alzheimer's care unit (AACU). Findings include:</p> <p>1. Observation on 8/9/16 at 8:35 a.m. and again at 11:20 a.m. revealed resident 2 was in her room sitting in a recliner with her legs up. It was an</p>	F 221	<p>F 221</p> <p>1) Resident #28 assessed for ability to use manual recliner on 8/31/2016. She is not able to lift the foot of the recliner but is able to put the foot of the recliner down and exit the recliner.</p> <p>Resident #2 assessed for ability to operate recliner on 8/31/2016. She is not able to operate the recliner. Restraint assessment completed and reviewed with family. Physician order obtained for restraint and care plan updated.</p> <p>2) All residents that utilize a recliner and are unable to operate the recliner controls have the potential to be affected. All residents with a recliner were assessed.</p>	<i>*9/30/16 JK/SDDOHHJEL</i>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Tiffany Schloemer</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>09.02.16</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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F 221	<p>Continued From page 1</p> <p>electric recliner with a controller.</p> <p>Observation and interview on 8/9/16 at 3:14 p.m. with licensed practical nurse (LPN) O revealed resident 2 was sitting in her recliner with her feet up. She was hollering out "Hey I want to get up." LPN O entered her room and told her it was not time to get up yet. She would have to wait until supper time. LPN O stated staff would have to remind resident 2 how to use the controller if she wanted to use it herself. Staff were the ones who controlled the recliner as the resident could not. She was unsure if they had assessed the recliner as a restraint and stated she would have to check the care plan.</p> <p>2. Observation on 8/8/16 at 8:45 a.m. and again at 5:30 p.m. revealed resident 28 had been in her recliner with her feet up. The chair had a manual lever on the side of the chair to put up the foot rest. She was yelling out "Hey."</p> <p>Observation on 8/11/16 at 9:30 a.m. of resident 28 revealed she was sitting in her recliner with her feet down and was trying to get up. Certified nursing assistant (CNA) P went into her room and asked her to stay sitting. CNA P then then pulled the lever and put her feet up in the recliner.</p> <p>3. Review of resident 2's and 28's medical record revealed the recliners had not been assessed for being a restraint.</p> <p>Interview on 8/11/16 at 10:45 a.m. with the director of the AACU revealed they had not assessed resident 2's or 28's recliners for being a restraint. She agreed those residents would not be able to use the controller or lever on their own.</p>	F 221	<p>F 221 (continued)</p> <p>3) Educate staff for resident #2 and #28 that a recliner can be considered a restraint and that a restraint assessment must be completed. Review guidelines titled "Physical Restraints Review Procedures" and "Restraint Evaluation and Utilization Guidelines". Directed in-service to educate all facility staff on restraint guidelines and that in certain situations a recliner can be considered a restraint. If considered a restraint, a restraint assessment must be completed. Staff unable to attend training will be educated prior to next scheduled shift.</p> <p>4) The Director of Nursing (DNS) or designee will audit at least 5 current residents with recliners to ensure appropriate designation use. Residents admitted after 8/31/2016 will be assessed upon admission, quarterly and PRN. Audits will be completed weekly x4 and monthly x2. DNS will submit a report of the QA monitoring to the QAPI committee at each monthly meeting with the committee recommendations followed.</p> <p> *JK/SDBH/EL</p>	

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<p>F 240</p> <p>F 240</p> <p>SS=D</p>	<p>Continued From page 2</p> <p>483.15 CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE</p> <p>A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335</p> <p>Surveyor: 36413 Based on observation, interview, and medical record review, the provider failed to ensure the basic needs had been met such as getting dressed and out of bed daily, for one of one sampled residents (14) who was dependent upon staff to meet all needs. Findings include:</p> <p>Surveyor 32335 1. Random observations on 8/9/16 and the morning of 8/10/16 of resident 14 revealed she was laying in her bed. She had not been put into her chair or taken out for activities. She had been wearing a hospital gown instead of clothes during those random observations.</p> <p>Surveyor 36413 Observation on 8/10/16 from 1:45 p.m. to 6:00 p.m. resident 14 remained in her bed wearing a hospital gown instead of clothes with the TV on at her bedside. Diagnosed with a ruptured brain aneurysm had left her unable to move and speech was very limited.</p> <p>Interview on 8/10/16 at 10:00 a.m. with licensed</p>	<p>F 240</p> <p>F 240</p> <p>F 240</p>	<p>F 240</p> <p>1) Resident #14 assessed multiple times by multiple nurses to determine tolerance to being out of bed and optimal schedule.</p> <p>2) Residents who are totally dependent for ADLs and have limited communication have the potential to be affected. Resident #14's activities reviewed with adjustments made.</p> <p>3) Educate staff for resident #14 that all residents including those residents with ADL dependence and/or limited communication must have care that maintains or enhances quality of life, including being out of bed and appropriate activities.</p> <p>Educate all staff that all residents including those residents dependent on staff for all cares and/or with limited communication must have care that maintains or enhances quality of life, and that these residents must be or attempted to be gotten out of bed.</p> <p>Educate all staff that residents with ADL dependence and/or limited communication must have appropriate activities available and offered which enhance or maintain quality of life.</p>	<p>*9/30/16</p> <p>JH/SDDOHT/EL</p>
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F 240	<p>Continued From page 3</p> <p>practical nurse (LPN) D revealed: *She rarely had seen the certified nursing assistants (CNA) get resident 14 up in the chair. *She did not know if they were supposed to get her in the chair or not.</p> <p>Interview on 8/10/16 at 10:20 a.m. with therapy staff H revealed his office was across the hall, and he rarely had seen resident 14 out of bed.</p> <p>Interview on 8/11/16 at 10:30 a.m. with housekeeper I revealed: *She very rarely had seen resident 14 out of her bed. *She knew she would get out of bed when she would deep clean the room. -Deep cleaning had been done on May 20, 2016 and July 12, 2016.</p> <p>Interview on 8/11/16 at 10:40 a.m. of activity staff person J revealed: *She provided activities in the AACU at 10:30 a.m. and 4:00 p.m. five days per week. *Resident 14 did not take part in those activities. *She did not provide activity for resident 14.</p> <p>Interview on 8/11/16 at 11:00 a.m. with the field service clinical director revealed: *All residents would have been expected to get out of bed at least once daily. *One-to-one activities would not have included watching TV or listening to the radio. *Taking a nap would not have been considered an activity.</p> <p>Review of resident 14's activity schedule revealed: *April 2016s calendar had eleven entries for the month.</p>	F 240	<p>F 240 (continued)</p> <p>4) DNS or designee will monitor that residents with ADL dependence and/or limited communication receive care that maintains or enhances quality of life, specifically that they are gotten up or attempts made to get them out of bed at least once daily. Such audits will be completed weekly x4 and monthly x2. The DNS will submit a report of the QA monitoring to the QAPI committee at each monthly meeting with committee recommendations followed.</p> <p>The Social Worker or designee will monitor that residents with extremely limited communication have activities available and offered that maintain or enhance quality of life. Such audits will be completed weekly x4 and monthly x2. Social Worker or designee will submit a report of the QA monitoring to the QAPI committee at each monthly meeting with committee recommendations followed.</p> <p> *JH/SDDOTHEL</p>	

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F 240	<p>Continued From page 4</p> <ul style="list-style-type: none"> -Six of those were categorized as sensory/relax/nap. -Two of those were when she was up in her chair. *July 2016s calendar included: -She was up in her chair nine times. -One-on-one activities included thirteen times when the TV or radio was turned on in her room. -Nine times were when a movie was turned on in her room. -Ten times were categorized as music therapy. -Nineteen times were categorized as sensory/relax/nap. -No other activities were marked on the July activity record. *August 2016s calendar to date had only included: -Sensory/relax ten times. -Music therapy once. -TV/radio seven times. <p>Review of the resident's current care plan revealed:</p> <ul style="list-style-type: none"> **"Please assist me out of the room setting for social stimulation of my living environment." **"Locomotion assistance to the day room or wherever else I may want or need to go." **"Staff will assist me to activities." <p>Review of the resident's complete medical record revealed the staff had documented eleven times that resident 14 had been out of bed in the last six months, on the resident recreation participation record.</p>	F 240		
F 250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest</p>	F 250	<p>1) Resident #15 had a new bed placed in his room 8/17/2016. He acknowledges during interview with Social Worker that he is satisfied with the bed.</p>	<p>*9/30/16 JH/SDOCHTEL</p>

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F 250	<p>Continued From page 5</p> <p>practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335</p> <p>Surveyor: 29162</p> <p>Based on record review, interview, and job description review, the provider failed to ensure social services followed through with a voiced concerned from one of one sampled resident (15) who attended the confidential group interview with the surveyors. Findings include:</p> <p>1. Confidential interview on 8/9/16 at 4:00 p.m. with a group of residents revealed resident 15 had asked his roommate to put on his call light for him when he needed help from the staff. He had issues with his bed tilting unexpectedly which caused him difficulty with breathing. The roommate had put on his call light for him four times this week for that issue.</p> <p>Interview on 8/10/16 at 5:30 p.m. with resident 15 revealed he:</p> <ul style="list-style-type: none"> *Sometimes had to ask his roommate to turn on the call light for him after he laid down. That had been because the head of his bed tilted downwards after he had laid in it for awhile. *Had to wait up to thirty minutes before he had received help after the head of his bed had tilted downward. *Did not like the current mattress on his bed. *Stated it felt like he was sliding out of bed and that he could not get his breath when this happened. 	F 250	<p>F 250 (continued)</p> <p>2) All residents have the potential to be affected. Grievance logs reviewed and no unresolved grievances noted.</p> <p>3) Educate all staff including Social Workers that resident concerns must be followed through on until concerns are resolved to the resident's or initiating party's satisfaction. Resolution and attempts at resolution must be documented.</p> <p>4) The Social Worker or designee will audit at least 5 residents regarding satisfaction weekly x4 and monthly x2. The Social Worker will submit a report of the QA monitoring to the QAPI committee with committee recommendations followed</p> <p><i>*JK/SDDOTT/EL</i></p>	

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F 250	<p>Continued From page 6</p> <p>*Stated he knew he was not falling out of bed, but it felt like the mattress or the bed springs were sliding downward.</p> <p>*When that happened he felt like he could not breathe.</p> <p>*Had talked with the social worker about three times about this. She had gotten him a different mattress to try before, but that had not worked.</p> <p>Interview on 8/11/16 at 10:45 a.m. with the social service coordinator revealed she:</p> <p>* Had gotten "at least three different mattresses" for the resident to try.</p> <p>*Stated "Maybe he just needs the head of his bed elevated."</p> <p>*Went to the person who could get a different mattress for him. That person might have been maintenance or staff development.</p> <p>*Had not been sure when the last new mattress had been provided to the resident.</p> <p>*Did not chart any of the conversations she had with resident 15.</p> <p>*Had not charted any of the mattress changes for the resident.</p> <p>*Stated the residents come in and visit with me freely. I do not always chart it.</p> <p>*Had not requested maintenance to look at the bed for mechanical concerns.</p> <p>*Stated she did not always go to nursing with the concerns of the residents.</p> <p>*Stated "I should probably go talk to the director of nursing and have a more team approach to this."</p> <p>Review of the provider's social service coordinator job description dated 8/30/11 revealed she was to:</p> <p>*Identify and provide for the resident's social, emotion, and psychological needs. That included</p>	F 250			

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F 281	<p>Continued From page 8 AMA form. Findings include:</p> <p>1. Review of resident 20's medical record revealed: *An admission date of 5/10/16. *Diagnoses of cerebral vascular accident, altered mental status, anxiety, Type II diabetic, and dementia with behavioral disturbances. *He had: -A history of behaviors towards staff and other residents. -A physician's order for Ativan and Trazadone to be given as needed (PRN) to help decrease his behaviors. -A history of falls due to poor safety awareness and impulsive behaviors. *On 6/7/16 the physician had ordered Seroquel 50 milligrams (mg) to be given twice a day (BID) for his continued inappropriate behaviors towards other residents and staff. -Those behaviors continued with further physician order changes to his medications made on 6/17/16. *On 6/17/16 the physician had: -Discontinued his PRN Ativan and Trazadone. -Increased his Seroquel to 50 mg three times a day (TID) and 150 mg at bedtime. *On 6/19/16 at 7:30 p.m. and on 6/20/16 at 3:28 a.m. he had fallen resulting in a major injury.</p> <p>Review of resident 20's nurses' progress notes revealed on: *6/17/16 at 8:40 p.m. he had received the above medication changes. -The provider had been in the process of transferring him to another facility. *6/19/16 at 2:41 a.m. a late entry had been made by licensed practical nurse LPN A for 6/17/16</p>	F 281	<p>F 281 (continued) Facility has had no contact with resident #19 since his departure AMA so the release form has not been completed. 2) All residents have the potential to be affected, including residents with allergies, residents receiving medications, residents who have sustained a head injury, residents experiencing an acute condition, residents experiencing change in condition including behavioral changes, residents discharging against medical advice (AMA) and residents newly admitted to the facility. 3) Educate LPN A of the necessity to assess and document behaviors, health status change, or other acute issues every shift; educate LPN A regarding the policy for neurological checks and the guideline titled "Falls Management"; educate LPN A of the necessity to document telephone orders in the resident's medical record. Educate staff for resident #7 to double check allergies prior to medication administration per policy titled "Administrative Procedures for all Medications". Educate medical records staff and all staff that enter orders to verify resident allergies prior to entering orders. Re-educate LPN D that medications must not be set up prior to administering them.</p>	

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F 281	<p>Continued From page 9 supporting a continuation of inappropriate behaviors.</p> <p>*6/19/17 at 7:30 p.m. "Heard alarm go off and went to get it and before I got there I heard a loud thud. Was laying flat on back on floor. History of falls. Did not respond to verbal stimuli at first and pupils were going from small to big at first. Became responsive to verbal stimuli shortly. VS [vital signs] attempted unable to obtain due to movement. Moving all extremities. Checked head for any bumps or bleedings. None Noted. Responds to some questions appropriately. Hospital notified. Ambulance notified. Ambulance notified. Ambulance here at 7:50 p.m. 8:00 p.m. left per stretcher per ambulance."</p> <p>*6/19/16 at 8:50 p.m. "Received phone call from [physician's name] and informed that he has a skull fracture with bleed. Also informed that he would be coming back to NH [nursing home]. Arrived at facility at 9:15 p.m. per stretcher. Order to hold insulin tonight. Instructed to give his hs meds. Oral hs meds given. Responds and answers appropriately at this time. Also received order from [physician's name] to hold aspirin." Family and administrator had been notified.</p> <p>*6/19/16 at 11:00 p.m. "Awakens easily cooperative with care at this time. VS obtained. Pupils sluggish. Moves all extremities. No complaints of pain. Call light within reach. He does not use it. Will continue to observe."</p> <p>*6/20/16 at 2:20 a.m. "VS taken. Is laying in bed at this time. Responds to verbal stimuli. Moving all extremities. Had been up in w/c [wheelchair] since 11:00 p.m. moving about facility. Is one on one care due to going in and out of rooms. Will cont [continue] to observe."</p> <p>*6/20/16 at 3:28 a.m. "[Name of certified nursing assistant] states that he had just wheeled past her in his wheelchair and went to end of hall and</p>	F 281	<p>281 (continued)</p> <p>Re-educate LPN E to complete the "Rights of Medication Administration" three times prior to giving residents medications.</p> <p>a) when the medication is selected b) when the dose is removed from the container, and c) after the dose is prepared and the medication is put away.</p> <p>Re-educate LPN E that medication administration must not be documented until medication is administered.</p> <p>LPN G is no longer working in the facility.</p> <p>Unidentified LPN working when resident #19 left AMA is no longer employed in the facility.</p> <p>Directed Inservice: Educate all nurses regarding the policy titled "Neurological Checks"; Educate all nurses that telephone orders must be documented in the medical record.</p> <p>Educate all nurses regarding the guideline titled "Clinical Health Status-Change of Condition".</p> <p>Educate all nurses, Certified Medical Assistants (CMAs) and medical records staff regarding the policy titled "Administration Procedures for All Medications" specifically regarding double checking allergies prior to order entry or medication administration.</p> <p>Educate all nurses and CMAs on guideline titled "Medication Administration - General Guidelines" emphasizing that</p>	

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F 281	<p>Continued From page 10</p> <p>stood up and out of w/c and feel back hitting head very hard. History of fall. No bleeding noted. Just is laying flat on back. Moves arms. Does not respond to verbal stimuli at first after a few minutes then responds. VS and blood sugar taken. Spoke with [physician's name] and will send to hospital for direct admit. Ambulance notified. Left per ambulance at 4:00 a.m.</p> <p>*6/23/16 at 2:35 p.m. the provider was informed the resident had passed away while under the care of the hospital.</p> <p>*No documentation to support:</p> <ul style="list-style-type: none"> -The professional nursing staff had assessed and monitored him on 6/18/16 after the physician had made changes to critical medications. -On 6/19/16 the day shift professional nursing staff had assessed or monitored him for behavioral and health changes. -On 6/19/16 neurological checks had been completed more than twice from 7:30 p.m. through 3:28 a.m. <p>Interview on 8/11/16 at 7:15 a.m. with LPN A regarding resident 20 revealed:</p> <ul style="list-style-type: none"> *She had been working the night shift on 6/19/16 and 6/20/16. *She had been aware of the medication changes made on 6/17/16. *She had agreed: -The physician had made significant medication changes for him on 6/17/16. -The staff should have assessed him and documented on any behavioral or health changes for each shift. *She had stated "[administrator's name] would have expected us to document on his behaviors and health issues. Its not typical not to have charting during the day shift." *A traveling nurse had been working in the facility 	F 281	<p>F 281 (continued)</p> <p>medications may not be set up prior to administration, completing the Rights of Medication Administration three times prior to giving the resident medication and that medication administration must be documented immediately after giving the medication.</p> <p>Educate all nurses on the procedure titled "AMA Release" specifically that when a resident discharges AMA the nurse must offer the resident to sign the form titled "Release of Responsibility for Discharge Against Medical Advice".</p> <p>Educate all nurses on the guideline titled "Clinical Health Status, Additional Assessments and Immediate Plan of Care" specifically that admission Clinical Health Status Assessments must be completed within 24 hours of admission and that an IPOC must be initiated that accurately reflects the residents current health status.</p> <p>4) The DNS or designee will audit documentation of at least 10% of residents affected with behavioral changes or other acute changes. Such audits will occur weekly x4 and monthly x2. DNS will submit a report of the QA monitoring to the QAPI committee at each monthly meeting with committee recommendations followed.</p> <p>The DNS or designee will audit documentation and the implementation of neurological checks. Such audits will occur weekly x4 and monthly x2. DNS will</p>		

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F 281	<p>Continued From page 11 for the day shifts of 6/18/16 and 6/19/16.</p> <p>*She had stated: -"The traveling nurse had never been in our facility before." -"The traveling nurse had been provided a check list to follow by our director of staff development." -"She had not received a formal orientation to the facility. This is normal for our traveling staff." -"The director of staff development had to finish her shift on 6/19/16 because she left. She was upset. She left because she had no orientation." *She confirmed: -The resident had fallen twice with a major injury occurring during her shift. -Neurological checks had not been completed on him frequently. She stated "Didn't need to do neuro checks on him per the PA [physician assistant]. Typical we do neuro checks with head injuries." *She had called the administrator and informed her of his first fall and orders to return to the facility.</p> <p>Interview on 8/11/16 at 8:15 a.m. with PA S revealed: *She had been working in the emergency department (ED) the night of 6/19/16. *She confirmed the resident had fallen and obtained a skull fracture with a subdural hematoma. *She and another physician had agreed it was acceptable to send the resident back to the facility. *She had stated: -"He was a code level II [no code] and they have skilled nursing care. They had the capability to monitor him." -"I informed the family his condition could worsen quickly and they requested him to be sent back to</p>	F 281	<p>F 281 (continued) submit a report of the QA monitoring to the QAPI committee at each monthly meeting with committee recommendations followed. The DNS or designee will monitor that telephone orders are placed in residents medical record. Such audits will occur weekly x4 and monthly x2. DNS will submit a report of the QA monitoring to the QAPI committee at each monthly meeting with committee recommendations followed. The DNS or designee will audit at least 5 residents with allergies to medications that they don't have medications ordered that they are allergic to. Such audits will occur weekly x4 and monthly x2. DNS will submit a report of the QA monitoring to the QAPI committee at each monthly meeting with committee recommendations followed. DNS or designee will audit at least 5 nurses and/or CMAs that they are not pre-setting up medications. Such audits will occur weekly x4 and monthly x2. The DNS will submit a report of the QA monitoring to the QAPI committee at each monthly meeting with committee recommendations followed. The DNS or designee will audit at least 5 nurses and/or CMAs that they are completing the Rights of Medication Administration. Such audits will occur weekly x4 and monthly x2. The DNS will submit a report of the QA monitoring to the QAPI committee at each monthly meeting</p>	

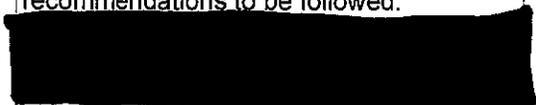
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F 281	<p>Continued From page 12</p> <p>the nursing home." -"I called the nurse with orders. They would not have received my progress note right away. I would not have said no neuro checks to be done. I had ordered neuro checks to be completed every three hours."</p> <p>Review of resident 20's 6/19/16 ED note revealed: *Impression and Plan: -"Altered mental status. -Epidural hematoma. -Skull fracture. -Anemia. -Pt. discharged to nursing home [NH]. Family preferred him to go back to the nursing home which is more familiar to him. We will have them hold his insulin tonight as he tends to drop very low and I would rather BS [blood sugar] be a little high than low over night. Will have them ASA until further notice. Neuro checks Q [every] 3 hours ordered. Family understands patient status may worsen quickly over the next 24 hours." *Call-consults: "[physician's name], consult, recommends patient going back to NH with neuro checks."</p> <p>Review of resident 20's physician's orders revealed no documentation to support LPN A had completed a telephone order on 6/19/16 after receiving the above verbal orders from PA S.</p> <p>Interview on 8/11/16 at 10:00 a.m. with the administrator and field services clinical director revealed: *The administrator had been aware: -Of the significant medication changes the physician had ordered for the resident on 6/17/16. -A traveling nurse had worked the day shifts for</p>	F 281	<p>F 281 (continued) with committee recommendations followed. DNS or designee will audit at least 5 nurses and/or CMAs that they are not signing that medication has been administered until actual medication administration has occurred. Such audits will occur weekly x4 and monthly x2. DNS will submit a report of QA monitoring to the QAPI committee at each monthly meeting with committee recommendations followed. DNS or designee will audit that admission clinical health status and an IPOC are completed within 24 hours of admission. DNS will submit a report of the QA monitoring to the QAPI committee at each monthly meeting with committee recommendations to be followed.</p> <p> *JK/SDDO/H/EL</p>	
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F 281	<p>Continued From page 13</p> <p>6/18/16 and 6/19/16 and had left early on the 19th.</p> <p>-Of the resident's falls with a major injury on 6/19/16 and 6/20/16.</p> <p>*They had:</p> <p>-Expected the nursing staff to have completed acute charting every shift.</p> <p>-Not been aware the nursing staff had not completed any acute charting on the resident regarding his recent medication changes.</p> <p>-Been aware the director of staff development had been responsible for the orientation of the traveling nurses.</p> <p>-Not known the process the director of staff development had in place for the traveling staffs orientation.</p> <p>*They had not been aware:</p> <p>-LPN A had not completed a telephone order for the verbal orders given to her by the PA on 6/19/16.</p> <p>-Neuro checks had not been completed as ordered by the physician and the facility protocol.</p> <p>*They would have expected LPN A to have completed:</p> <p>-A telephone order for the orders received on 6/19/16 by the PA.</p> <p>-Neuro checks as ordered and directed by the PA and facility protocol.</p> <p>*The field services clinical director had stated "Neuro's are an expectation of fall with head injury."</p> <p>*They had no policy or procedure in place for professional nursing staff to follow for documentation on a resident with:</p> <p>-Behavioral and mood changes.</p> <p>-Significant medication changes.</p> <p>Review of the provider's 3/24/15 Clinical Health Status-Change of condition Guideline policy</p>	F 281		
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F 281	<p>Continued From page 14 revealed:</p> <p>**The process for identification of change of condition includes gathering objective data and documenting assessment findings, resident/patient responsive, and physician and family notification."</p> <p>**Communication both written and verbal, are integral part of actions needed for change of condition."</p> <p>Review of the provider's Falls Management Guidelines policy revealed "Following a resident's fall: The licensed nurse assesses the resident for injuries (including neuro checks if indicated)."</p> <p>Review of the provider's 12/1/15 Neurological checks policy revealed:</p> <p>**"Neurological checks should be performed periodically for 72 hours."</p> <p>**"Frequency of neurological checks shall be determined by physician order or as resident condition or presentation warrants."</p> <p>**"Every 15-minute checks shall be initiated whenever there is a deterioration in neurological status until the physician can give further guidance and/or consider further diagnostic testing."</p> <p>**"Neurological checks shall be documented on the designated record and changes in neurological status and/or level of consciousness."</p> <p>Surveyor: 26632 2. Observation and interview on 8/10/16 at 3:30 p.m. with LPN D revealed:</p> <p>*Two plastic medication cups with medications in them.</p> <p>*Those medication cups were located in the top</p>	F 281		

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F 281	<p>Continued From page 15</p> <p>drawer of the south medication cart.</p> <p>*The first name and the last initial of the resident was on each cup.</p> <p>*The residents were 5 and 12.</p> <p>*LPN D stated she had set those medications up earlier and had placed them in the medication cart drawer.</p> <p>*She stated resident 12 had just those medications left for the day, and she would give them to him later.</p> <p>*Resident 5's medication was due at 4:00 p.m.</p> <p>*She was aware medications should not have been set-up prior to administration.</p> <p>Review of the provider's revised November 2011 Medication Administration - General Guidelines policy revealed "Medications are not pre-poured."</p> <p>3. Observation on 8/9/16 from 5:35 p.m. through 6:00 p.m. revealed LPN G:</p> <p>*Poured medications for resident 23.</p> <p>*Before she administered those medications she had documented in the electronic medication administration record (eMAR) those medications had already been administered.</p> <p>*She used the same process for resident 24.</p> <p>Observation and interview on 8/10/16 at 9:00 a.m. with LPN E:</p> <p>*Poured medications for resident 22.</p> <p>*Before she administered those medications she had documented in the electronic medication administration record (eMAR) those medications had already been administered.</p> <p>*LPN E stated she knew not to document before but had done it to make sure she gave all the medications.</p> <p>Review of the provider's revised November 2011</p>	F 281			

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F 281	<p>Continued From page 16</p> <p>Medication Administration - General Guidelines policy revealed "The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given."</p> <p>4. Observation on 8/10/16 at 9:00 a.m. of LPN E preparing medications for resident 22 revealed: *She stated she was going to pour potassium chloride (KCL) twenty miliequivalents per fifteen milliliters (ml). *She took a bottle out of the medication cart and poured fifteen ml into it. *LPN E handed the bottle to this surveyor and had gone on to prepare the next medication. *This surveyor looked at the bottles label and noted it to be acetaminophen. This surveyor stated "Oh this is acetaminophen." *LPN E then said "Oh it's supposed to be KCL," and then disposed of the acetaminophen dose and poured the correct dose of KCL. *She had been unaware of the error until this surveyor had noticed it.</p> <p>Review of the provider's revised November 2011 Medication Administration - General Guidelines policy revealed: *The five rights of medication administration included the right drug. *A triple check of the five rights was recommended at three steps in the process of preparation of medication for administration. -1. When the medication was selected. -2. When the dose is removed from the container. -3. Just after the dose was prepared and the medication was put away.</p> <p>5. Review of resident 6's admission clinical health status assessment revealed the following</p>	F 281		

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F 281	<p>Continued From page 17</p> <p>sections had not been fully completed:</p> <ul style="list-style-type: none"> *Section C "Activities of Daily Living." *Section D "Presence of Edema." *Section G "Sleep Patterns." *Section H "Nutritional Risk." *Section I "Risk for Dehydration." *Section J "Medications." *Section K "Risk for Elopement." *Section L "Devices and Restraints." <p>Review of resident 6's medical record revealed:</p> <ul style="list-style-type: none"> *She had been admitted on 7/26/16. *Her diagnoses included congestive heart failure, chronic obstructive pulmonary disease, chronic kidney disease, a pressure sore to her coccyx, she had both a urostomy and a colostomy, cachexia, weakness, ataxia, and dependence on tobacco products with withdrawal. *Her immediate plan of care (IPOC) had been initiated on 7/26/16. *The IPOC included problems for elopement, behaviors, and pressure ulcer risk. *The elopement and behavior risk IPOC stated "No issues @ this time." Only the behavior IPOC had been signed by the nurse. *IPOCs for fall risk, smoking withdrawal, urinary and bowel status, and dehydration/fluid maintenance risk had not been completed. <p>6. Review of resident 19's medical record revealed:</p> <ul style="list-style-type: none"> *He had been admitted on 12/24/15. *His diagnoses included hypertension, cirrhosis of the liver, and asthma. *The only IPOCs that had been signed by the nurse were the elopement risk and behavioral symptoms risk IPOCs. *They had both been noted as "No issues @ this time." 	F 281		

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F 281	<p>Continued From page 18</p> <p>7. Continued review of resident 19's medical record revealed: *He had eloped from the facility on 1/9/16. *His niece had been notified and stated she would come and take him home the next day. *A 1/10/16 progress note revealed: -His niece had come to take him home. -The on-call physician had been called for discharge orders. That physician had not given discharge orders and wanted the resident to wait until the next day when his primary physician could be notified. -The resident refused to wait, and he was discharged against medical advice (AMA). *No AMA release form had been completed and signed.</p> <p>Review of the provider's 1/11/16 AMA Release policy revealed: *Complete the "Leaving Hospital Against Medical Advice" release form. *Present form to resident or legal representative regardless of whether it was believed the resident or legal representative would sign. The release form should have been offered for signature in the presence of witnesses.</p> <p>Surveyor: 29162 7. Review of resident 7's medical record revealed acetaminophen had been listed as an allergy on the following: *Signed physician's orders of 8/3/16. *Quarterly interdisciplinary resident review. *Office clinic note that had been dated 4/26/16. *Care plan printed an 4/12/16. *July and August 2016 medication administration records.</p>	F 281		
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F 281	<p>Continued From page 19</p> <p>Resident 7 had been given acetaminophen on 8/4/16.</p> <p>Interview on 8/9/16 with the director of nurses revealed she agreed the resident should not have been given the acetaminophen. She stated resident 7 was alert and should know if she could not take acetaminophen.</p> <p>A policy for allergy documentation and verification had been requested. One had not been received by the end of the survey.</p> <p>8. Interview on 8/10/16 at 4:45 p.m. with the administrator and the field services clinical director revealed they agreed:</p> <ul style="list-style-type: none"> *Medications should not have been pre-set up and stored in the medication cart. *Documentation of medications administered should have been completed after the medications had been administered and taken by the resident. *LPN E should have followed the five rights of medication administration to prevent a possible medication error. *The admission clinical health status assessment was to have been fully completed. *The IPOC should have reflected the resident's status revealed in the admission clinical health status assessment. *The IPOCs for residents 6 and 19 were not reflective of their status when admitted. *An AMA form should have been completed for resident 19. *Professional nursing standards and policy and procedures had not been followed. *The IPOCs should have followed the Resident Assessment Instrument guidelines. <p>Surveyor: 29162</p>	F 281			

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F 323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on record review, interview, and policy review, the provider failed to ensure fall interventions had been investigated and reviewed for 5 of 11 sampled residents (2, 5, 8, 20, and 21) who had a history of falls. Findings include:</p> <p>1. Review of resident 8' 5/20/16, 6/12/16, 6/18/16, and 6/27/16 computerized post-fall analysis/plans revealed: *She was found on the floor at various times of the day. *No documentation to support: -The details of the fall. -The exact location of the fall, and the position the resident had been laying on the floor. -The responsible party for her had been notified of the fall for three out of the four incidents. -Recommendations and interventions post-fall for three out of the four incidents. -The re-enactment of the fall had occurred. *The falls had been referred to the interdisciplinary care team (IDT) for further review and recommendations. *There was no documentation to support the IDT had reviewed the incident to ensure no further</p>	F 323	<p>F 323 1) Resident #20 <i>*and 21 are JH/SDDOT/EL</i> no longer in the facility. Review of residents #2, 5, & 8 revealed they did not experience an adverse event <i>*9/30/16 JH/SDDOT/EL</i> related to the documentation of the fall event or investigation. 2) Any resident that experiences a fall has the potential to be affected. 3) Review "Falls Management Guideline" and policy titled "Verification of Investigation" process. Directed in-service to educate all nurses on "Falls Management Guideline" including that when a fall occurs documentation must be present to support the details of the fall, the exact location of the fall, the position the resident is laying in on the floor, notification of responsible party, recommendations and interventions post fall, occurrence of fall re-enactment, interviews with staff, referral of the fall to the interdisciplinary team (IDT) for further review and recommendations, the physical assessment of the resident after the fall, the last time the resident had been toileted or voided, what medications the resident had taken in the eight hours prior to the fall, and the residents activities during the three hours prior to the fall. Directed Inservice for IDT regarding documentation of IDT recommendations as well as the policy titled "Verification of Investigation" process.</p>

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F 323	<p>Continued From page 21</p> <p>action from the staff were required for two out of the four falls.</p> <p>2. Review of resident 20's 6/1/16, 6/6/16, 6/9/16, 6/14/16, 6/19/16, and 6/20/16 computerized post-fall analysis/plans revealed: *He was found on the floor at various times of the day. *No documentation to support: -The details of the fall. -The physical assessment after the fall had not been completed for two out of the six incidents. -The last time he had been toileted or voided for three out of the six incidents. -What he had taken for medications for four out of the six incidents. -The resident's activities during the three hours prior to the fall for three out of the six incidents. -Recommendations and interventions post-fall for four out of the six incidents. -The re-enactment of the fall had occurred for all six of the incidents. *The falls had been referred to the IDT for further review and recommendations. *There was no documentation to support the IDT had reviewed the incident to ensure no further action from the staff were required for four out of the six falls.</p> <p>Surveyor: 26632</p> <p>3. Review of resident 5's medical record revealed: *She had been found on the floor of her bathroom on 7/27/16 at 1:30 a.m. *A post-fall analysis/plan had been completed after the fall. *She had lost her balance while attempting to transfer to the toilet from her wheelchair.</p>	F 323	<p>F 323 (continued)</p> <p>4) DNS or designee will audit that falls documentation includes details of the fall, the exact location of the fall, the position the resident is laying in on the floor, notification of responsible party, recommendations and interventions post fall, occurrence of fall re-enactment, interviews with staff, referral of the fall to the IDT for further review and recommendations, the physical assessment after the fall, the last time the resident had been toileted or voided, what medications the resident had taken, the resident's activity during the three hours prior to the fall, referral of the fall to the IDT for further review and interventions. Such audits will occur weekly x4 and monthly x2. The DNS will submit a report of the QA monitoring to the QA committee at each monthly meeting with committee recommendations followed.</p> <p>The DNS or designee will audit that IDT documentation is present to prove the team reviewed the incident to ensure no further action was required from staff. Such audits will occur weekly x4 and monthly x2. DNS will submit a report of the QA monitoring to the QAPI committee at each monthly meeting with committee recommendations followed.</p>	<p>*3-5 falls JK/SDDO/H/EL</p> <p>*3-5 falls JK/SDDO/H/EL</p> <p>*JK/SDDO/H/EL</p>

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F 323	<p>Continued From page 22</p> <p>*She had a history of falls and impaired safety awareness.</p> <p>*She had a bruise noted on her upper back.</p> <p>*She had bare feet and was incontinent of urine.</p> <p>*No possible cause or contributing factors and observations or recommendations had been completed to prevent further falls.</p> <p>*Medications had not been reviewed.</p> <p>*The interdisciplinary team review and recommendations had been signed on 7/27/16 with "Cont. current intervention."</p> <p>*She was seen via eLTC on 8/1/16 for complaints of increase pain to her hip and spine.</p> <p>*She was then sent to the emergency department for x-rays.</p> <p>*She did not have any fractures but was prescribed a pain relieving patch.</p> <p>Review of her 1/31/13 care plan for falls revealed: **"Frequently gets up at night on her own even after educating on risks of falling and being injured."</p> <p>*Interventions included: -Encourage to wear gripper socks to bed. -Frequent visual checks. -Remind her to use the call light. -Remind her to use footwear when walking. -Staff to assist her to and from the bathroom. *A 7/26/16 handwritten note to "Continue current interventions."</p> <p>Review of her 1/31/13 care plan for her physical functioning deficit revealed she required extensive assistance with the use of the toilet.</p> <p>Review of the provider's investigative reports from October 2015 through 8/8/16 revealed no investigation related to her fall. There had been no new interventions added to prevent further</p>	F 323		
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F 323	<p>Continued From page 23 falls.</p> <p>Surveyor: 32335</p> <p>4. Review of resident 2's medical record revealed: *She had fallen on 7/12/16 at 5:20 a.m. and again at 9:15 p.m. -The fall at 9:15 p.m. had resulted in a neck fracture. *She had fallen on 7/13/16 at 6:55 a.m. with no injury. *The Post Fall Analysis/Plans had not been complete. It had not included the following: -Interviews with staff working during those shifts. -The re-enactment of the fall. -Details of the fall.</p> <p>5. Review of resident 21's medical record revealed: *He had fallen on 2/26/16 at 2:55 a.m. and on 4/1/16 at 10:17 p.m. *The Post Fall Analysis/Plans had not been complete. It had not included the following: -Interviews with staff working during those shifts. -The re-enactment of the fall. -Details of the fall.</p> <p>6. Interview on 8/10/16 at 4:00 p.m. with the administrator and the director of clinical education revealed: *They used the Post Fall Analysis/Plans as the initial investigation into the fall. *If there was an injury or "unusual" circumstance they would then complete the verification of investigation form. *The interdisciplinary team met each morning and discussed any falls that had occurred the day before.</p>	F 323		
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F 323	Continued From page 24 *They would interview staff that had been working during those shifts to determine if there had been any neglect or abuse. *They would review medications and care plans. *None of that information had been documented on the Post Fall Analysis/Plans or in the residents chart. *They had agreed the information regarding the investigation into the falls should have been documented. Review of the provider's 2/12/16 Verification of Investigation Process policy revealed: *In the event of an alleged violation involving bodily harm, mistreatment, neglect, abuse, injuries of unknown source, or misappropriation of property, the provider should have investigated the violation thoroughly. *Documentation should have reflected resident assessment, record reviews, and employee interviews that assisted in the conclusion of the investigation.	F 323			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	F 441 Resident #25 is no longer in the facility. Infection control logs have been reviewed and there is no evidence of infection for residents in the facility resulting from inadequate decontamination of glucose meters. Infection control logs have been reviewed and there is no evidence of residents being adversely affected by the medication cart top, side compartments, drawers & related supplies not being cleaned after each medication pass. Infection control logs have been reviewed and there is no evidence of residents being adversely affected by the frequency of cleansing of the foot area on the lifts, therapy room equipment or exercise equipment. All ice packs have been removed from food storage areas. All facility lifts including foot areas have been cleaned. Therapy room equipment and exercise equipment including foot areas have been cleaned. Wheelchair arms for residents # 5, 11, 29 & 30 have been replaced.	*9/30/16 JK/SDDO/H/EL	

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F 441	<p>Continued From page 25</p> <p>(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: 26632 Based on observation, interview, and policy review the provider failed to ensure: *One of three observed residents (25) dressing changes by one of two licensed nurses (F) had used proper infection control techniques. *Two of two observed licensed nurses (F and G) had sanitized the glucose meter between residents use. *Five of five medications carts had been kept in a clean condition. *Five of five medication crushers had been kept in a clean condition.</p>	F 441	<p>F 441 (continued)</p> <p>Review of medical records and physical assessment has been completed for residents #5, 11, 29 & 30. No evidence of adverse events related to wheelchair arms.</p> <p>2) All residents have the potential to be affected.</p> <p>An alternative method of ice pack storage has been implemented.</p> <p>Therapy room equipment and exercise equipment including the foot areas will be cleaned after each use.</p> <p>All wheelchair arms have been inspected. Additional wheelchair arms ordered.</p>	

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F 441	<p>Continued From page 26</p> <p>*Two of two secured care unit freezers had resident use ice packs separated from food products.</p> <p>*Five of five resident lifts had been kept in a clean condition.</p> <p>*One of one therapy room equipment and exercise equipment had been kept in a clean condition.</p> <p>*Four of four randomly observed residents' (5, 11, 29 and 30) wheelchair arms were in good repair to ensure a cleanable surface.</p> <p>Findings include:</p> <p>1. Observation on 8/9/16 from 1:55 p.m. through 2:10 p.m. of registered nurse (RN) F during resident 25's left foot and toe dressing change revealed:</p> <p>*She had placed packages of Xerofoam and gauze on the bedside table.</p> <p>*She also placed a pair of scissors on that table.</p> <p>*She washed her hands and then realized there were no gloves.</p> <p>*She left the room and returned with a box of gloves.</p> <p>*She put on gloves, moved the garbage can closer to the bed, and removed soiled dressings from the top of resident 25's left foot, bunion area, and second toe.</p> <p>*Removed her gloves and opened the package of Xerofoam.</p> <p>*She cut the Xerofoam with the scissors. One fourth of what she cut fell into the open top drawer of the bedside table.</p> <p>*She removed that piece, and then placed two paper towels on the pillow beside resident 25's left foot.</p> <p>*She placed the Xerofoam on that barrier.</p> <p>*She put on gloves without washing or sanitizing her hands.</p>	F 441	<p>F 441 (continued)</p> <p>3) Educate RN F on "Dressing Change, clean" policy.</p> <p>Educate RN F that glucometers must be sanitized prior to use, between each resident use, and after use per policy titled "Blood Glucose Monitor Decontamination".</p> <p>LPN G is no longer working in the facility.</p> <p>Educate all nurses and CMAs that tops of medication carts, side compartment, drawers and all related supplies such as medication crushers, must be kept clean per policy titled "Equipment and Supplies for Administering Medications".</p> <p>Educate all nurses regarding change in ice pack storage.</p> <p>Educate all staff that lifts must be cleaned between resident use, including the foot area of the lift per policy titled "Cleaning and Disinfection of Resident Care Items and Equipment".</p> <p>Educate therapy staff that therapy room equipment and exercise equipment, including the foot rest area must be cleaned after each use per policy titled "Cleaning and Disinfection of Resident Care Items and Equipment".</p>	

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F 441	<p>Continued From page 27</p> <p>*Without cleansing any of the wounds she placed the Xerofoam gauze on the wounds. *Removed her gloves and without washing or sanitizing her hands opened the package of gauze. *Put on gloves, cut the gauze with the scissors, and taped the gauze in place. *Put resident 25's left sock back on his foot. *Put the scissors in her pocket. *Washed her hands. *Went to the electronic treatment administration record screen on the computer and documented the dressing change. *She then placed the scissors in the top of drawer of the medication cart without sanitizing them.</p> <p>Interview on 8/10/16 at 9:30 a.m. with RN F confirmed the above findings. She had thought of placing a barrier for the dressing change supplies in the middle of the dressing change. She had not realized she should have sanitized her hands between glove changes. She had not realized she had not sanitized the scissors after she had used them.</p> <p>Review of the provider's 2/4/16 Dressing Change, Clean policy revealed: *Place a plastic bag near the foot of bed to receive soiled dressing. *Create a clean field with paper towels or other clean barrier. *Open dressing packages. *Perform hand hygiene. *Put on gloves. *Remove soiled dressing and dispose of in plastic bag. *Remove gloves and perform hand hygiene. *Put on gloves. *Cleanse wound with prescribed solution.</p>	F 441	<p>F 441 (continued)</p> <p>Educate staff for residents #5, 11, 29 & 30 that wheelchairs must be in good repair so as to maintain a safe, cleanable surface.</p> <p>Directed Inservice to: Educate all nurses on policy titled "Dressing Change, Clean". Educate all nurses and CMAs on policy titled "Blood Glucose Monitoring Decontamination". Educate all staff regarding ice pack storage process. Educate all nurses and CMAs on the policy titled "Equipment and Supplies for Administering Medications", including keeping medication carts, side compartments, drawers and related medication administration supplies clean. Educate all staff, including therapy staff on the policy titled "Cleaning and Disinfection of Resident Care Items and Equipment", specifically that lifts including the foot area must be cleaned between resident use and that therapy room equipment and exercise equipment, including the foot area must be cleaned between resident use. Educate all staff that wheelchairs including arms must be kept in good repair so as to maintain a safe cleanable surface. When wheelchairs are in disrepair maintenance must be notified so necessary repair can be completed.</p>	

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F 441	<p>Continued From page 28</p> <p>*Apply dressings and secure with tape. *Remove gloves, discard all unused supplies, and perform hand hygiene.</p> <p>2a. Observation on 8/9/16 at 11:30 a.m. of RN F during a blood glucose test revealed: *She placed gloves in her pocket. *Went into resident 8's room and placed the glucose meter on the bedside table. *Took the gloves from her pocket and put them on after she had washed her hands. *After she completed the blood glucose test she removed her gloves and left the room. *She then placed the glucose meter on the top of the medication cart while she retrieved a bleach wipe. *She wiped the glucose meter with the bleach wipe and placed it in a basket with the unused lancets, unopened alcohol wipes, and a bottle of test strips. *She did not sanitize the top of the medication cart.</p> <p>b. Observation on 8/9/16 at 4:55 p.m. of licensed practical nurse (LPN) G during a blood glucose test revealed: *She was in the hall and had brought the glucose meter out of resident 27's room. *She placed the glucometer in a basket with the unused lancets, unopened alcohol wipes, and a bottle of test strips. *She had not sanitized the glucose meter. *She moved the medication cart in front of resident 26's room. *Without washing or sanitizing her hands she put on gloves. *Placed the glucose meter on the top of the medication cart. *After she had completed the blood glucose test</p>	F 441	<p>F 441 (continued)</p> <p>4) DNS or designee will observe dressing changes. Such audits will occur weekly x4 and monthly x2. DNS will submit a report of the QA monitoring to the QAPI committee at each monthly meeting with committee recommendations followed.</p> <p>DNS or designee will monitor at least 5 nurses and/or CMAs that glucometers are being decontaminated prior to use, between each resident and after use. Such audits will be conducted weekly x4 and monthly x2. DNS will submit a report of the QA monitoring to the QAPI committee at each monthly meeting with committee recommendations followed.</p> <p>The DNS or designee will audit medication carts for cleanliness of the carts, including the top of the cart, side compartments, drawers and supplies such as pill crushers and will audit at least 5 nurses and/or CMAs that carts are being cleaned after each medication pass. Such audits will occur weekly x4 and monthly x2. DNS will submit a report of the QA monitoring to the QAPI committee at each monthly meeting with committee recommendations followed.</p>	<p>* 3-5 JN/SDOCH/EL * for twice with different nurses. 8/14/SDOCH/EL</p>	

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

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MOBRIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 4TH AVENUE EAST POST OFFICE BOX 937 MOBRIDGE, SD 57601		
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F 441	<p>Continued From page 29</p> <p>for resident 26 she placed the glucose meter back in the basket without sanitizing it. *She then removed her gloves and did not sanitize her hands.</p> <p>c. Review of the provider's 5/5/16 Blood Glucose Monitor Decontamination policy revealed: *After performing glucose testing the nurse, while wearing gloves, would use a disposable wipe to clean all external parts of the monitor. *Leave monitor damp for maximal kill time indicated on the product label. *Place clean monitor on a clean surface. *Remove gloves and perform hand hygiene.</p> <p>3. Observation on 8/10/16 from 3:45 p.m. through 4:30 p.m. of all five of the medication carts (south, north 1 and 2, AACU, I and ACU) revealed: *All five medication carts side compartments that held spoons, medication cups, gloves, and other supplies had moderate to heavy amounts of debris. *The north 2 cart had a large amount of red sticky residue in the bottom drawer. *The medication crushers on all five medication carts had medication debris and a black substance present.</p> <p>Review of the provider's revised November 2011 Equipment and Supplies for Administering Medications policy revealed: *Equipment and supplies were acquired and maintained by the provider for the proper storage, preparation, and administration of medications. That equipment included: -Medication carts and devices for crushing and splitting tablets. *The charge nurse on duty would ensure that equipment and supplies related to medication</p>	F 441	<p>F 441 continued</p> <p>DNS or designee will monitor that ice packs for resident use are kept separate from food products. Such audits will occur weekly x4 and monthly x2. DNS will submit a report of the QA monitoring to the QAPI committee at each monthly meeting with committee recommendations followed.</p> <p>DNS or designee will audit that lifts including the foot areas are cleaned between resident use. Such audits will occur weekly x4 and monthly x2. DNS will submit a report of the QA monitoring to the QAPI committee at each monthly meeting with committee recommendations followed.</p> <p>Physical Therapist or designee will audit that therapy room equipment and exercise equipment including the foot area is cleaned between each resident use. Such audits will occur weekly x4 and monthly x2. Physical Therapist or designee will submit a report of the QA monitoring to the QAPI committee at each monthly meeting with committee recommendations followed.</p>		

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F 441	<p>Continued From page 30 administration were clean and orderly.</p> <p>4. Interview on 8/10/16 at 4:45 p.m. with the administrator and field services clinical director confirmed: *Proper infection control practices had not been followed with the dressing change and the glucose testing. *The medication carts and medication crushers were in need of cleaning.</p> <p>Surveyor: 36413</p> <p>5. Observation of two lifts on 8/9/16 at 8:40 a.m. in the north hallway were dirty and had loose particles around the outside edges of the of the foot rests.</p> <p>Observation on 8/10/16 at 9:30 a.m. in the AACU hallway revealed the foot rest on the SARA lift was visible dirty with loose particles around the outside edges.</p> <p>Observation on 8/10/16 at 9:45 in the south hallway revealed the two lifts were visibly dirty and loose particles around the outside edge of footrest.</p> <p>Interview on 8/10/16 at 9:35 a.m. with staff P revealed: *Staff usually wiped off the lift after each resident use where their body touches the lift but do not wipe off the foot rests. *She agreed the foot rests were soiled.</p> <p>Interview on 8/11/16 at 11:00 am with the field services clinical director revealed she would have expected the nursing staff to clean the lifts between between each resident including the feet</p>	F 441	<p>F 441 (continued) DNS or designee will audit at least 5 wheelchairs that wheelchairs arms are in good repair so as to maintain a safe, cleanable surface. Such audits will occur weekly x4 and monthly x2. DNS will submit a report of the QA monitoring to the QAPI committee at each monthly meeting with committee recommendations followed.</p> <p> *JH/SDDOH/EL</p>		

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F 441	<p>Continued From page 31 rests.</p> <p>6. Observation on 8/9/16 at 10:10 a.m. revealed the therapy/exercise equipment with foot rests were visibly soiled and had debris around the outer edges.</p> <p>Interview on 8/10/16 at 9:00 a.m. with therapist R revealed therapy staff would wipe off the equipment in the exercise area between residents. But they never wiped down the foot rests or deep cleaned the equipment.</p> <p>Interview on 8/11/16 at 11:00 am with the field services clinical director revealed therapy would have been expected to clean their own equipment.</p> <p>Interview on 8/11/16 at 1:00 p.m. with the housekeeping supervisor revealed: *Housekeeping staff were not responsible to clean the lifts or exercise equipment. *When the above mentioned were noticeably dirty they might wipe off or dust. *There had not been any scheduled cleaning of the above mentioned equipment.</p> <p>Review of the provider's undated Cleaning and Disinfection of Resident Care Items and Equipment policy revealed durable medical equipment must be cleaned and disinfected before reuse by another resident.</p> <p>A policy for cleaning of therapy equipment had been requested from this surveyor. One had not yet been received by the end of survey.</p> <p>7. Observation on 8/9/16 during the initial tour observing all wings of residents' rooms revealed</p>	F 441			

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F 441	<p>Continued From page 32</p> <p>four resident's wheelchairs (5, 11, 29, and 30) were cracked and needing repair.</p> <p>Interview on 8/10/16 at 9:00 a.m. with therapy assistant R revealed they notified maintenance about cracked wheelchair arms that were in need of repair.</p> <p>Interview on 8/10/16 at 9:30 with the maintenance supervisor revealed: *They tried to keep up with repairs as time and funding allowed. *There was no documentation to keep track of repairs.</p> <p>A policy for maintenance the therapy equipment had been requested from this surveyor. One had not yet been received by the end of survey.</p> <p>Surveyor: 29162</p> <p>8. Observation on 8/11/16 at 10:30 a.m. of the Alzheimer's Care Unit refrigerator revealed two ice packs in the freezer door and two ice packs inside the freezer. There had been packages of food in the freezer.</p> <p>Interview with LPN C at that same time revealed there had been one resident using the ice packs at this time. She stated she did not have a process for cleaning or storage of the ice packs.</p> <p>Observation on 8/11/16 at 11:00 a.m. of the Advanced Alzheimer's Care Unit refrigerator revealed four ice packs in the freezer. Those ice packs were laying among the food products in the freezer. Interview with LPN D at that same time revealed she stated none on the unit had an ice pack. She stated the ice packs in the freezer</p>	F 441		
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F 441	Continued From page 33 were the ones she would use if she needed one. Review of the provider's Ice Pack policy with effective date of 5/3/16 revealed no mention of storage of ice pack or cleaning of them.	F 441		
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K 000	<p><i>*Addendums noted per 9/15/16 per telephone with facility administrator. LF/SDDOH/EL</i></p> <p>INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/9/16. Golden LivingCenter-Mobridge was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K038 and K147 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	Preparation, submission, and implementation of this plan of correction does not constitute an admission of an agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continually improve the quality of and to comply with all the applicable state and federal regulatory requirements.	K000 09/30/16
K 038 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation, testing, and interview, the provider failed to ensure all means of egress were readily accessible at all times at two of two exit egress doors from the Advanced Alzheimer's Care Unit (ACU) gated area. Findings include:</p> <p>1. Observation at 2:15 p.m. on 8/9/16 in the AACU revealed a fenced outside use area. The fence area was provided with two gates to allow egress away from that fenced area. The gates were provided with a magnetic lock that deactivates per input of a code from an adjacent keypad. The special locking arrangement was permitted in a secured unit area. Testing of those gates revealed the administrator was unaware of the proper code to unlock these gates. When</p>	K 038	<p>K 038</p> <p>1) The bad circuit in the keypad was repaired on 08/12/16. 2) All residents in the AACU had the potential to be affected by this deficient practice. 3) Education to all staff on the proper functioning of the doors and the code for the door will be provided by maintenance on 09/06/16. 4) Maintenance or designee will conduct audits daily for 2 weeks, then weekly for 4 weeks, then monthly. Results of these audits will be reported to the monthly QAPI meetings by maintenance or designee for further review and recommendations.</p> <p><i>*OS preventative maintenance. LF/SDDOH/EL</i></p>	K038 09/30/16

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

Tiffany Schloemer

TITLE

Executive Director

(X6) DATE

09.02.16

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.

SEP 06 2016

SD SOH LSC

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K 038	Continued From page 1 staff within the AACU asked what the code was it was revealed other staff were also unfamiliar with the code to unlock these gates. All staff throughout the facility shall be knowledgeable on how to unlock these gates. One of four staff members in the AACU at the time of observation knew the code. 2. Testing the keypad after the code was found in the above observation revealed one of the two gates were still not unlocking. Interview with the maintenance supervisor at the time of the above testing revealed a bad circuit in the keypad was causing the keypad to not function properly. The administrator and maintenance supervisor confirmed that condition. They were aware those doors should unlock upon entering of the code, and they were aware all staff should be knowledgeable of the code. This deficiency has the potential to affect one of seven smoke compartments.	K 038		
K 147 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure electrical equipment was maintained in multiple residents' rooms throughout the facility. Residents were allowed to use the lighting fixtures as shelves for personal items. Findings include: 1. Observation at 12:30 p.m. on 8/9/16 revealed a	K 147	K 147 1) All rooms have been checked and items removed from on top of the light fixtures above the beds. 2) All residents have the potential to be affected by this deficient practice. 3) All staff will be educated by the DNS, DCE or designee on NOT placing any items on tops of any over-the-bed light fixtures on 09/06/16.	K147 09/30/16

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K 147	Continued From page 2 resident room in the north wing. The lighting fixture over the resident's bed was being used as a shelf to hold personal items. Those lighting fixtures were provided with a bottom and top light and were not intended to be used as a shelf for storage of any items. Further observation throughout the building revealed that same condition in multiple residents' rooms. Interview with the administrator at the time of the above observation confirmed that condition. She was unaware of the potential hazard that created. Interview with the maintenance supervisor at the exit interview confirmed that condition. He indicated he believed those fixtures were okay to be used as shelves. This deficiency has the potential to affect five of seven smoke compartments.	K 147	4) Audits will be conducted by ED, maintenance, or designee of resident rooms to ensure that no items are on top of lights above the bed. Said audits will be conducted weekly for 4 weeks, then bi-weekly for 4 weeks, then monthly. Results of these audits will be reported to the monthly QAPI meetings by maintenance or designee for further review and recommendations.	

**AS
preventative
maintenance
LF/SDDOT/TEL*

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10656	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/11/2016
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S 000 Compliance/Noncompliance Statement

Surveyor: 32334
A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, requirements for nursing facilities, was conducted from 8/9/16 through 8/11/16. Golden LivingCenter - Mobridge was found not in compliance with the following requirement: S169, S210, S236, and S253.

S 000

Preparation, submission, and implementation of this plan of correction does not constitute an admission of an agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continually improve the quality of and to comply with all the applicable state and federal regulatory requirements.

*LF/SDDO/H/EL

S 169 44:73:02:18(5-7) Occupant Protection

The facility shall take at least the following precautions:
(5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters shall be provided in wet areas and for outlets within six feet of sinks;
(6) Install an electrically activated audible alarm on all unattended exit doors. Any other exterior doors shall be locked or alarmed. The alarm shall be audible at a designated staff station and may not automatically silence when the door is closed;
(7) A portable space heater and portable halogen lamp, household-type electric blanket or household-type heating pad may not be used in a facility;

S 169

S169
1) Signs posted on both front exit and service hall exit were removed on 08/09/16
2) All residents had the potential to be affected.
3) Education was conducted at all-staff inservice on 08/25/16 and will again be conducted on 09/06/16 by ED. *LF/SDDO/H/EL

S169
09/30/16

This Administrative Rule of South Dakota is not met as evidenced by:
Surveyor: 32334
Based on observation and interview, the provider failed to ensure all unattended exit doors to the exterior were locked, monitored, or alarmed at 1 of 13 exit doors (main entrance). Findings include:

*Addendums noted with an asterisk per 9/15/16 per telephone with facility administrator. LF/SDDO/H/EL

*Front and Rear exit doors will be audited weekly for 4 weeks then monthly as preventative maintenance to check for re-posting of exit instructions. If found posted instructions will be removed. ED or designee will bring report to monthly QAPI meeting for further review and recommendations.

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

Jessy Schloman

TITLE

Executive Director

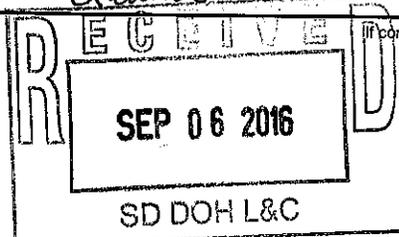
(X6) DATE

09.02.16

STATE FORM

6899

YNDT11



If continuation sheet 1 of 8

South Dakota Department of Health

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S 169	<p>Continued From page 1</p> <p>1. Observation at 10:00 a.m. on 8/9/16 revealed the main entrance was provided with an alarm. The policy was to have that alarm active at all times. That alarm was capable of being deactivated upon pressing a green button adjacent to the door. A note was posted on the door indicating press the green button to deactivate the alarm prior to exiting. That door cannot be considered alarmed when instructions to deactivate the alarm were posted at the door.</p> <p>Interview with the administrator at the time of the above observation revealed she was unaware the instructions to deactivate the alarm could not be posted at the door. Interview with the maintenance supervisor during the exit interview confirmed that condition. He believed that was an acceptable solution to alarm that door.</p>	S 169		
S 210	<p>44:73:04:06 Employee Health Program</p> <p>The facility shall have an employee health program for the protection of the residents. All personnel shall be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Any personnel absent from duty because of a reportable communicable disease which may endanger the health of residents and fellow employees may not return to duty until they are determined by a physician or physician's designee, physician assistant, nurse practitioner, or clinical nurse</p>	S 210	<p>S210</p> <p>1) Employee health documentation will be completed for employees K, L, & M. Employee N is no longer employed with us.</p> <p>2) All residents had the potential to be affected.</p> <p>3) Education completed on 09/01/16 by ED with DCE and staff development regarding proper procedures for timely processing and documentation of new hire employee health requirements.</p> <p>4) ED or designee will conduct audit of all employee files for proper employee health documentation. Biweekly audits will be conducted on all new hire employee files for 3 months.</p> <p>Results of these audits will be reported to the monthly QAPI meetings by ED or designee for further review and recommendations.</p>	S210 09/30/16

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GOLDEN LIVINGCENTER - MOBRIDGE

**1100 4TH AVENUE E POST OFFICE BOX 937
MOBRIDGE, SD 57601**

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S 210	<p>Continued From page 2</p> <p>specialist to no longer have the disease in a communicable stage.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 23059 Based on record review and interview, the provider failed to ensure four of five sampled employees (K, L, M, and N) had a health evaluation completed within fourteen days of being hired. Findings include:</p> <p>1. Review of the following employees' personnel records revealed: *Employee K had been hired on 2/8/16. *Employee L had been hired on 2/4/16. *Employee M had been hired on 4/12/16. *Employee N had been hired on 5/3/16. *There was no documentation in the above employees' personnel files a health evaluation for free of communicable disease had been reviewed and signed by a health care professional.</p> <p>Interview on 8/11/16 at 10:50 a.m. with the administrator and field services clinical director confirmed: *There was no documentation in employee K, L, M, and N's personnel files a health evaluation for free of communicable disease had been completed within fourteen days of being hired. *The corporate office kept records of that information. *She had not been able to access that information and confirmed she had no documented evidence those health evaluations had been completed. *They did not have a policy specific to the need for health evaluations to have been completed within fourteen days of being hired.</p>	S 210		

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S 236	Continued From page 3	S 236	S236	S236
S 236	<p>44:73:04:12(1) Tuberculin Screening Requirements</p> <p>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;</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 23059 Based on record review, interview, and policy review, the provider failed to ensure four of five sampled employees (K, L, M, and N) had completed the two-step method for the Mantoux tuberculin (TB) skin test or TB screenings within</p>	S 236	<p>1) TB screening documentation will be completed for employees K, L, & M. Employee N is no longer employed with us. 2) All residents had the potential to be affected. 3) Education completed on 09/01/16 with DCE and staff development regarding proper procedures for timely processing and documentation of new hire TB screening requirements. 4) ED or designee will conduct audit of all employee files for proper TB screening documentation. Biweekly audits will be conducted on all new hire employee files for 3 months. Results of these audits will be reported to the monthly QAPI meetings by ED or designee for further review and recommendations.</p>	09/30/16

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S 236 Continued From page 4

fourteen days of being hired. Findings include:

1. Review of the following employees' personnel records revealed:

- *Employee K had been hired on 2/8/16.
- *Employee L had been hired on 2/4/16.
- *Employee M had been hired on 4/12/16.
- *Employee N had been hired on 5/3/16.
- *There was no documentation in the above employees' personnel files a two-step TB skin test or screening had been completed within fourteen days of being hired.

Interview on 8/11/16 at 10:50 a.m. with the administrator and field services clinical director confirmed:

- *There was no documentation in employee K, L, M, and N's personnel files a two-step TB skin test or screening had been completed within fourteen days of being hired.
- *The corporate office kept records of that information.
- *She had not been able to access that information and confirmed she had had no documented evidence those health evaluations had been completed.

Review of the provider's 8/10/15 Tuberculosis, Screening Employees and New Hires policy revealed "each newly hired employee would be screened for TB infection and disease after an employment offer had been made, but prior to the employee's duty assignment."

S 236

S 253 44:73:04:14 Memory Care Units

Each facility with memory care units shall comply with the following provisions:

(1) Each physician's, physician assistant's, or

S 253

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S 253	<p>Continued From page 5</p> <p>nurse practitioner's order for confinement that includes medical symptoms that warrant seclusion or placement shall be documented in the resident's chart and shall be reviewed periodically by the physician, physician assistant, or nurse practitioner;</p> <p>(2) Therapeutic programming shall be provided and shall be documented in the overall plan of care;</p> <p>(3) Confinement may not be used as a punishment or for the convenience of the staff;</p> <p>(4) Confinement and its necessity shall be based on a comprehensive assessment of the resident's physical and cognitive and psychosocial needs, and the risks and benefits of this confinement shall be communicated to the resident's family;</p> <p>(5) Locked doors shall conform to Sections: 18.2.2.2 and 19.2.2.2 of NFPA 101 Life Safety Code, 2012 edition; and</p> <p>(6) Staff assigned to the memory care unit shall have specific training regarding the unique needs of residents in that unit. At least one caregiver shall be on duty on the memory care unit at all times.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 26632</p> <p>Surveyor: 32335 Based on observation, record review, interview, and policy review the provider failed to provide therapeutic activities for three of three sampled residents (1, 2, and 4) in the advanced Alzheimer's care unit (AACU). Findings include:</p> <p>1. Random observations during the survey from 8/9/16 through 8/11/16 in the AACU revealed resident 1 scooted throughout the hallway in her wheelchair. Resident 2 had been in her room in</p>	S 253	<p>S 253</p> <p>1) Activity care plans reviewed and updated for residents 1, 2, and 4.</p> <p>2) All residents in the ACU & AACU have the potential to be affected by the lack of activities.</p> <p>3) Evaluation of programming needs was completed by the GLC - Lead Alzheimer's Care Director (ACD) who provided training to the ED, DNS, and ACD on appropriate and effective activities, activity calendar, and activity documentation. Dementia Activity training will be provided to all staff that work in the ACU/AACU by ACD 09/07/16.</p> <p>4) Audits of activity calendars, attendance and documentation will be audited weekly for 4 weeks, biweekly for 4 weeks, then monthly for 2 months. Results of these audits will be presented by ACD or designee to monthly QAPI meeting for further review and recommendations.</p>	S253 09/30/16

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S 253	<p>Continued From page 6</p> <p>the recliner or bed or in the dining room for meals. Resident 4 had been brought to one activity that lasted ten minutes.</p> <p>Observation on 8/10/16 from 10:35 a.m. through 10:45 a.m. revealed an activities staff person had come to the AACU. She had six residents in the dining room including resident 4. She passed out hymnals and sang two songs. She then read the daily devotion and exited the AACU. The six residents in the dining room were then left in front of the television. There had been no other activities for the above mentioned residents.</p> <p>Review of resident 1's 8/1/16 through 8/10/16 activities documentation revealed they had marked five days for "television/radio" and ten days for "visiting." On 8/3/16 and 8/6/16 she had exercised independently. There had been no other activities marked.</p> <p>Review of resident 2's 8/1/16 through 8/10/16 activities documentation revealed they had marked ten days for "visiting" and ten days for "sensory/relax." She had one day marked for trivia, cards/games/dice, and pre-meal. There had been no other activities marked.</p> <p>Review of resident 4's 8/1/16 through 8/10/16 activities documentation revealed they had marked ten days for "visiting" and ten days for "sensory/relax." There had been no other activities marked.</p> <p>Review of the provider's undated unit criteria policy revealed they had not addressed therapeutic programming or activities.</p> <p>Surveyor: 26632 Interview on 8/10/16 at 4:00 p.m. with the activity</p>	S 253		

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S 253	Continued From page 7 director revealed: *Activities were provided for residents in the AACU at 10:30 a.m. and 4:00 p.m. by the activity staff. *The activities department only provided supplies and at times volunteers for bingo in the ACU. *The unit coordinator made all the activity calendars for the ACU and AACU.	S 253		