

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

PRINTED: 04/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/07/2016
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NAME OF PROVIDER OR SUPPLIER LAKE ANDES SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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<p>F 166 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO SS=E RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, it was determined the facility did not promptly resolve grievances for 2 of 11 sampled residents (#8 and #5). These grievances involved pain management and bathing. Specifically, the facility did not have a process in place to investigate grievances in order to ensure that grievances were resolved timely. The facility failed to have a system in place to assure that after receiving a complaint/grievance, the facility actively seeks a resolution and keeps the resident appropriately apprised of its progress toward resolution. The findings included:</p> <p>1. Resident #8 was admitted to the facility on 3/1/16 with diagnoses which included: COPD (chronic obstructive pulmonary disease), CHF (congestive heart failure), pulmonary hypertension, lower back pain generalized edema and a puncture wound to the right foot with cellulitis. The resident's admission assessment on 3/8/16 showed the resident was cognitive with a BIMS (brief Interview for mental status) score of 15.</p> <p>Resident #8's medical record was reviewed. The progress notes included entries on 4/2/16 which showed the resident verbalizing pain. The notes included:</p>	<p>F 166</p> <p>F166 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:</p> <ol style="list-style-type: none"> 1) Resident #8 received pain medication per physician's order and the pain was under control per the resident. Resident #8 discharged to home on 4/15/16 per plan. Interim Director of Nursing (IDNS) and Social Service Designee (SSD) visited with Resident #5 regarding his conversation of wanting showers daily as he had previously versus three times per week as he does now. Resident was asked he would like to have a shower daily and stated he wanted the three times per week as it has been. Resident will let facility know if he wants bathing more frequent than three times per week. 2) All existing grievances were reviewed for resolution and follow through.
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Sheryl Long for Candace Dvorak* TITLE *Interim ED* (X6) DATE *5-5-16*

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.

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F 166 Continued From page 1

F 166

At 2:59 AM, "Pain: verbalizes pain yes. 6 (score 0-10) left upper leg , Tramadol and Hydrocodone provided some relief Non-verbal pain indicators present..."

At 3:19 PM, "Resident Pain: verbalizes pain yes. 8 (score 0-10) left upper leg , Tramadol and Hydrocodone provided some relief Non-verbal pain indicators present..."

At 7:01 PM showed the resident had received PRN Tramadol x 2 due to pain in the upper leg this shift.

The entry in the progress notes dated 4/3/2016 revealed the following: "At 7 P yesterday (4/2/16), (name__), deputy Charles Mix County, stopped at facility and wanted to talk to the nurse. Both this nurse and (name__) LPN who was just coming on went to talk. (name__ Deputy) stated that this resident had called the sheriff's office a couple of times stating that we are not taking care of his pain and won't give him enough medication for it. (name__ Deputy) stated that they told the resident that we can only give as much as the doctor orders to be given. This nurse told (name__ Deputy) that resident received scheduled Hydrocodone and also PRN Tramadol x 2 throughout the day. (name__ Deputy) stated understanding and that he just had to stop since resident had called more than once. Notified (name__), ED about situation as well. Continuing to monitor resident's pain to upper left leg, which has very dry skin. Applied barrier cream x 2 this shift."

There was no documentation the resident's physician was called on 4/2/16 to report the

- 3). Staff were re-educated to the Grievance process on 4/21/16 and Grievance training will be included in orientation to all new staff. Residents will be encouraged at the next resident council meeting to let SSD, the Interim Executive Director (IED) or any staff member know of a grievance. The grievance will be documented on the Feedback form. All new admissions will receive information regarding the grievance process and feedback forms to write their grievance. All grievances will be added to the grievance log and reviewed at IDT as well as Quality Assurance (QA) for resolution. The log will be used to identify patterns of grievances which will be reviewed at QA for action.
- 4) The Social Service Designee or her Designee will audit the grievance log three times per week for two months and then one time per week for one month. The data collected will be presented to the QA Committee at least quarterly by the Social Service Designee or her Designee including any identified patterns or system failure. The committee will make the decision for further action.
- 5) Completion Date: 5/10/2016

5/10/16

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F 166	Continued From page 2 resident had contacted the sheriff's office due to his uncontrolled pain. The progress notes showed a request for the physician to see the resident was not sent until 10:49 AM on 4/4/2016 (Monday). It noted the resident had complaints of pain in his groin and surrounding areas and buttocks. It stated, "Resident started voices complaints on Friday (4/1/16) during the day. Resident has some slight redness noted around these areas. No open areas are seen. Resident does have some patchy grayish areas on lower buttock and upper leg. Any slight touch to area causes the resident great pain. Treatment with barrier cream is helping little to none. Could you come over and assess resident and make recommendation from there?" The resident was seen by the CNP (Certified Nurse Practitioner) at 3:57 PM. The note showed a diagnosis of shingles and an order to increase the resident's Hydrocodone to QID (four times per day). [Reference: (NIH National Institute of Health-Senior Health) Shingles is caused by a reactivation of the chickenpox virus. The virus that causes shingles is a herpes virus, (Another name for shingles is herpes zoster.) The most common complication of shingles is pain -- a condition called post-herpetic neuralgia (PHN). People with PHN can have severe pain in the areas where they had the shingles rash, even after the rash clears up.] Interviews on 4/7/16 confirmed that the facility had not follow up with the sheriff's office voiced concerns with resident concern for lack of adequate pain management as a grievance. At	F 166		

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F 166	<p>Continued From page 3</p> <p>11:15 AM in an interview with the Interim ED who had been contacted on 4/2/16 as documented in the progress note confirmed she did not initiate or start this as a voiced grievance. The ED preceptor also joined the interview and reported she was not aware of the situation. The Chief Clinical Operations Officer also joined the conversation and instructed the Interim ED on the procedure for handling voiced grievances and resident complaints.</p> <p>Interview on 4/7/15 at 11:45 AM with SS (Social Services) also confirmed she was aware of the resident calling the sheriff's office because of pain but she had not treated it as a voiced grievance.</p> <p>Resident #8 was interviewed on 4/7/16 after the noon meal. He reported that he was getting along better and pain was currently being controlled.</p> <p>2. Resident #5 was admitted to the facility on 11/7/11 and had a readmission on 10/28/15. The resident's diagnoses included: Atrial fibrillation, hypertension, GERD (gastro-esophageal reflux disease), COPD (chronic obstructive pulmonary disease), pain and obesity.</p> <p>a. Interview with the resident on 4/5/16 at 10:30 AM the resident expressed concerns with not getting baths or showers as often he needed them. He reported he had been on a daily bath schedule due to skin issues but it was changed and he was not getting them often enough to address skin issues. He reported he had talked to facility staff about it but had no results. He stated, "They wipe me off but it is not like getting a shower everyday. I get that rash and I think I need it more often."</p>	F 166		

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F 166 Continued From page 4

b. Interviews with the Acting DON and Nurse consultant were conducted on 4/6/16 to see if the resident's voiced concerns with bathing/showers had been addressed. The facility had no documentation to show the facility had talked to the resident about his concerns or that the facility made efforts to resolve the resident's grievance.

c. Interview with the bath aide on 4/6/16 confirmed that the resident had been on a daily bath schedule a couple months ago but it had been changed. She reported that the resident was not happy about the change in the bath schedule and he wanted them more often.

d. Review of the physician telephone orders noted an order on 1/25/16 which included:
"1) D'C (discontinue) Q (every) day shower,
2) Give showers as scheduled throughout week,
3) Wash back of thighs with warm water and soap Q AM & Q HS."

e. Review of the TAR (Treatment Administration record) for March 2016 and first five days of April 2016 showed the resident was getting one bath/shower per week and having skin issues. It showed the following:

- "Weekly weight with bath on Sat." (one bath per week),

- "Wash back of thighs with warm water and soap everyday and night shift for skin breakdown, start date 1/26/16",

- "Skin prep open area on right inner thigh till healed everyday and night shift for skin breakdown, start date 1/26/16",

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F 166 Continued From page 5
-"Nystatin powder apply to abdominal fold topically as needed for abdominal fold yeast infection four times a day as needed, start 10/29/15" (This was used 22 times in March.)

f. Review of the resident's MDS (minimum data set) assessment dated 3/14/16 showed the resident was cognitive and dependent on staff for bathing, personal hygiene and transfers with a lift. It also identified the resident at risk for skin breakdown.

F 166

5/10/16

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:

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F280

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:

1. Resident #8's care plan was updated to reflect current plan of care on 4/7/16 including diagnosis of shingles, "Contact Isolation" and increased pain. Resident #9's care plan was updated to reflect current plan of care on 4/8/2016 and interventions appropriate for someone with Alzheimer's disease. Resident #7's shoulder injury is resolved and care plan reflects current plan of care including fall prevention. Resident #10 was discharged 3/11/2016.

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F 280 Continued From page 6

Based on observation, medical record review and staff interviews the facility failed to ensure residents plans of care were evaluated and revised to meet residents' individual needs. This was identified for four of eleven sampled residents (#8 , #9, #7, and #10).

The findings included:

1. Resident #8 was admitted to the facility on 3/1/16 with diagnoses which included: COPD (chronic obstructive pulmonary disease), CHF (congestive heart failure), pulmonary hypertension, lower back pain generalized edema and a puncture wound to the right foot with cellulitis. The resident's admission assessment on 3/8/16 showed the resident was cognitive with a BIMS (brief Interview for mental status) score of 15.

a. On the initial tour of the facility on 4/5/16 at 9:00 AM with the Interim DON, she was asked if there were any resident's that had infections or any resident in isolation. She reported there were a couple residents on antibiotics for urinary tract infection but no residents in isolation. There were no isolation supplies noted outside residents' rooms during the tour. Then at 12:30 PM an isolation cart was observed outside resident #8's room. The nurse (A) reported resident #8 was on "Contact Isolation" due to having shingles.

b. Review of the resident's progress notes revealed the resident was seen by the CNP (Certified Nurse Practitioner) at 3:57 PM on 4/4/16. The note showed a diagnosis of shingles and an order to increase the resident's Hydrocodone to QID (four times per day). The progress notes also identified the resident having

- F 280
2. Care plans were reviewed/ revised by the IDT to assure they reflect individual's plan of care. All care plans will be reviewed and updated quarterly and with a change in condition to reflect resident current needs.
 3. Licensed staff were re-educated to timely updating of care plans to reflect individualized resident needs and interventions specific to the resident's plan of care including infection control, isolation, and use of personal protective equipment on 4/28/2016 by the IDNS and the IDT was re-educated by the MDS Consultant to the same information on 5/3/2016.
 4. Two care plans will be audited for individualized needs and interventions weekly for two months and then one care plan per week for one month by the Interim Director of Nursing/Designee to assure they reflect each individual's plan of care. The data collected will be presented to the QA Committee at least quarterly by the IDNS or her designee including any system failure. The committee will make the decision for further action.
 5. Completion date: 5/10/2016

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F 280 Continued From page 7 F 280

issues with uncontrolled pain. (Refer to F309)

c. Review of the resident's plan of care on 4/6/16 revealed the resident's plan of care had not been updated or revised to address the resident having shingles, "Contact Isolation" or the resident's increased pain.

d. On 4/7/16 the surveyor was provided and update plan of care for resident #8 addressing his current needs.

2. Resident #9 was admitted to the facility on 1/6/16 with diagnoses which included: Alzheimer's disease late onset, major depressive disorder, muscle weakness, anemia, GERD (gastro-esophageal reflux disease) and history of pressure sores and malignant neoplasm of the large intestine and prostate. The resident was also assessed to be a High Fall risk and was identified on the resident's plan of care dated 1/6/16. It stated, "High risk for falls r/t (related to) unaware of safety needs, gait/balance problems, deconditioning, wandering".

a. Resident #9's medical record was reviewed. The progress notes showed the resident had falls multiple falls with three falls occurring in March 2016. The entries included a note on 3/3/16 that identified the resident was having increased confusion, wandering in and out of resident rooms and having exit seeking behaviors. It also addressed that the resident reported burning with urination.

The resident was identified as having a fall with injury on 3/10/16 and being sent to the hospital. The resident was identified with a right hip femoral neck fracture and scalp laceration. The

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F 280 Continued From page 8
resident returned from the hospital on 3/14/16 and continued to have two more falls on 3/19/16. (Refer to F323)

F 280

b. The resident's plan of care dated 1/6/16 was reviewed. It stated, "High risk for falls r/t (related to) unaware of safety needs, gait/balance problems, deconditioning, wandering". There were three approaches to falls added after the resident continued to have more falls. However, the added approaches were not appropriate to meet this resident's needs and prevent further falls from occurring. The approaches included:

-3/10/16 (the date of the fall which resulted in right hip fracture and scalp laceration), "Remind to use call light." [Note: This approach is not appropriate for a resident with severe cognitive impairment and post surgical repair of right hip fracture.]

-3/19/16, "Continue to remind resident to call for assistance and that he needs assistance for mobility."

-3/21/16, "Landing Strip by bed."

The facility failed update this resident's plan to ensure this resident, who was dependent for care, received adequate supervision and appropriate interventions to prevent ongoing falls /accidents.

3. On 4/7/16 medical record review for resident #7 evidenced the resident had diagnoses that included schizoaffective disorder, dementia without behavioral disturbances, hypertension, fracture of left clavicle, and polyosteoarthritis.
a. Review of the resident's 1/4/16 significant

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F 280	Continued From page 9 change Minimum Data Set (MDS) assessment revealed that the resident was assessed to need extensive assistance from one or two staff members for bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. The assessment noted that the resident had one fall with injury and one fall with major injury. The resident's BIMs on 1/4/16 was "99", indicating that the resident could not be interviewed. The staff assessed the resident to have short and long time memory issues and was rated as severely impaired. On 1/4/16 and 4/4/16 the resident was determined on the Morse Fall Scale to be high risk for falls. b. Review of the resident's progress notes revealed that the resident experienced falls on 12/24/15 11:15 AM, 12/24/16 11:50 AM, and 3/31/16. c. Review of the care plan did not show that the facility addressed the resident's shoulder injury and how that impacted the resident's care. Additionally, the care plan did not include added interventions after the three falls, two of which resulted in injuries. d. On 4/7/16 in the morning, the resident's falls were discussed with the Administrative team. They indicated that the pommel cushion was added to the wheelchair immediately with the first two falls and monitoring the resident every one to two hours was implemented after the third fall. There was no evidence to show that monitoring the resident at this frequency would decrease the resident's accidents/falls. 4. On 4/7/16 closed medical record review for resident #10 evidenced the resident was admitted on 3/17/15 and had diagnoses that included dementia with behavioral disturbances, depressive disorder, anxiety disorder, hypertension, and malignant melanoma of the	F 280		

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F 280	<p>Continued From page 10</p> <p>skin.</p> <p>a. Review of the resident's 3/7/16 significant change MDS assessment revealed that the resident was assessed to need total assistance from one or two staff members for bed mobility, transfer, locomotion on and off the unit, dressing, eating, toilet use, personal hygiene, and bathing. The assessment noted that the resident had two falls with no injury and two falls with injury. The resident's BIMs on 3/7/16 was not rated, indicating that the resident could not be interviewed. The staff assessed the resident to have short and long time memory issues and was rated as severely impaired. The resident expired on 3/11/16 in the facility.</p> <p>b. Review of the resident's care plan for being high risk for falls was initiated on 3/30/15 due to the resident's confusion, wandering, unaware of safety needs, psychoactive drug use, and incontinence. The resident's goal was to be "free of falls through the review date". The interventions were: Anticipate and meet needs Be sure call light is within reach and encourage to use it for assistance as needed. Respond promptly to all requests for assistance. Coordinate with appropriate staff to ensure a safe environment with: Floors even and free from spills or clutter, Adequate, glare-free light, Call light, Bed in low position at night. Side rails are ordered, Handrails on walls, Personal items within reach. Ensure that ___(Name) is wearing appropriate footwear-wears athletic shoes when ambulating. 2/3/16 - check on res Q 1/2 hr 2/19/16 - fall mat at bedside.</p> <p>c. Review of the Quarterly Assessment summary for the ARD (assessment reference date) of 12/14/15 revealed that "...Has had 2</p>	F 280		
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NAME OF PROVIDER OR SUPPLIER LAKE ANDES SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356		
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F 280	<p>Continued From page 11</p> <p>recent falls and has hematoma and bruises from falls..."</p> <p>d. Review of the resident's Progress Notes for February, 2016 and March, 2016 evidenced entries related to falls on 2/1/16 at 6:55 PM, 2/3/16 12:10 PM, 2/3/16 1:40 PM, 2/6/16 2:46 PM, 2/6/16 4:15 PM, 2/19/16 2:30 PM, and 2/25/16 11:15 AM.</p> <p>3/7/16 10:16 AM - "...had a Morse fall scale completed. Previous falls are Yes. More than one diagnosis on file is Yes. Ambulatory aids are None/bedrest/wheelchair/nurse assist...Gait is Normal/bedrest/wheelchair...Overestimates or forgets limits. Overall Morse Fall Score is High Risk for Falling risk."</p> <p>e. Review of the February, 2016 Medication Administration Record (MAR) evidenced that the resident received Rocephin 1 gram IM on 2/5/16 and for three days (2/9, 2/10, and 2/11/16) for a urinary tract infection.</p> <p>f. Fax Communication to Physician forms revealed:</p> <p>A fall on 1/7/16 with a small abrasion to left shoulder</p> <p>A fall on 2/6/16 at 3:50 PM hit back of had with 10 cm round hematoma; BP 220/140, eyes dilated. The provider response was "Will be seen by _____(name) tomorrow." The immediate intervention implemented according to the documentation on the incident report was to check/monitor q 1 h.</p> <p>A fall on 2/6/16 with res sitting on bathroom floor Although the facility provided a Living Directive dated 2/3/16 for Comfort Care with no hospitalization, there was no evidence that the provider assessed the resident after the significant head injury. The facility addressed the behaviors, some of which were happening at the same time as the resident had a urinary tract</p>	F 280		

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F 280 Continued From page 12
infection. There was a lack of information to show that the resident's multiple falls were evaluated, addressed, with the implementation of appropriate, effective interventions.

F 280

5/10/16

F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
SS=D

F 309

F309

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:

This REQUIREMENT is not met as evidenced by:
Based on record review and resident interview, it was determined that the facility failed to provide care in a manner to ensure adequate pain management for a resident who experienced increased pain. This failure affected one of 11 sampled residents' (#8) ability to reach his highest practicable level of physical, mental, and/or psychosocial functioning. The findings included:
Resident #8 was admitted to the facility on 3/1/16 with diagnoses which included COPD (chronic obstructive pulmonary disease), CHF (congestive heart failure), pulmonary hypertension, lower back pain generalized edema and a puncture wound to the right foot with cellulitis. The resident's 3/8/16 admission Minimum Data Set (MDS) assessment showed the resident was cognitive with a BIMS (brief interview for mental status) score of 15.

1. Resident #8 received increased pain medication per physician's order on 4/4/2016 with positive results. Resident #8 was discharged to home on 4/15/2016.
2. Residents with scheduled pain medication were reviewed to assure pain medication was effective. Those residents exhibiting or verbalizing pain are receiving pain medication and or physician is notified of new pain or pain not being managed with current medications.
3. Licensed staff were re-educated to the Pain Guidelines by the IDNS on 4/28/2016. This training will be given in the orientation program for new employees.

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F 309 Continued From page 13

Resident #8's medical record was reviewed. The progress notes included entries on 4/2/16 which showed the resident verbalizing pain. The notes included:

At 2:59 AM, "Pain: verbalizes pain yes. 6 (score 0-10) left upper leg, Tramadol and Hydrocodone provided some relief Non-verbal pain indicators present..."

At 3:19 PM, "Resident Pain: verbalizes pain yes. 8 (score 0-10) left upper leg, Tramadol and Hydrocodone provided some relief Non-verbal pain indicators present..."

At 7:01 PM showed the resident had received PRN Tramadol x 2 due to pain in the upper leg this shift.

The entry in the progress notes dated 4/3/2016 revealed the following: "At 7 P yesterday (4/2/16), (name__), deputy Charles Mix County, stopped at facility and wanted to talk to the nurse. Both this nurse and (name__) LPN who was just coming on went to talk. (name__ Deputy) stated that this resident had called the sheriff's office a couple of times stating that we are not taking care of his pain and won't give him enough medication for it. (name__ Deputy) stated that they told the resident that we can only give as much as the doctor orders to be given. This nurse told (name__ Deputy) that resident received scheduled Hydrocodone and also PRN Tramadol x 2 throughout the day. (name__ Deputy) stated understanding and that he just had to stop since resident had called more than once. Notified (name__), ED about situation as well. Continuing to monitor resident's pain to upper left leg, which has very dry skin. Applied barrier cream x 2 this

F 309

4. IDNS will audit three residents for pain management one time per week for three months. The data collected will be presented to the QA Committee at least quarterly by the Interim Director of Nursing or her Designee including any identified patterns or system failure. The committee will make the decision for further action.

5. Completion Date: 5/10/2016.

5/10/16

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F 309	Continued From page 14 shift."	F 309		
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There was no documentation the resident's physician was called on 4/2/16 to report the resident had contacted the sheriff's office due to his uncontrolled pain.

The progress notes showed a request for the physician to see the resident was not sent until 10:49 AM on 4/4/2016 (Monday). It noted the resident had complaints of pain in his groin and surrounding areas and buttocks. It stated, "Resident started voices complaints on Friday (4/1/16) during the day. Resident has some slight redness noted around these areas. No open areas are seen. Resident does have some patchy grayish areas on lower buttock and upper leg. Any slight touch to area causes the resident great pain. Treatment with barrier cream is helping little to none. Could you come over and assess resident and make recommendation from there?"

The resident was seen by the CNP (Certified Nurse Practitioner) at 3:57 PM. The note showed a diagnosis of shingles and an order to increase the resident's Hydrocodone to QID (four times per day).

Resident #8 was interviewed on 4/7/16 after the noon meal. He reported that he was getting along better and pain was currently being controlled.

[Reference: (NIH National Institute of Health-Senior Health) Shingles is caused by a reactivation of the chickenpox virus. The virus that causes shingles is a herpes virus, (Another name for shingles is herpes zoster.) The most common complication of shingles is pain – a condition called post-herpetic neuralgia (PHN).

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F 323 Continued From page 16

with injury and one fall with major injury. The resident's BIMs on 1/4/16 was "99", indicating that the resident could not be interviewed. The staff assessed the resident to have short and long time memory issues and was rated as severely impaired in decision making.

b. On 1/4/16 and 4/4/16, using the Morse Fall Scale, the resident was determined to be high risk for falls.

c. On 4/7/16 at 9:15 AM, the resident was observed seated in the day room in her wheelchair with no foot pedals on the chair and her feet dangling above the floor. The facility staff was notified of the resident's positioning. The staff went to check on the resident and verified that the resident should have foot pedals in place on the wheelchair.

d. Review of the resident's progress notes revealed the following:
12/24/15 11:15 AM - "...on floor face down - carpet burn on LFH (left forehead) and slight bruise on left cheek."
12/24/16 11:50 AM - "RN saw resident stand and fall onto left shoulder and rolled face down. Intervention to use pommel cushion in chair - got black eye..."
12/28/15 CNA (Certified Nurse Aide) noticed difficulty raising left arm" - was sent for an X-ray and diagnosed with a fractured left clavicle.
3/31/16 - "... laying on ground in day room - right side with blood dripping from head and wheelchair tipped over on top of resident..."

e. Review of the Resident Incident Report and Fall Investigations for the falls noted the following:
12/24/15 - Immediate Intervention Implemented - Pommel cushion in w/c
1st fall - day room and unwitnessed
2nd fall - hall and witnessed
3/31/16 - Immediate Intervention Implemented -

F 323

3) Licensed staff was educated to appropriate interventions for prevention and reduction of incidents & accidents on 4/28/2016 by the IDNS. All IDT members will be re-educated to appropriate interventions for prevention and reduction of incidents & accidents on 5/3/2016 by the MDS Consultant. This training is included in the orientation program for new staff.

4) Two care plans will be audited for individualized needs and interventions weekly for two months and then one care plan per week for one month by the Interim Director of Nursing/Designee to assure they reflect each individual's plan of care. The data collected will be presented to the QA Committee at least quarterly by the IDNS or her designee including any system failure. The committee will make the decision for further action.

5) Completion Date: 5/10/2016

5/10/16

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F 323 Continued From page 17

none noted
 Found on floor in day room and unwitnessed; hit cube cabinet; w/c on top of resident
 Intervention to prevent future falls - Continue to check on resident every 1 - 2 hours
 Describe Fall History - "Resident's last fall was on 12/24/15 with no injury noted." (Note: Record review evidenced that the resident was injured in the 12/24/15 fall.)
 f. Review of the resident's Order Summary Report dated 3/14/16 revealed that the resident was ordered to receive four medications for hypertension (Bumetanide, Cozaar, Metoprolol, and Norvasc) and two medications for the diagnosis of schizoaffective disorder (Depakote and Seroquel). These medications all have the potential for causing dizziness (Nursing 2016 Drug Handbook), increasing the risk for falls.
 g. Review of the resident's Telephone Orders revealed the following orders:
 3/31/16 - "Monitor stitches on nose & apply triple antibiotic ointment & change Band-Aid Q day"
 4/6/16 - "Increase Tyl to 650 mg po tid (Tylenol 650 mg orally three times a day); OT (occupational therapy) to eval & treat for w/c seating."
 h. Review of the care plan did not show that the facility addressed the resident's shoulder injury and did not include added interventions after the three falls two of which resulted in injuries. (Cross refer to F280)
 i. On 4/7/16 in the morning, the resident's falls were discussed with the Administrative team. They indicated that the pommel cushion was added to the wheelchair immediately with the first two falls and monitoring the resident every one to two hours was implemented after the third fall. There was no evidence to show that monitoring the resident at this frequency would decrease the

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<p>F 323 Continued From page 18</p> <p>resident's accidents/falls.</p> <p>2. On 4/7/16 closed medical record review for resident #10 evidenced the resident was admitted 3/17/15 and had diagnoses that included dementia with behavioral disturbances, depressive disorder, anxiety disorder, hypertension, and malignant melanoma of the skin. The resident expired on 3/11/16 in the facility.</p> <p>a. Review of the resident's 3/7/16 significant change MDS assessment revealed that the resident was assessed to need total assistance from one or two staff members for bed mobility, transfer, locomotion on and off the unit, dressing, eating, toilet use, personal hygiene, and bathing. The assessment noted that the resident had two falls with no injury and two falls with injury. The resident's BIMs on 3/7/16 was not rated, indicating that the resident could not be interviewed. The staff assessed the resident to have short and long time memory issues and was rated as severely impaired in decision making.</p> <p>b. Review of the resident's care plan for being high risk for falls was initiated on 3/30/15 due to the resident's confusion, wandering, unaware of safety needs, psychoactive drug use, and incontinence. The resident's goal was to be "free of falls through the review date". The interventions were:</p> <p>Anticipate and meet needs Be sure call light is within reach and encourage to use it for assistance as needed. Respond promptly to all requests for assistance. Coordinate with appropriate staff to ensure a safe environment with: Floors even and free from spills or clutter, Adequate, glare-free light, Call light, Bed in low position at night. Side rails are ordered, Handrails on walls, Personal items within reach.</p>	<p>F 323</p>
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F 323	<p>Continued From page 19</p> <p>Ensure that ___(Name) is wearing appropriate footwear-wears athletic shoes when ambulating. 2/3/16 - check on res Q 1/2 hr 2/19/16 - fall mat at bedside. c. Review of the Quarterly MDS Assessment summary for the ARD (assessment reference date) of 12/14/15 revealed that "...Has had 2 recent falls and has hematoma and bruises from falls..." d. Review of the resident's Progress Notes for February, 2016 and March, 2016 evidenced the following entries related to falls: 2/1/16 at 6:55 PM - "...tried to sit on her rm mates bed and missed causing her to fall to floor, landing on buttocks, as witnessed by CNA...No evidence she hit head, no injury identified..." 2/2/16 6:33 AM - "...bruise noted to R hip..." 2/3/16 12:10 PM - "This nurse heard ___(name) yelling and went to check on her, she is on the floor in rm ___ on her buttocks...No injury identified, no evidence she hit head..." 2/3/16 1:40 PM - "Kitchen staff called for this nurse and when arrived in dining rm ___(name) is on the floor on her buttocks. Staff reports ___(name) was amb in dining rm and tried to lean against the coffee cart and fell landing on buttocks. Noted light pink area L posterior arm and light pink area L mid back. No redness noted to buttocks or coccyx and no c/o or s/s of pain..." 2/3/16 2:00 PM - "...CNA will stay with resident 1 on 1 as res is so confused and agitated that she may fall again." 2/6/16 2:46 PM - "At 8:10 AM Res on floor in her bathroom. Sitting with feet forward toward toilet..." 2/6/16 4:15 PM - "At 3:10 PM CNAs heard a thump from res room. Res on floor acrossway from chair res was sitting with head under bed...Blood on floor. Removed res from under the bed and has a 10 cc hematoma with a 2 cm cut in</p>	F 323		

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the middle of hematoma....Eyes were dilated....Notified _____(name of hospital)..."

2/6/16 7:27 PM - "Correction Res was lying in bed. It is a low bed and the bed was in the low position. Res fell from the bed instead of the chair."

2/19/16 2:30 PM - "At 9:20 AM res lying on floor by bedside with pillow under head and comforter from bed under res on the floor...."

2/25/16 11:15 AM - "CNA came to this nurse and said resident was sitting on the floor by her bed...was sitting on fall mat on floor...Appears resident slid out of bed from sitting there..."

3/7/16 10:16 AM - "...had a Morse fall scale completed. Previous falls are Yes. More than one diagnosis on file is Yes. Ambulatory aids are None/bedrest/wheelchair/nurse assist...Gait is Normal/bedrest/wheelchair...Overestimates or forgets limits. Overall Morse Fall Score is High Risk for Falling risk."

e. Fax Communication to Physician forms revealed:

A fall on 1/7/16 with a small abrasion to left shoulder

A fall on 2/6/16 at 3:50 PM hit back of had with 10 cm round hematoma; BP 220/140, eyes dilated. The provider response was "Will be seen by _____(name) tomorrow." The immediate intervention implemented according to the documentation on the incident report was to check/monitor q 1 h.

A fall on 2/6/16 with res sitting on bathroom floor f. Review of the February, 2016 Medication Administration Record (MAR) evidenced that the resident received Rocephin 1 gram IM on 2/5/16 and for three days (2/9, 2/10, and 2/11/16) for a urinary tract infection.

g. Review of the provider visit notes for February, 2016 evidenced that the resident was having

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behaviors and agitation. Medication changes included:
 2/1/16 - Increased Duragesic patch (12 to 25 mcg every 72 hours)
 3/17/15 - Sertraline 100 mg by mouth at bedtime; discontinued 2/12/16,
 3/18/15 - Seroquel 50 mg two times a day; discontinued 2/12/16,
 2/4/16 - Lorazepam 0.5 mg oral q12h,
 2/3/16 - Lorazepam 2 mg IM as needed for agitation, repeat in 12 h if needed; discontinued 2/10/16,
 2/24/16 - Haldol 1 mg q12h IM for severe agitation,
 2/23/16 - Haldol 1 mg q4h IM as needed for agitation,
 2/24/16 - Clonazepam 0.25 mg sublingual twice a day.

Although the facility provided a Living Directive dated 2/3/16 for Comfort Care with no hospitalization, there was no evidence that the provider assessed the resident after the significant head injury. The facility addressed the behaviors, some of which were happening at the same time as the resident had a urinary tract infection. There was a lack of information to show that the resident's multiple falls were evaluated, addressed, with the implementation of appropriate, effective interventions.

3. Resident #9 was admitted to the facility on 1/6/16 with diagnoses which included: Alzheimer's disease late onset, major depressive disorder, muscle weakness, anemia, GERD (gastro-esophageal reflux disease), history of pressure sores, and malignant neoplasm of the large intestine and prostate. The resident was also assessed to be a High Fall risk and was identified on the resident's plan of care dated

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NAME OF PROVIDER OR SUPPLIER LAKE ANDES SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 323 Continued From page 22

1/6/16. It stated, "High risk for falls r/t (related to) unaware of safety needs, gait/balance problems, deconditioning, wandering".

a. Resident #9's medical record was reviewed. The progress notes showed the resident had multiple falls with three falls occurring in March, 2016. The entries included a note on 3/3/16 that identified the resident was having increased confusion, wandering in and out of resident rooms and having exit seeking behaviors. It also noted that the resident reported burning with urination.

The resident was identified as having a fall with injury on 3/10/16 and being sent to the hospital. The resident was identified with a right hip femoral neck fracture and scalp laceration. The resident returned from the hospital on 3/14/16 and continued to have two more falls on 3/19/16.

b. Review of the "Resident Incident Reports" for resident #9's falls included:

-3/10/16 at 5:00 PM, "This nurse entered rm (room) and (resident name___) on the floor on his L (left) side in front of the recliner, noted laceration R (right) posterior head 10 cm irreg shape (sign with) some depth- minimal bleeding. Neuro (sign check) is normal-verbal response normal. He also c/o (complained of) R hip pain and noted outward rotation R foot. Lg (large) BM in toilet pants half down pad wet... Immediate intervention implemented: Transported to hospital for head and possible hip fracture."

-3/19/16 at 3:20 PM, "Res sitting on floor by bed. Res was in bed. His 4 x 4 was also (word unknown) (sign for not) hit head. ROM (range of

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F 323	Continued From page 23 motion) WNL (within normal limits) for res. VS (vital signs) done assisted to feet and res req (requested) to toilet... Immediate intervention implemented: Encourages not to get up and keep eye on him and use call lite." -3/19/16 at 7:30 PM, "Res sitting on floor in front of w/c (wheelchair). W/C brakes locked. Res denies c/o's. ROM WNL for res. No injuries noted. Assisted to feet, into w/c then assisted to bed. Did not hit head... Immediate intervention implemented: Check on res freq. Cont to remind res to call for assist and needs assistance to walk/mobility." c. Review of the resident's significant change MDS (minimum data set) five day assessment dated 3/21/16 showed the resident had severe cognitive impairment and required extensive assistance from staff for all ADL's (activities of daily living). d. Review of the resident's plan of care dated 1/6/16. It stated, "High risk for falls r/t (related to) unaware of safety needs, gait/balance problems, deconditioning, wandering". There were three approaches to falls after the resident continued to have more falls. The approaches included: -3/10/16 (the date of the fall which resulted in right hip fracture and scalp laceration), "Remind to use call light." [Note: This approach is not appropriate for a resident with severe cognitive impairment and post surgical repair of right hip fracture.] -3/19/16, "Continue to remind resident to call for assistance and that he needs assistance for mobility."	F 323		

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F 323 Continued From page 24

-3/21/16, "Landing Strip by bed."

The facility failed to ensure this resident, who was dependent for care, received adequate supervision and assistive devices to prevent ongoing falls/accidents.

F 329 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS
SS=D

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:

F 323

F 329

F329

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:

- 1) Resident #3's Gradual Dose Reduction recommendations are current and physician's orders are being followed for the correct doses ordered. Resident #3 receives his medication from the VA and it was ordered timely but the VA does not send medication immediately. Charge nurse was re-educated to notify physician at time of order regarding the delay in medication from the VA and review start date of new order.
- 2) All residents were reviewed on 4/22/16 to ensure that Gradual Dose Reductions had been recommended at least annually and have been followed up by the physician for acceptance of recommendation for reduction or documentation as why it is clinically contraindicated to reduce the dosage.

5/10/16

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F 329	<p>Continued From page 25</p> <p>Based on record review and staff interview, it was determined that the facility failed to determine and document adequate indications for drug use and to ensure medications were not given in excessive amounts or for excessive lengths of time for one of 11 sampled residents (#3). The findings included:</p> <p>A review of resident #3's medical record showed this resident had been on an anti-psychotic medication for over a year without an attempt at reduction, without any documentation of behaviors for indication for use. This was confirmed by staff interview. On 3/18/16 when there was an order for an attempted reduction, the facility failed to ensure the medication was obtained and administered timely.</p> <p>Resident #3's medical record review revealed the resident was admitted to the facility on 9/18/12. The resident's diagnoses included: dementia with behavioral disturbances, hypertension, hypothyroidism, anxiety, BPH (benign prostatic hypertrophy) with indwelling Foley catheter and history of cancer of the colon with colostomy.</p> <p>a. Review of the resident's MAR (medication administration record) for March and April 2016 showed the resident's medications included:</p> <p>-"Remeron 15 mg 8 P(PM) po (orally) senile dementia with delirium, unspecified psychosis with start date of 4/7/2014. [Note: Remeron (Mirtazapine) is an anti-depressant used to treat depression.]</p> <p>-Seroquel 50 mg PO at bedtime for psychosis, anxiety state started 4/21/15. This order was changed on 3/18/16 to a reduced dosage of 25</p>	F 329	<p>3) All licensed staff were re-educated to the guidelines for Gradual Dose Reduction by the interim Director of Nursing on 4/28/2016. This training is included in the orientation program for all new licensed staff.</p> <p>4) Drug Regimen Review will be reviewed monthly by the IDNS to ensure a response is received from the physician and direction regarding the dose reduction. In addition, for those residents getting their medications from the VA, physician will be made aware at the time of the delay of receiving medications from the VA. Families will be contacted to be given choice to order locally or wait for the VA medication. For those choosing to wait, physician will be notified of delayed start time and a new order will be sought. IDNS will meet monthly with Pharmacist to review drug regimen reviews and gradual dose reductions. The data collected will be presented to the QA Committee at least quarterly by the IDNS or her designee including any system failure. The committee will make the decision for further action.</p> <p>5) Completion Date 5/10/2016</p>	5/10/16

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F 329 Continued From page 26
mg. However, on 3/18/16 an entry on the MAR read to continue to give 50 mg dose until new (25 mg) dosage arrives. There was one entry of a 25 mg dose being administered on 3/23/16. (Staff reported the pill had been split for this dose. However, it should not have been as the pill was not scored to ensure appropriate dose.) From 3/24/16 until the time of survey 4/5/16, the resident was still receiving the Seroquel 50 mg dosage. Staff confirmed that the new dosage had still not arrived.

F 329

[Note: Seroquel (Quetiapine) is known as an anti-psychotic drug (atypical type). It works by helping to restore the balance of certain natural substances (neurotransmitters) in the brain. This medication is used to treat certain mental/mood conditions (such as schizophrenia, bipolar disorder, sudden episodes of mania or depression associated with bipolar disorder)]

b. Review of the TAR (treatment administration records) was completed for the last six months (10/1/2015 to 4/1/2016). It showed on 8/22/14 that the facility started monitoring each shift for delusions. The side effects of the psychoactive Med use (Remeron and Seroquel) were started 7/15/14. There was no documentation to show the resident had delusions or side effects during this time, as all entries were marked as zero.

c. Review of the form from the Consultant Pharmacist dated 2/29/16 revealed this comment. "(Resident name___) has received quetiapine since June of 2013. He is currently using quetiapine 50 mg Q HS. He also continues to use mirtazapine 15 mg at bedtime. Per federal regulations, his dosage should now be decreased unless you can provide documentation as to why

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its clinically contraindicated... Please consider a trial of decreasing the quetiapine to 25 mg at HS."

F 329

This form had a checkmark by, "I accept the recommendation as above, please implement as written." The written note showed an order to decrease quetiapine to 25 mg at HS and see orders as of 3/18/16.

A Consultant Pharmacist review on 2/11/15 (a year early) also identified the resident as being on "Seroquel 50 mg and Remeron 15 mg QHS and had asked for a gradual dose reduction. However, there was no response (noted on the form) by the physician to the request.

5/10/16

F 332 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE
SS=D

F 332

F332

The facility must ensure that it is free of medication error rates of five percent or greater.

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and staff interview, it was determined that the facility failed to ensure that it was free of medication errors. Two of twenty-eight medications passed were observed to be incorrectly administered, resulting in an error rate of 7.1%. The findings included:

1. On 4/6/16 at 11:25 AM during the medication pass, nurse (A) was observed to prepare an insulin injection for resident #2, using a Novolog Flex Pen. Based on the resident's standing order for 8 units and the sliding scale dose for a blood

- 1) Nurse (A) was re-educated to prime the insulin pen on 4/7/2016.
- 2) Insulin pen is being primed prior to insulin administration.
- 3) All licensed staff were re-educated to "Flex Pen" administration guidelines on 4/28/2016 by the IDNS.

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F 332 Continued From page 28

glucose of 222, the resident was to receive 12 units total. The nurse was observed to dial 12 units on the pen and inject this dosage. The nurse did not prime the pen prior to giving the injection.

2. On 4/6/16 at 11:35 AM during the medication pass, nurse (A) was observed to prepare an insulin injection for resident #12, using a Novolog Flex Pen. Based on the resident's standing order for 10 units and the sliding scale dose for a blood glucose of 280, the resident was to receive 16 units total. The nurse was observed to dial 16 units on the pen and inject this dosage. The nurse did not prime the pen prior to giving the injection.

3. On 4/7/16, per request of the surveyor, the nurse consultant provided the "Diabetic Medication Pen Administration Reference Sheet". This sheet was dated 2012 and included the following direction:

"Prime (a.k.a. "safety test" or "air shot") the INSULIN pen before each injection:
Always dial to 2 units of insulin before each injection and remove the needle shields.
After dialing 2 units, point pen upward, tap the cartridge gently with finger to collect air bubbles at the the top and push the injection button as directed."

Review of this facility reference revealed that the insulin pens needed to be primed prior to each injection.

4. On 4/7/16 in the morning, the usage of the insulin pen was discussed with the Administrative staff. The nurse consultant verified that the

F 332

4) Medication Administration audit will be completed 2 times per week at varying times for 3 months by the Interim Director of Nursing or her designee for accurate use of the insulin pen including priming prior to injection. The data collected will be presented to the QA Committee at least quarterly by the IDNS or her designee including any system failure. The committee will make the decision for further action.

5) Completion Date: 5/10/2016

5/10/16

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F 332 Continued From page 29
Novolog insulin pen needed to be primed each time it was used.

5. On 4/7/16 in the afternoon in an interview with nurse (A), she knew that the pens had to be primed prior to administration of the insulin. She confirmed that she had not primed the pens during the medication pass observation on 4/6/16.

F 332.

5/10/16

F 365 483.35(d)(3) FOOD IN FORM TO MEET SS=D INDIVIDUAL NEEDS

Each resident receives and the facility provides food prepared in a form designed to meet individual needs.

F 365.

F365

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and resident and staff interviews, it was determined that the facility failed to provide food/liquids prepared in a form designed to meet the individual needs of two of eleven sample residents (#11 and #3). The findings included:

1. On 4/5/16 at 10:30 AM during an observation of the kitchen with dietary staff (B), the Speech Therapist (ST) came into the kitchen. She was working with resident #11, who the ST said was to have pudding consistency liquids. The ST had a glass of liquid which was prepared for the resident. The liquid was observed to be thinner than pudding consistency. The ST stated that the liquid was honey thick and it needed to be pudding thick.

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:

- 1) Resident #11 is receiving pudding thickened liquids through use of the powder thickener. Resident #3 is receiving ground meat texture for all meats served.
- 2) All resident's diets were reviewed and all residents are being served fluid consistency and food texture per their physician's order.
- 3) All dietary staff were re-educated to the physician ordered diets, food texture and fluid consistencies guidelines on 4/28/2016 by the Dietary Manager.

Dietary staff (B) explained that they were now

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F 365 Continued From page 30

using the liquid thickener, instead of the powder. She indicated that staff had added the right amount according to the directions provided by the supplier and posted above the bottle of thickener. Staff (B) said that if the ST wanted the order changed, she needed to talk with the nurse. The ST tried to explain that the order was for pudding thick, not honey thick. The ST left the kitchen to find the nurse.

2. During the evening meal observation on 4/5/16, resident #11 was being assisted (total) to eat her meal. The resident's water and juice were not pudding thick. The surveyor notified the Interim Director of Nursing (DON) that the resident was served liquids which were too thin for pudding consistency. The DON intervened and had the liquids changed to pudding consistency.

3. On 4/6/16 at 11:50 AM during an observation in the kitchen, dietary staff (C) confirmed that they had been educated about the use of the thickener. She said the plan was to use the powder thickener for resident #11. Staff (C) was observed mixing thickened liquids and placing them in the refrigerator.

4. Medical record review for resident #11 revealed that the resident was re-admitted on 8/4/15 with diagnoses that included multiple sclerosis (MS), depressive disorder, convulsions, and diabetes (Type II).

a. Review of the resident's 1/4/16 and 3/28/16 quarterly Minimum Data Set (MDS) assessments revealed that no swallowing disorders or weight loss had been identified. The nutritional section of the assessment listed mechanically altered,

F 365

4) A diet and fluid consistency audit will be completed by the IDNS or her designee three times per week at varying meals for three months. The data collected will be presented to the QA Committee at least quarterly by the IDNS or her designee including any system failure. The committee will make the decision for further action.

5) Completion Date: 5/10/2016

5/10/16

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therapeutic diet. The resident was assessed to need extensive eating assistance (1/14/16) and total eating assistance (3/28/16) by one staff. The resident was observed to need total assistance with eating.

b. Review of a "Fax Communication to Physician" form, dated 3/28/16, related to the resident noted "resident RTF (return to the facility) from _____ (name of hospital) on 12/21/15 with orders for pudding thick liquids. The latest order that was signed on 3/9/16 was for honey consistency liquids. Can you clarify the order for either honey consistency liquids or pudding thick liquids?" The provider's response on 3/30/16 was "Await the ST eval and & recommendations."

c. Review of the resident's "Therapy Screen Form" for ST, signed 3/30/16 at 2:15 PM, had the following comment: "Pt on modified diet and thickened liquids excessive coughing and s/s (signs and symptoms) of aspiration noted."

d. Review of the resident's physician telephone orders evidenced an order dated 3/30/16 at 2:15 PM which stated "Liquids should be pudding thick."

e. Review of the resident's care plan revealed a goal of "... will tolerate pudding consist fluids X 90 days", initiated on 1/6/16. One of the interventions was "follow fluid order by MD (pudding consist. fluids)".

The facility failed to follow the ST recommendation, physician orders for the fluid consistency, and care planned approaches for this resident.

F 365

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F 365 Continued From page 32 F 365

2. Resident #3's medical record review revealed the resident was admitted to the facility on 9/18/12. The resident's diagnoses included dementia with behavioral disturbances, hypertension, hypothyroidism, anxiety, BPH (benign prostatic hypertrophy) with indwelling Foley catheter, and history of cancer of the colon with colostomy.

Review of the resident's MAR (medication administration record) for March and April 2016 showed the resident was on a regular diet with ground meat texture and health supplements of 240 cc everyday with a start date of 2-16-16.

Review of the resident's progress notes included entries on 3/28/16 which showed the resident was on a regular diet with ground meat texture. It also showed the resident was interviewable and cognitively intact with a BIMS score of 15.

During an observation of the noon meal on 4/7/16, the resident was observed to leave the table shortly after receiving his meal. The resident had received a shredded beef sandwich. Review of the menu for this meal evidenced that the regular with ground meat should have been served a ground hot beef sandwich.

During an interview on 4/7/16 with the resident he expressed concerns about the food. He reported that the meat was not always served ground so he could eat it. The resident stated, "My only concern is about the food. The shredded beef we had I couldn't eat it balls up in your mouth and throat. You just can't eat it. The vegetables are served to hard too and you can't chew them. I am supposed to be getting ground meat but they forget. The food used to be a lot better but

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F 365 Continued From page 33
something changed and it isn't good".

F 371 483.35(i) FOOD PROCURE,
SS=F STORE/PREPARE/SERVE - SANITARY

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and staff interview, it was determined that the facility failed to ensure that food was stored, prepared, and distributed in a sanitary manner. The findings included:

1. On 4/5/16 at 10:10 AM during the initial tour of the kitchen with a dietary staff member (B), the following observations were made:

a. In the refrigerator, there was a large plastic bag of hard boiled eggs. The bag was open and there was no date on the bag.

b. In the shake freezer, there were numerous Mighty Shakes which were thawed and did not have a thaw date indicated. Dietary staff member (B) said that they use 43 Mighty Shakes a day.

c. In freezer 1, there was an open, partially unwrapped package of bacon with no date on it.

F 365

F 371 F371

5/10/16

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:

- 1) All refrigerator and freezer food items are closed/sealed and dated when opened and labeled with food name. Items sensitive to thaw dates such as Mighty Shakes will be labeled with a "thaw date" when removed from the freezer. Dishes will be cleaned when stored. Dishwasher will be at 120 degrees or greater prior to the dishes being cleaned in the dishwasher. A new and larger water heater is being ordered. All dishes washed in the three compartment sink will be immersed for at least 10 seconds in the chlorine sanitizer solution. The food storage area is clean and will be placed on a routine cleaning schedule weekly to assure all items are stored off the floor and free of debris. This will be completed by the Maintenance Director.
- 2) All dietary staff were re-educated to the above items on 4/28/2016 by the Dietary Manager. This training will be provided during orientation for new staff.

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F 371 Continued From page 34
The bacon appeared dried on the edges.

Dietary staff member (B) verified the above findings. She threw the bacon out.

d. There was a dirty bowl in the dish cupboard. This observation was verified by dietary staff member (C).

e. Dietary staff (C) was sending dishes through the dishwasher. Observation and interview confirmed that the wash and rinse cycles for the dishwasher needed to reach 120 degrees F. During the first run of the dishwasher, the maximum temperature reached was 110 degrees; 115 degrees was the maximum temperature reached on loads two and three. The dishes were not re-run to ensure that the required temperature of 120 degrees was reached. These temperatures were verified by staff member (C). Additionally, the staff member showed the surveyor the temperature log documentation for the dishwasher which revealed similar temperatures to those observed.

2. On 4/6/16 starting at 11:48 AM, the following observations were made in the kitchen:

Dietary staff member (D) was preparing the pureed foods for the noon meal service. The Executive Director Interim (EDI) was observed to come into the kitchen to assist staff member (D). When the EDI washed several items in the 3 compartment sink, she dipped the items into the sanitizer and immediately removed them. For the sanitizing solution to be effective the dishes need to stay in the sanitizing solution for ten seconds (chlorine sanitizer), thirty seconds (iodine sanitizer), or as directed by the manufacturer of

F 371 3) Dietary Manager/Designee will audit food storage including (dry storage, refrigerator and freezer), dishwasher temperatures and sanitizing of dishes three times per week at varying times for three months.
4) The data collected will be presented to the QA Committee at least quarterly by the Dietary Manager or her designee including any system failure. The committee will make the decision for further action.
5) Completion Date: 5/10/2016

5/10/16

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F 371	<p>Continued From page 35 the chemical used.</p> <p>3. On 4/6/16 at 3:20 PM, observation and interview with dietary staff (E) who was sending dishes through the dishwasher confirmed that the wash and rinse cycles for the dishwasher needed to reach 120 degrees F. At the time of the observation, the staff member ran the dishwasher four times. The highest temperatures varied from 110 to 130 degrees F. The staff member verified that this is the normal temperature range for the dishwasher.</p> <p>4. On 4/6/16 at 3:34 PM, two Certified Nurse Aides (CNAs) returned a tray with three Mighty Shakes to the kitchen. These shakes did not have thaw dates on them. Dietary staff member (F) was observed to return the Mighty Shakes to the refrigerator in the kitchen. (Note: Mighty Shakes are to be used within 14 days of when they are thawed. Without a thaw date, there is no way to ensure when the shake was thawed.)</p> <p>5. On 4/6/16 during the environmental tour with the Maintenance Supervisor (MS) and the Interim NHA (Nursing Home Administrator), the basement was checked and concerns were identified with the area used for food storage and supplies.</p> <p>The basement area was being used for laundry processing, storage of food/freezers, general storage, medical record storage, equipment storage, as well as housing the mechanical area for the facility.</p> <p>The MS reported that they had been having issues with sewer backing up and water in the basement in the past. He reported, "It is a wet</p>	F 371		
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F 371 Continued From page 36
basement and when we get rain we can have water problems. He also reported that when the sewer backed up from the mechanical room, it came into the hallways as well as the room being used for food/freezers and general storage. There was a build up of debris and water marks on the floor in these areas.

Observation of the large room which had freezers and food storage revealed the room was also used for general storage. The area had chest and upright freezers on pallets to prevent water damage. However the floor had a build up of debris and water marks, showing past water/sewer backup. The area had boxes and equipment on the floor creating a potential area for pests. There were also other racks with miscellaneous food supplies.

The Maintenance Supervisor (MS) and the Interim NHA (Nursing Home Administrator) confirmed the floor and room were in need of cleaning.

F 371

5/10/16

F 441 483.65 INFECTION CONTROL, PREVENT SS=F 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,

F 441

F441
The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:

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F 441 Continued From page 37
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 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on record review, observation, and staff interview, it was determined that the facility failed to establish and/or implement and maintain an infection control program in order to provide a safe, sanitary, and comfortable environment which minimized the potential for the spread of infection among the residents. The findings included:

INFECTION CONTROL PROGRAM

On 4/7/16, review of the "Infection Control

- F 441
- 1) The facility has an established infection control program. Residents with signs and symptoms of infections are being monitored and concurrent surveillance of residents is in place to ensure timely follow up and prevention of infections in the facility. Resident #8 has been discharged to home. Resident #2, #12 and #13 has had the glucometer cleaned after each use.
 - 2) Residents were reviewed and those with infections are being monitored and concurrent surveillance of residents is in place. Tracking and trending of infections is in place. Residents needing immediate isolation precautions are care planned individually and timely intervention/precautions are in place. The glucometer is cleaned between each use and Nurse A was re-educated to glucometer cleaning, proper glove use/changing and handwashing procedure related to infection control.
 - 3) Licensed staff were re-educated on 4/28/2016 to the Infection Control Program including concurrent surveillance, tracking and trending, care planning infection and isolation status, glucometer cleaning, glove use/changing and handwashing. Direct care staff were re-educated to glove use/changing and handwashing on 4/28/16 by the IDNS.

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F 441 Continued From page 38
Program" documentation and interview with the Interim Director of Nursing (DON) and Nurse Consultant identified concerns with the infection control program. The staff revealed that there had been changes in staffing and the person who had been doing the duties of the ICC (Infection Control Coordinator) was no longer there. They had been unable to find the the infection control logs and documentation for the program for the past 12 months. They had gone back and started the infection control tracking logs for February and March. There were no other tracking logs available for review at the time of survey.

There was no evidence the facility had maintain an effective infection control program. Nor that a concurrent surveillance of residents having signs and symptoms of infections was done to ensure timely follow up and prevention of infections in the facility.

LACK OF TIMELY INFECTION CONTROL INTERVENTIONS

1. On the initial tour of the facility on 4/5/16 at 9:00 AM with the Interim DON, she was asked if there were any residents who had infections or any resident in isolation. She reported there were a couple residents on antibiotics for urinary tract infections but there were no residents in isolation. There were no isolation supplies noted outside any of the resident rooms during the tour.

Then at 12:30 PM an isolation cart was observed outside resident #8's room. The nurse (A) reported resident #8 was on "Contact Isolation" due to having shingles.

F 441 4) An infection control audit will be completed including, identifying, tracking, care planning residents with infections, glucometer cleaning, glove use/changing and handwashing through observation and record review two times per week for three months. The data collected will be presented to the QA Committee at least quarterly by the IDNS or her designee including any system failure. The committee will make the decision for further action.

5) Completion Date: 5/10/16.

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Review of resident #8's medical record revealed the resident was admitted to the facility on 3/1/16 with diagnoses which included COPD (chronic obstructive pulmonary disease), CHF (congestive heart failure), pulmonary hypertension, lower back pain, generalized edema, and a puncture wound to the right foot with cellulitis. Review of the resident's admission Minimum Data Set (MDS) assessment dated 3/8/16 showed the resident was cognitive with a BIMS (brief Interview for mental status) score of 15.

Review of the resident's progress notes revealed the resident was seen by the CNP (Certified Nurse Practitioner) at 3:57 PM on 4/4/16. The note showed a diagnosis of shingles and an order to increase the resident's Hydrocodone to QID (four times per day) for pain.

Review of the resident's plan of care on 4/6/16 revealed the resident's plan of care had not been updated or revised to address the resident having shingles, "Contact Isolation" or the resident's increased pain.

On 4/7/16 the surveyor was provided an updated plan of care for resident #8 addressing his current needs.

The facility failed to ensure timely infection control procedures were implemented for this resident.

CARE OF EQUIPMENT

On 4/6/16 starting at 11:25 AM, observation during a medication pass by nurse (A) revealed the following:

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F 441

The glucometer was taken into resident #2's room to check his blood sugar level. The meter was placed on a surface in the resident's room. After the meter was used, the nurse returned with it to the medication cart. She used a chemical wipe to wipe the meter and then left it wrapped in the wipe until she had administered the resident's insulin. She confirmed that the glucometer needed to be cleaned after each use since it was a shared glucometer.

Next the nurse took the glucometer into resident #12's room to check his glucose level. The meter was placed on a surface in the resident's room. After the meter was used, the nurse returned it to the cart. No cleansing was done. The nurse administered the resident's insulin.

Then the nurse took the glucometer into resident #13's room without cleaning it or the cleaning the medication cart.

PERICARE and TREATMENT

On 4/6/16 starting at 10:00 AM, during an observation of nurse (A) and two Certified Nurse Aides (CNA G and H) providing pericare and a treatment to resident #1, the following was observed:

The resident's groin and perineum was coated with Eucerin cream.

The resident had a catheter in place but needed pericare to clean up some fecal matter.

The nurse pointed out the three area of skin

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F 441 Continued From page 41
breakdown which were now healed (labia, left buttock, and right thigh) and the rectal fistula which had a small opening. There was a red line on the resident's inner thighs. The staff indicated that the line was from the resident's catheter tubing and they questioned a possible allergy to the tube.

F 441

The nurse changed her gloves and applied Bacitracin to the posterior right thigh. Then she opened the resident's bedside stand and got out the Eucerin container. Then one of the CNAs applied the Eucerin and the nurse returned the container to the drawer. The nurse's gloves were not changed during this part of the care and treatment.

5/10/16

F 467 483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC
SS=E

F 467 F467

The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two.

This REQUIREMENT is not met as evidenced by:

Based on observation and staff interview, it was determined that the facility failed to ensure adequate, properly functioning mechanical ventilation in the following rooms: public restroom, the medication room and two areas in the laundry room. The findings included:

1. During the environmental tour on 4/6/15 with the Maintenance Supervisor (MS) and the Interim NHA (Nursing Home Administrator) issues with the mechanical ventilation system were identified. These rooms had no alternate source of

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- 1) Mechanical ventilation for the public restroom, medication storage area, soiled linen and laundry room was repaired on 4/6/2016.
- 2) All vents were verified to be in working condition throughout the building on 4/7/2016.

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F 467 Continued From page 42

ventilation such as a window and were dependent on mechanical ventilation for adequate air flow. The ventilation system in each of these rooms was checked by holding a single ply tissue paper against the fan vent. There was not enough air movement to hold the tissue up to the vent.

a. The public restroom ventilation was checked and found not working.

b. The mechanical ventilation in the medication storage room was checked due to noted elevated temperatures in the room. The thermometer, which was located on the counter, indicated the temperature in the room was 76 degrees Fahrenheit (F). There were medications, including respiratory treatment medications, that were to be stored at a maximum temperature of 77 degrees F. These medications were stored in cupboards above the counter. The mechanical ventilation was found not working. The MS later reported that the public restroom and the medication storage room were on the same mechanical ventilation unit. Additionally, he had been on the roof and found the mechanical ventilation unit not working so a belt was replaced.

c. The laundry rooms in the basement had a small room identified as the soiled laundry area and an area above the washing machines with mechanical ventilation which were found not working. The MS reported that both of the mechanical ventilation units were supposed to be working to draw air out of the areas. The main laundry room unit was supposed to take air out above the washing machine to prevent cross contamination of linens and to provide acceptable air flow. He was not aware that the units were not working.

F 467

3) Maintenance Director was re-educated to the guidelines of preventative maintenance including the ventilation system by Interim Executive Director on 4/7/2016. The preventative maintenance through TELS electronic system has been updated to include ventilation vents checked for function /cleaned two times per month.

4) Interim Executive Director/Designee will monitor three ventilation units for function/cleaning including TELS completion for preventative maintenance weekly for three months. The data collected will be presented to the QA Committee at least quarterly by the interim Executive Director/ Designee including any system failure. The committee will make the decision for further action.

5) Completion Date: 5/10/2016

5/10/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 04/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/07/2016
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NAME OF PROVIDER OR SUPPLIER

LAKE ANDES SENIOR LIVING

STREET ADDRESS, CITY, STATE, ZIP CODE

740 EAST LAKE ST POST OFFICE BOX 130
LAKE ANDES, SD 57356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 516 Continued From page 43
F 516 483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SS=E SAFEGUARD CLINICAL RECORDS

F 516
F 516. F516

A facility may not release information that is resident-identifiable to the public.

The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

The facility must safeguard clinical record information against loss, destruction, or unauthorized use.

This REQUIREMENT is not met as evidenced by:

Based on observation and staff interviews, the facility failed to ensure resident clinical records were safeguarded to minimize the potential risk against loss, destruction, or unauthorized use. The facility failed to store resident medical records in a manner to minimize risk of water damage. The findings included:

On 4/6/16 during the environmental tour with the Maintenance Supervisor (MS) and the Interim NHA (Nursing Home Administrator), the basement was checked and concerns were identified.

The basement area was being used for laundry processing, storage of food and freezers, general storage, medical record storage, equipment storage as well as housing the mechanical area for the facility.

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:

- 1) The Medical Records temporary relocation project was completed and all records are off the floor.
- 2) Medical Records will continue to be stored off the floor on shelving.
- 3) Staff responsible for storage of medical records were re-educated by the Executive Director to the requirement that medical records must be stored off the floor. The medical records will again be relocated to a larger central space once shelving and new locks are secured.
- 4) Interim Executive Director/Designee will audit medical records storage area one time per week for three months to ensure medical records are stored off the floor and secured. The data collected will be presented to the QA Committee at least quarterly by the interim Executive Director/ Designee. The committee will make the decision for further action.
- 5) Completion Date: 5/10/2016

5/10/16

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NAME OF PROVIDER OR SUPPLIER LAKE ANDES SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356
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F 516 Continued From page 44

The MS reported that they had been having issues with the sewer backing up and water in the basement in the past. He reported, "It is a wet basement and when we get rain we can have water problems. He also reported that when the sewer backed up from the mechanical room it came into the hallways as well as the room being used for food/freezers and general storage. The observation of these rooms and areas noted a build up of debris and water marks on the floor.

The room located off the laundry area was unlocked by MS and identified as the room being used to store medical records. Observation evidenced multiple boxes of medical records sitting on the floor in this room. The MS reported that the records were supposed to be on pallets to prevent water damage to records. The Interim NHA reported that some records had been moved to the area recently and should not have been placed on the floor.

F 520 483.75(o)(1) QAA
SS=F COMMITTEE-MEMBERS/MEET
QUARTERLY/PLANS

A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of

F 516

F 520 F520

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:

5/10/16

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F 520 Continued From page 45
action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, and record review, the facility failed to maintain a QAA (quality assessment and assurance) committee consisting of the director of nursing services, a physician designated by the facility, and at least three other members of the facility's staff. The facility also failed to ensure the QAA committee met at least quarterly to identify issues with respect to which quality assessment and assurance activities were necessary and to develop and implement appropriate plans of action to correct identified quality deficiencies. The facility census was 34. The findings included:

QAA PROGRAM

1. A review of the QAA (Quality Assessment & Assurance) program was done on 4/7/16 at 10:00 AM with the Interim NHA (Nursing Home Administrator). She reported she had been the Interim Administrator for approximately 6 months. The NHA reported the facility had been through recent changes with the DON position and she (previous DON) had been meeting with the MD

- F 520 1) Medical Director was notified via email of the results of the most recent state and Federal survey on 4/8/2016. Quality Assurance was held on 4/19/2016 with the Pharmacist and Medical Director in attendance.
- 2) Members were educated to the Quality Assurance regulation and guidelines on March 30th. Medical Director will attend Quality Assurance meetings at least quarterly.
- 3) All Quality Assurance Committee members were re-educated to the Quality Assurance and Quality Assurance Performance Improvement by another company NHA on 4/14/2016. Training included: Leadership Responsibility and accountability, development of QAPI plan, feedback- data systems and monitoring to identify trends and patterns, performance improvement projects, root cause analysis, systemic analysis and action. Several QAPI tools were reviewed as well.
- 4) Interim Executive Director/Designee will audit Quality Assurance data systems, performance improvement plans and action items one time per month and ongoing. The data collected will be presented to the QA Committee at least quarterly by the Interim Executive Director/ Designee. The committee will make the decision for further action.
- 5) Completion Date: 5/10/2016

5/10/16

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F 520 Continued From page 46
(Medical Director) independently and not as committee about QAA. However, there was no documentation the Medical Director was attending at least quarterly QAA committee meeting or that there was an actual QAA committee in place for the past year. The Interim NHA could only speak to the QAA process in the last month and they were now meeting monthly but had not had the MD in attendance. The facility was working on getting the QAA program in place to be effective and work on appropriate plans of action to correct identified quality deficiencies.

F 520

DEFICIENCIES IDENTIFIED IN SURVEY
2. The deficiencies cited during this survey, included system failures with the delivery of care and services which showed the QAA committee was not functioning effectively in identifying ongoing and current quality deficiencies. This survey's examples of the deficiencies included but were not limited to:
F323: "Accidents and Supervision" was failure to provide a safe environment and adequate supervision to prevent accidents. (Cross refer to F323)
F441: The facility failed to have a functioning Infection Control Program. (Cross refer to F441)
F371: The facility failed to ensure that food was stored, prepared, and distributed in a sanitary manner. (Cross refer to F371)

5/10/16