

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2016
NAME OF PROVIDER OR SUPPLIER UNITED LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 405 FIRST AVE BROOKINGS, SD 57006	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p><i>*Addendums noted with an asterisk per 2/29/16 per telephone with facility administrator. JVE/SDD08/EL</i></p> <p>INITIAL COMMENTS: Surveyor. 29354 A Minimum Data Set (MDS) focus health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/19/16 through 1/21/16. United Living Community was found not in compliance with the following requirements: F278, F323, F441, and F514.</p>	F 000		
F 278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a</p>	F 278	<p>F278</p> <ol style="list-style-type: none"> The MDS assessment for resident #1 & #7 were modified to correctly code the injury. All residents with an admission/readmission who sustained a major injury prior to admission have had their MDS assessment reviewed for accuracy. The MDS/Registered Nurses were provided a method for obtaining the most current RAI manual to insure that responses to MDS questions are accurate. This method will be reviewed monthly for updates by the Administrator. The MDS responses for two (2) admission/readmission assessments will be audited weekly for six (6) weeks by an MDS/Registered Nurse not completing the assessment. If there is no or fewer than two admission/readmission assessment, the audit will continue until twelve (12) audits have been completed. The Director of Nursing (DON) will bring audit results to the monthly QAPI/QA committee for review/recommendations until the QAPI/QA committee advises to discontinue. 	3-11-2016

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

TITLE

(X6) DATE

Katherine A. Solland

Administrator

2/11/2016

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 above findings and plans of correction 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.

FEB 16 2016

SD DOH L&C

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F 278	<p>Continued From page 1 material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on interview, record review, manual review, and policy review, the provider failed to ensure the Minimum Data Set (MDS) assessment had been completed accurately for two of ten sampled residents (1 and 7). Findings include:</p> <p>1. Review of resident 1's medical record revealed: *An admission date of 6/11/15 from the hospital. *He had been living at home prior to his admission into the hospital and had fallen. That fall had resulted in a subdural (inside of the skull) bleed. *The 6/18/16 admission/five day MDS assessment under section J1900 had not been coded for a major injury.</p> <p>Interview on 1/21/16 at 11:05 a.m. with the administrator, director of nursing (DON), MDS/registered nurses (RN) F and G regarding resident 1 revealed: *They had agreed the resident had: -Fallen at home prior to his admission. -Received a subdural bleed from that fall. *They had not been aware: -The 6/18/16 MDS assessment was not coded correctly to reflect a major injury. -That assessment had the resident appearing to be healthier upon admission than he was.</p> <p>Surveyor: 29354 2. Review of resident 7's medical record</p>	F 278		

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F 278	Continued From page 2 revealed: *She had an original admission date of 8/2/10. *She had fallen in the facility on 11/22/15 resulting in a left femur fracture. *She had been admitted to the hospital for the fracture then readmitted to the facility. *The significant/five day MDS assessment under section J1700 revealed the fall history was not coded as having a fall. Interview on 1/21/16 at 11:05 a.m. with the administrator, DON, MDS/RNs F and G regarding resident 7 revealed: *They agreed the resident: -Had fallen at the facility on 11/22/15. -Had returned to the facility following the hospitalization for the left femur fracture. *They disagreed the MDS had been coded incorrectly. Review of the Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, October 2014, section J1900, revealed: *Major injuries include bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma. *Coding Instructions for J1900C, Major Injury: Code 1, as one "If the resident had one major injurious fall since admission, entry or reentry or prior assessment (OBRA or Scheduled PPS.)" Review of the provider's undated Resident Assessment Instrument policy revealed "A comprehensive assessment of a resident's needs shall be made within fourteen (14) days of the resident's admission."	F 278			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323			

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F 323	Continued From page 3 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, record review, and policy review, the provider failed to ensure a safe environment for one of one sampled resident (11) who smoked while using oxygen without a physician's order. Findings include: 1. Observation on 1/20/16 at 1:05 p.m. as three surveyors drove by the facility revealed *A female resident was sitting in a wheelchair on the east side of the building at the end of the sidewalk. *A visable cloud of smoke was in the air. *A large oxygen tank was near the resident. Interview on 1/20/16 at 1:10 p.m. with the administrator, the director of nursing (DON), and Minimum Data Set (MDS) registered nurse (RN) G regarding resident 11 revealed: *She currently smoked. *Her Brief Interview for Mental Status assessment score (BIMS) was fifteen indicating she was alert and oriented. *She had been educated to leave the campus to smoke. *The state and local ombudsman had been involved and felt the facility had been doing	F 323	F323 1. Resident #11 has expired. All residents who smoke have been evaluated for independent smoking. 2. The facility has revised the smoking policy to state that oxygen dependent residents must leave their oxygen tank in a stand at the reception desk when going outside to smoke. Facility staff was educated on the policy revision on February 8, 2016. 3. The Administrator will audit residents who smoke for safe smoking practices once weekly for six weeks. The Administrator will bring the audit results to the monthly QAPI/QA committee for review/recommendations until the QAPI/QA committee advises to discontinue.	3-11-2016

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F 323	<p>Continued From page 4 everything they could for the resident regarding the smoking.</p> <p>Interview on 1/20/16 at 1:20 p.m. and again at 2:20 p.m. with the DON regarding resident 11 revealed:</p> <ul style="list-style-type: none"> *She took herself outside to smoke. *She was not sure if the resident kept smoking supplies on herself or turned them into the nurse when she came back into the building. *She felt if the smoking supplies were removed from the resident she would go to a local convience store and buy more smoking supplies. *They had not activley looked for alternate placement for the resident. *She was her own durable power of attorney (DPOA [made her own decisions]) . *She could be defiant and did what she wanted to do. *The physician and the provider had not wanted her to smoke. *There was no physician's order for her to smoke. <p>Review of resident 11's medical record revealed:</p> <ul style="list-style-type: none"> *A 11/19/14 signed acknowledgement by the resident and the administrator at that time that stated: <ul style="list-style-type: none"> - "Should you choose to smoke, and be able to, we require the following: <ul style="list-style-type: none"> --All smoking materials must be held with staff and not kept in resident rooms. --Must sign out when you leave campus to smoke. --You may not take oxygen devices outside with you to smoke." - "Failure to follow the above will mean termination of your smoking rights." - "Acknowledgement that resident has read and understood the above information. Signed and 	F 323		

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F 323	<p>Continued From page 5</p> <p>dated by the resident on 11/19/14."</p> <p>*Current diagnoses: chronic obstructive airway, morbid obesity, congestive heart failure exacerbation, and respiratory failure.</p> <p>*Physician's orders dated 12/23/15:</p> <p>-CO2 retainer and oxygen should not be increased without physician notification.</p> <p>-Oxygen at 10 liters continuoulsly.</p> <p>-Keep oxygen sat (saturation) greater than 89%. Use mask if needed.</p> <p>-May self-administer medications after set-up.</p> <p>Review of the 12/22/15 care plan revealed:</p> <p>*"Facility policy regarding smoking changed effective 11/17/14. I was informed of the new rules regarding the smoking policy. I signed a form agreeing that I understood the new rules. I understand that if I violate the rules that I will terminated my right to smoke while a resident of the facility."</p> <p>*"I have been noncompliant with my smoking rules. I was seen outside smoking (off campus) by myself with my oxygen tank between my legs. I am no longer allowed to smoke due to risk of injury to self and others. I have agreed to use the gum but state I do not know how much it helps."</p> <p>*"I know that the facility will not allow me to take the portable oxygen tanks outside to smoke due to safety concerns. I am aware that I can use the portable oxygen tanks outside of the facility if I wish to go on an outing or sit outside but CAN NOT use them if I am going to smoke."</p> <p>*Oxygen saturation on 11/16/15 was 92%.</p> <p>Review of the 12/18/15 Smoking-Safety Screen revealed:</p> <p>*She smoked five to ten cigarettes per day.</p> <p>*She was able to light her own cigarette.</p> <p>*She did not need the faciltiy to store her lighter</p>	F 323			

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F 323	<p>Continued From page 6 and cigarettes.</p> <p>*Notes on safety: "Resident has gum available. Denies waiting to quit at this time. Denies wanting assistance with quitting. Education provided on health risks. Resident states understanding." -Team decision: "Safe to smoke without supervision." -Rationale/conditions: "Resident alert and oriented. Resident has good hand dexterity. Resident aware not to have smoking items in facility, needs to be signed out, not to have oxygen on, and needs to be off campus. Aware wheelchair needs to have battery power to get her back into facility."</p> <p>Review of the January 1 through 20, 2016 MAR revealed she could self-administer medications after set-up. She was to have been monitored for appropriateness for self-administering her medications weekly on Tuesday.</p> <p>Review of resident 11's 12/15/15 MDS, section Q - Participation in Assessment and Goal Setting revealed: *She had participated in the assessment. *Active discharge planning already occurring for the resident to return to the community was marked "0."</p> <p>Review of resident 11's 12/22/15 care plan revealed she planned to stay in the facility, did not want to be asked about returning to the community on every assessment, did not want to talk to anyone about the possibility of returning to the community to live, and lived in the nursing facility for the past three years and felt that was where she needed to be.</p> <p>Review of the following physician's progress</p>	F 323			

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F 323	<p>Continued From page 7</p> <p>notes regarding resident 11 revealed on: *11/24/15: She continued to smoke. She was in a precontemplative stage of quitting. The physician had encouraged smoking cessation. *12/23/15: The physician had encouraged smoking cessation. She was in a precontemplative state.</p> <p>Review of the following progress notes regarding resident 11 revealed on: *8/8/15: "Writer witnessed resident shut off oxygen tank but did not remove or unplug nasal cannula. Resident noted to be sitting outside for extended period of time, upon checking on resident writer noted resident out smoking with nasal cannula on and oxygen canister within reach of resident." *1/3/16: "Resident was found outside the front door, of [facility] in a regular wheelchair. she had an oxygen tank with her and while the nasal cannula was not in her nose, she was smoking a cigarette with the oxygen tank sitting at her feet. She was told she could go off the property to smoke. she said she cannot go that far without her elctric scooter. Resident educated about the dangers of fire and oxygen tanks. she did agree to put out her cigarette after asking if she could finish it." *1/9/16: "Resident was noted entering the front door after being outside. Writer checked sign in/out book and she had not been signing herself out."</p> <p>Interview on 1/20/16 at 2:45 p.m. with the administrator and the DON regarding resident 11 revealed: *On 11/5/15 the state ombudsman had been in the facility and had the facility ask the resident if she had any plans to hurt herself.</p>	F 323			

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F 323	<p>Continued From page 8</p> <p>*There was no documentation in the progress notes regarding the above conversation. **A few days later MDS/RN G had followed up with resident 11. Was not sure if the conversation had been documented."</p> <p>Interview on 1/20/16 at 2:50 p.m. with the licensed social worker (LSW) regarding resident 11 revealed: *They had not tried any other placement for her. *She was comfortable living at the facility. *She was aware of the resident's non-compliance with smoking. *She had discussed the resident's non-compliance with smoking with the local ombudsman. *The local ombudsman felt the facility was doing everything they could regarding resident 11's smoking. *She had not documented the above conversation with the local ombudsman.</p> <p>Observation on 1/20/16 at 3:04 p.m. in the chapel area revealed resident 11 had just finished playing Bingo. She then: *Unhooked the tubing from the oxygen concentrator. *Backed into the portable oxygen canister attached to a hand pulled cart causing the oxygen cannister to fall to the floor. -A volunteer walked by the resident, looked at the oxygen canister on the floor, and then looked away. -Told a random staff member the oxygen canister was on the floor. -The random staff member then picked the oxygen canister up off the floor.</p> <p>Interview on 1/20/16 at 3:10 p.m. with the</p>	F 323			

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F 323	<p>Continued From page 9</p> <p>licensed social worker regarding resident 11 revealed:</p> <p>*Discharge planning included:</p> <ul style="list-style-type: none"> -She liked living at the facility. -She had contacted the local ombudsman. -She had refused mental health services. -The LSW was not sure if the resident was currently receiving mental health services but would check into it. -The local ombudsman had visited with the LSW and the resident had felt what the facility was currently doing in regards to her smoking was sufficient. <p>*The conversation with the local obmbudsman had not been documented. She had used it as a professional consultant to see if they were going in the right direction with the resident and her smoking.</p> <p>Observation and interview on 1/20/16 at 3:15 p.m. with resident 11 in her room revealed:</p> <p>*She had just gotten to her room.</p> <p>*A staff member brought in her oxygen concentrator, left the room, and returned with a new oxygen tank.</p> <p>*She removed the adapter from the old oxygen tank and placed it onto the new oxygen tank.</p> <p>*Interview at the above time revealed:</p> <ul style="list-style-type: none"> -She had smoked up to ten or eleven times a day but currently was smoking once or twice a day due to her motorized scooter not being available. -When she had her motorized scooter she went outside by herself to smoke. -If she was in a regular wheelchair the staff pushed her to the door then she propelled the wheelchair by herself to the east side of the building at the end of the sidewalk. -She kept the cigarettes and lighters with her at all times. 	F 323			

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F 323	<p>Continued From page 10</p> <ul style="list-style-type: none"> -If she ran out of smoking supplies she went to the local convience store to purchase items herself. -The provider had not bought her smoking supplies. -She always had the oxygen tank with her when outside smoking but "always shut the tank off before smoking." -No one had ever showed her how to shut the oxygen tank off. She figured it out by herself. -She used oxygen at all times. -She had not worn a smoking protector apron while smoking. -She had been without her electric scooter this week due to needed repairs. -The staff had visited with her about the risks of smoking and oxygen use. -It was her choice to continue to smoke. -She was aware of the oxygen tank and the dangers of smoking with an oxygen tank next to her. <p>Interview on 1/20/16 at 3:35 p.m. with MDS/RN G regarding resident 11 revealed:</p> <ul style="list-style-type: none"> *They had not done a formal assessment in regards to the resident using the oxygen tank or oxygen concentrator. *She had been able to turn the oxygen concentrator off and on. *They had not documented self-administration of oxygen for her. *There was not a policy for self-administration of oxygen. *When asked what her expectations would have been for her to self-administer oxygen she stated she would "have to converse and get back to this surveyor on self-administration of oxygen." <p>Interview on 1/20/16 at 3:40 p.m. with the DON</p>	F 323		

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F 323	<p>Continued From page 11</p> <p>and MDS/RN G regarding resident 11 revealed: *They considered oxygen and medications the same for self-administration of medications. *The resident had an order to self-administer oxygen. *Self-administration of medication assessments were done quarterly. *The oxygen was assessed weekly, documented on the medication administration record (MAR), and she visually showed the nurses she was able to self-administer oxygen.</p> <p>Interview on 1/21/16 at 11:05 a.m. with the administrator, DON, MDS/RNs F and G regarding resident 11 revealed: *The administrator considered the 11/19/14 smoking contract an invalid agreement. *The resident had been aware of the smoking policy. *She currently received oxygen at ten liters per nasal cannula. *She was unable to go without oxygen. *The mental health consultant was more involved with the case managers. *Since she had been using the regular wheelchair while the electric scooter was being fixed it was currently a problem where to place the oxygen cylinder. *Confirmed when she went outside to smoke and had used the electric scooter the oxygen cylinder was placed in front of her between the seat and herself. *The ombudsman had been involved, however they all agreed the visits had not been documented. *Confirmed the resident had a safety issue. *Confirmed the 12/22/15 care plan had been her current care plan. *Confirmed the resident had not always signed</p>	F 323			

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F 323	<p>Continued From page 12 out when leaving the facility.</p> <p>Review of the provider's undated Oxygen Therapy policy revealed: *Oxygen was a drug. *There was no documentation in regards to oxygen and the self-administration of medications.</p> <p>Review of the provider's revised December 2014 Smoking Policy - Residents policy revealed: *"Smoking articles may be kept with residents who are deemed appropriate. *Any resident found to violate these rules may be given a notice of eviction from the facility."</p> <p>Review of the provider's revised 4/2/15 Safety and Supervision of Residents policy revealed: *"When accident hazards are identified, the QAPI Committee shall evaluate and analyze the cause(s) of the hazards and develop strategies to mitigate or remove the hazards to extent possible. *Employees shall be trained and in-serviced on potential accident hazards and how to identify and report accident hazards, and try to prevent avoidable accidents. *The Interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for that resident. The care team shall target interventions to reduce the potential for accidents. *Implementing interventions to reduce accident risks and hazards shall include the following: -a. communicating specific interventions to all relevant staff. -b. assigning responsibility for carrying out interventions.</p>	F 323			

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F 323	Continued From page 13 -c. providing training, as necessary. -d. ensuring that interventions are implemented. -e. documenting interventions. *Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. *Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include smoking."	F 323	*Resident #1 will have dressing changes audited by all nurses who do dressing changes. JVE/SDDO/H/EL F 441	3-11-2016
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 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	1. CNA A, B, C & D and RN C have been individually educated on proper hand hygiene. CNA B has been individually educated on denture care. Resident #1 received a new toothbrush and items were rearranged in the cupboard on January 20, 2016. All residents' bathroom cupboards have been arranged to separate by resident and usage, with shelves labeled. 2. *The policy for multiple dressing changes and storage of personal care items were revised. Nursing staff were educated on proper hand hygiene, denture care, storage of personal care items and multiple dressing changes on February 8, 2016. 3. Hand hygiene audits will be completed by Staff Education Director on a minimum of ten (10) employees per week for six weeks to insure proper technique focusing on opportunities between glove changes. Denture care audits will be completed by Staff Education Director on ten (10) employees per week for six weeks	

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F 441	<p>Continued From page 14</p> <p>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: 32572 Based on observation, record review, interview, policy review, and manufacturer's review, the provider failed to ensure sanitary conditions had been maintained during: *Proper hand hygiene of personal care for two of four sampled residents (1 and 8). *Cleaning of dentures for one of one sampled resident (1). *Storage of residents' personal care items in a shared bathroom for two of two residents (1 and 12). *One of one dressing change for multiple lower extremity wounds for one of one sampled resident (1). Findings include:</p> <p>1. During observation on 1/20/16 at 9:30 a.m. certified nursing assistants (CNA) D and E were providing personal care including toileting for resident 8. The CNAs missed four opportunities for hand washing during that time. They did not</p>	F 441	<p>to insure proper techniques. Audits by Staff Education Director of cupboard order for ten (10) residents will be completed for six weeks to insure proper storage of personal items. Infection control wound care audits by the Director of Nursing for all Registered Nurses (RN) and Licensed Practical Nurses (LPN) will be completed by March 12, 2016. The Director of Nursing (DON) will bring audit results to the monthly QAPI/QA committee for review/recommendations until the QAPI/QA committee advises to discontinue.</p>		

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F 441	<p>Continued From page 15 wash their hands between glove use.</p> <p>Interview at that time with the above CNA confirmed this was their practice.</p> <p>Surveyor: 32355 2. Observation on 1/20/16 at 7:40 a.m. with CNA A and B with resident 1 revealed: *The resident had been resting in bed. *The CNAs got the necessary supplies to assist the resident with personal care, dressing, and getting out of bed. *During that time the CNAs missed three opportunities for hand washing after glove removal.</p> <p>Review of the provider's undated Handwashing policy revealed "Always wash your hands or use hand sanitizer after removal of gloves."</p> <p>Interview on 1/20/16 at 2:55 p.m. with the director of nursing confirmed she expected hand washing or use of hand gel to have occurred after glove removal.</p> <p>3. Observation on 1/20/16 at 7:50 a.m. with CNA B with resident 1 revealed she: *Washed her hands after assisting the resident with personal care. *Placed a wash cloth in the bottom of the sink and put them on top of the wash cloth. *Turned on the water, filled the sink half full of water completely covering the dentures, and started cleaning them. *Had not cleaned or disinfected the sink surfaces prior to set-up and cleaning of the resident's dentures.</p>	F 441			

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F 441	<p>Continued From page 16</p> <p>During the above process the surveyor stopped CNA B from completing that task. Interview with CNA B during the above process revealed:</p> <ul style="list-style-type: none"> *That had been her usual process for cleaning all residents' dentures. *She had been trained to clean dentures using that process. *She was not aware the sink surfaces would have been considered dirty. *She agreed that had not been a good practice. <p>Interview on 1/20/16 at 2:50 p.m. with the director of nursing (DON) confirmed the above process had been performed by the CNA in an unsanitary manner. She agreed there had been the potential for cross-contamination of bacteria being transmitted from one resident to another. She was the infection control nurse and had been responsible for the staff training.</p> <p>Review of the provider's March 2013 Denture Cleaning and Storing policy revealed the staff should "Hold the dentures in the palm of your hand and over the sink while brushing to prevent them from dropping on the floor. Rinse the dentures thoroughly."</p> <p>4. Observation on 1/20/16 at 8:00 a.m. of resident 1's bathroom revealed:</p> <ul style="list-style-type: none"> *He had shared the bathroom with resident 12. *Resident 12 had required the use of a catheter (tube inserted directly into the bladder to assist with urine drainage). *There had been a cupboard attached to the bathroom wall. *On top of the cupboard bottom shelf there had been: -A plastic container to empty the urine from resident 12's catheter collection bag into. 	F 441		

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F 441	<p>Continued From page 17</p> <p>-A plastic emesis basin containing resident 1's toothbrush and toothpaste. That emesis basin and toothbrush had been touching the outside surfaces of resident 12's urine collection container.</p> <p>*Inside of the cupboard there had been several personal care products for both residents 1 and 12 including:</p> <ul style="list-style-type: none"> -Lotions. -Deodorants. -Perineal (private area between the thighs) wash and protective cream. -Electric razors. -Toothbrushes. -Toothpaste. <p>*All of the above items even though individually marked were mixed together.</p> <p>Interview on 1/20/16 at 8:00 a.m. with CNA B regarding the above observation confirmed:</p> <ul style="list-style-type: none"> *The personal care items for both of the residents had not been stored in a sanitary manner. *She agreed there had been the potential for cross-contamination of bacteria from one resident to another. <p>Interview on 1/20/16 at 2:55 p.m. with the DON confirmed the interview with CNA B.</p> <p>The provider did not have a policy and procedure for proper storage of personal care items.</p> <p>5. Observation on 1/20/16 at 9:35 a.m. of registered nurse (RN) C during multiple dressing changes for resident 1 revealed:</p> <ul style="list-style-type: none"> *She had made a copy of the resident's treatment assessment record (TAR). *She got several supplies to complete a dressing change including five kerlix gauze wraps. 	F 441		

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F 441	<p>Continued From page 18</p> <p>*Those wraps had not been inside a package, and their surfaces were exposed.</p> <p>*She placed all of those wraps directly on top resident 1's paper copy TAR.</p> <p>*She entered the resident's room and placed her supplies on a clean towel.</p> <p>*The resident had been laying in bed with his both of his feet and legs covered with kerlix wrap.</p> <p>*RN C washed her hands, and did the following:</p> <p>-Removed the kerlix wraps from his legs and feet exposing with yellow colored drainage from some of the wounds.</p> <p>-Got several 4 x (by) 4 gauze squares and sprayed wound cleanser on them.</p> <p>-Cleansed several wounds with those gauze squares before removing her gloves and washing her hands.</p> <p>*She had cleaned all of the resident's wounds using the same process observed above.</p> <p>*She had not been observed changing her gloves and washing her hands after cleansing each separate wound.</p> <p>*After she had completed cleansing the wounds she washed her hands again and changed her gloves. With those clean gloves she:</p> <p>-Opened several betadine (solution that helps decrease bacteria growth) packages.</p> <p>-Cleansed several wounds with those betadine wipes before removing her gloves and washing her hands.</p> <p>*She applied dressings to the wounds per physician's orders.</p> <p>*She covered the dressings with the kerlix wrap that had been sitting on the resident's TAR.</p> <p>*Removed her gloves and left the resident's room to get cloth coverings for both of his legs.</p> <p>*She had not been observed washing her hands and changing her gloves for several opportunities during the above process.</p>	F 441		

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F 514	<p>Continued From page 20</p> <p>medication administration records (MAR), treatment administration records (TAR), follow-up for as needed (prn) medications, and wound assessments for eight of ten sampled residents (1, 2, 5, 6, 7, 8, 9, and 10). Findings include:</p> <p>1. Review of resident 1's 1/1/16 through 1/19/16 MAR and TAR revealed the following missing documented entries:</p> <ul style="list-style-type: none"> *Calcium (supplement) one out of thirty-eight times. *Cerovite (vitamin) one out of nineteen times. *Clopidogrel (thins the blood) one out of nineteen times. *Metoprolol (high blood pressure) two out of thirty-eight times. *Sodium Chloride two out of twelve times. *Aquaphor ointment (moisturizer) to legs twice a day twenty-seven out of thirty-seven times. *Change dressing to left upper arm daily five out of nineteen. *Betadine to right second toe and right heel two times a day nineteen out of thirty-eight times. *Monitor skin tear to left elbow five out of nineteen times. *Monitor right fourth toe daily until healed eleven out of nineteen times. *Monitor broken blister on right heel eighteen out of thirty-eight times. *Monitor for blister on right shin daily fourteen out of nineteen times. *Betadine to left heel and left great toe seven out of nineteen times. *Monitor bruising to low back until healed thirteen out of nineteen times. <p>Review of resident 1's 8/24/15 through 1/19/16 weekly pressure ulcer flow sheets for the left and right heels revealed:</p>	F 514		

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F 514	<p>Continued From page 21</p> <p>*They had failed to identify the following areas of concern for seventeen out of eighteen weeks: -Type of drainage and amount. -Undermining and/or tunneling. -Odor. -Pain. *No year had been identified on several of those weekly dates.</p> <p>Review of the provider's 9/9/15 Skin Assessment and Pressure Ulcer Prevention and Treatment policy revealed "The MDS [Minimum Data Set] coordinator will document any changes in exudate (drainage), amount of exudate, odor, tissue surrounding wound and if any undermining or tunneling is present."</p> <p>2. Review of resident 2's 1/1/16 through 1/19/16 TAR revealed: *The nebulizer set (equipment used to deliver breathing medication) was to have been changed weekly. There was no documentation to support that equipment had been changed three out of three weeks. *The nebulizer machine was to have been cleaned weekly. There was no documentation to support that machine had been cleaned three out of three weeks.</p> <p>Review of resident 2's 1/1/16 through 1/19/16 Pain Assessment Flow Sheet revealed nineteen entries that did not have follow-up documentation.</p> <p>Interview on 1/20/16 at 8:45 a.m. with MDS assessment coordinator F confirmed if there was no documentation by staff the tasks had been considered not completed.</p>	F 514			

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F 514	<p>Continued From page 22 Surveyor: 32572 3. Review of resident 5's January 1 through 19, 2016 MAR, TAR, and Pain Assessment Flow Sheet revealed the following. *The MAR had the following missing documented entries: -Blood glucose testing four times a day had seven. -Aspirin had two documentation. -Diltiazem XR (for the heart) had two. -Docusate sodium (stool softner) had two. -Fluoxetine HCL (for mood) had two. -Melatonin (for rest) had one. -Mycophenolate (anti-rejection drug) had one. -Polyethylene glycol (stool softner) had one. -Potassium citrate (prevent kidney stones) had one. -Tacrolimus (anti-rejection drug) had one. -Vitamin D3 had one. -Warfarin sodium (blood thinner) had one. -Check Fentanyl (strong pain medication) patch placement had nine. -Destruction of Fentanyl patch had one.</p> <p>*The TAR had the following missing documented entries: -Monitor bottom for change for thirty days had seven. -Monitor left great toe for change for thirty days had six. -Sween cream (barrier incontinent cream) to bottom twice a day and as needed had fourteen.</p> <p>The Pain Assessment Flow Sheet had three entries that did not have follow-up documented.</p> <p>4. Review of resident 6's January 1 through 19, 2016 MAR, TAR, and Pain Assessment Flow Sheet revealed the following.</p>	F 514		

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F 514	<p>Continued From page 23</p> <p>*The MAR had the following missing documented entries:</p> <ul style="list-style-type: none"> -Duonebs (breathing treatment) had one. -Xarelto (for the heart) had two. -Acetaminophen had two. -Combigan eye drops had one. -Latanoprost eye drop had one. -Sertraline (for depression) had one. -Vitamin C had one. -Check Fentanyl patch placement had six. -Destruction of Fentanyl patch had two entries had only one nurse initials. <p>*The TAR had the following missing documented entries:</p> <ul style="list-style-type: none"> -Incentive spirometer (breathing exercises) treatment had: <ul style="list-style-type: none"> -Four full days with no documentation. -One day with three missing entries. -One day with six missing entries. -Four days with eleven missing entries. -Monitor buttock daily and apply protective cream had fifteen. -Monitor small abrasion on right arm had six. -Monitor callous on bottom of left foot had eight. <p>*The Pain Assessment Flow Sheet had the following missing documentation:</p> <ul style="list-style-type: none"> -Sixteen entries that did not have follow up documented. -Two lines had dates but nothing else. -One line had no recording of pain, acceptable pain, and location. <p>5. Review of resident 8's January 1 through 19, 2016 MAR, TAR, and Pain Assessment Flow Sheet revealed the following missing entries.:</p> <p>*The MAR had the following missing documentation entries:</p>	F 514		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	<p>Continued From page 24</p> <ul style="list-style-type: none"> -Aspirin had one. -Donepezil (for dementia) had one. -Levothyroxine (for thyroid) had one. -Mirtazapine (for depression) had one -Risperidone (for mood) had two. -Sween cream had three. <p>Surveyor: 29354</p> <p>6. Review of resident 7's January 1 through 19, 2016 MAR revealed the following items had not been documented as given:</p> <ul style="list-style-type: none"> *Artificial eye drops two out of eighteen times. *Citalopram HBR (antidepressant medication) one out of eighteen times. *Mirtazapine (antidepressant medication) one out of eighteen times. *Senna Plus (medication for constipation) two out of eighteen times. <p>7. Review of resident 9's January 1 through 19, 2016 MAR, TAR, and pain assessment flowsheet revealed the following items had not been documented as given nor follow-up for pain relief:</p> <p>The MAR:</p> <ul style="list-style-type: none"> *Debrox ear drops two out of three times. *Budesonide (lung medication) one out of thirty-eight times. <p>The TAR:</p> <ul style="list-style-type: none"> *Change nebulizer set-up weekly on Tuesday two out of two times. *Check oxygen saturation BID (twice a day) fourteen out of thirty-eight times. *Clean oxygen concentrator and filter weekly on Monday two out of three times. *Check finger nails weekly one out of three times. *Rinse nebulizer set-up after every use, no documentation. 	F 514		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER UNITED LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 405 FIRST AVE BROOKINGS, SD 57006		
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F 514	<p>Continued From page 25</p> <p>*Wanderguard to be placed and check placement two times a day, no documentation that had occurred.</p> <p>Pain Assessment Flowsheet had no follow-up for pain relief four out of thirteen times.</p> <p>8. Review of resident 10's January 1 through 19, 2016 MAR, TAR, and pain assessment flowsheet revealed the following items had not been documented as given nor follow-up for pain relief: The MAR: *Metoprolol (medication for blood pressure) 50 milligrams (mg) BID one out of seven times. *Diltiazem (medication for the heart and blood pressure) one out of three times. *Calcium (supplement) one out of eighteen times. *Metoprolol 75 mg BID one out of thirty-one times.</p> <p>The TAR: *Left ankle apply telfa and ABD (type of dressing) for weeping. Check BID and prn (when necessary) eleven out of thirty-eight times. *Wrap left lower leg with ACE wrap with 1/4 to 1/2 stretch for light compression ten out of thirty-six times.</p> <p>Pain Assessment Flowsheet had no follow-up for pain relief ten out of thirty times.</p> <p>9. Interview on 1/21/16 at 11:05 a.m. with the administrator, director of nursing, MDS/RNs F and G regarding all of the above residents' records agreed the documentation was incomplete.</p> <p>Review of the provider's undated Documentation of Medication Administration policy revealed:</p>	F 514			

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NAME OF PROVIDER OR SUPPLIER UNITED LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 405 FIRST AVE BROOKINGS, SD 57006		
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F 514	<p>Continued From page 26</p> <p>*"The facility shall maintain a medication administration record to document all medications administered.</p> <p>*A Nurse or Certified Medication Aide shall document all medications administered to each resident on the resident's medication administration record (MAR).</p> <p>*Administration of medication must be documented immediately after (never before) it is given.</p> <p>*Documentation must include, as a minimum: -Signature and title of the person administering the medication. -Resident response to the medication, if applicable (e.g. PRN, pain medication, etc.)"</p> <p>Review of the provider's undated Charting and Documentation policy revealed: *"All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record." *"All observations, medications administered, services performed, etc., must be documented in the resident's clinical records."</p>	F 514			