

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MEADOWBROOK			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 ARROWHEAD DR RAPID CITY, SD 57702	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	The following represents the plan of correction for the alleged deficiencies cited during the survey conducted on 3-3-2016. Please accept this plan of correction as the living center's Credible Allegation of Compliance with the completion date of 3-31-2016. The completion and execution of this plan of correction does not constitute an admission of guilt or wrongdoing on the part of the living center.	
F 176 SS=D	<p>Surveyor: 29162 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/29/16 through 3/3/16. Golden LivingCenter-Meadowbrook was found not in compliance with the following requirements: F176, F241, F253, F280, F281, F325, F431, F441, F466, and F520.</p> <p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, interview, record review, and policy review, the provider failed to properly assess and obtain a physician's order to self-administer medications (med) for one of one random resident (16) observed during medication administration. Findings include:</p> <p>1. Observation and interview on 3/1/16 from 8:40 a.m. through 9:05 a.m. with licensed practical nurse B during medication administration for resident 16 revealed: *She brought into the resident's room several medications including: -Pills. -Nose spray. -Inhaler (breathing medication).</p>	F 176	<p>The plan of correction is completed in good faith and as the living center's commitment to quality outcomes for the residents. In addition, this plan of correction is completed as it is required by law.</p> <p>Resident #16 had a Self Administration of Medication Assessment completed on 3-1-2016 during the actual survey with the results provided to survey team. The original readmission Clinical Health Record assessment was corrected on 3-1-2016 and a note written to reflect the correction. An order was obtained from the CNP on 3-16-2016 to Self - Administer her Nose spray, Inhaler, and Nebulizer once set up is provided by the Licensed Nurse. Resident notified. The individualized care Plan was revised 3-17-2016 to include the agreement by the Intra-disciplinary Team.</p> <p>All current residents require assessment</p>	

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

TITLE

(X8) DATE

[Signature] **ADMINISTRATOR** **3/24/16**

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 for approved plans of correction, results to continued program participation.

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F 176	<p>Continued From page 1</p> <ul style="list-style-type: none"> -Ointment for her skin. -Insulin (injectable diabetic medication). -Nebulizer (a device that turns liquid medication into a mist for inhaling into the lungs) treatment. *The resident self-administered her nose spray, inhaler, and nebulizer after it was set up by the nurse. *LPN B left the room after starting the resident's nebulizer. She stated she would return to the resident's room when the treatment was done to shut off the nebulizer. *She stated she typically did not stay with the resident during her nebulizer administration. -The resident was able to do her own nose spray, inhaler, and nebulizer after it was set up by the nurse. -She agreed that would have been considered self-administration of medications. -She was unsure if the resident had been assessed to self-administer her medications or if she had physician's orders to do so. -She was unsure of the provider's policies related to self-administration of medication. <p>Review of resident 16's medical records revealed:</p> <ul style="list-style-type: none"> *She had returned to the facility on 2/24/16 from an inpatient hospice facility where she had been for a few months in-between admissions. *Upon re-admission to the facility she had: <ul style="list-style-type: none"> -A 2/24/16 Clinical Health Status assessment that stated she did not wish to self-administer medications. -A 2/24/16 Evaluation for Self-Administration of Medications assessment that was checked as "Not Applicable" for self-administration. -No documentation her physician had approved for her to self-administer medications. *No mention of self-administering her medications on her 3/1/16 care plan. 	F 176	<p>and Intra-disciplinary Team recommendations to the MD/designee for Self Administration of Medication when appropriate. All residents will have current MD Self Administration orders re-assessed by the DNS/Designee to confirm the ability to administer Self-Administration of the medications ordered. All of these assessments were completed and MD orders reconciled on 3-18-2016. All of these resident's care plans were reviewed and revised if needed on 3-18-2016.</p> <p>All current Residents who are self administering medications will be reassessed quarterly, upon significant change and annually by the DNS/designee, according to their RAI schedule.</p> <p>All other residents that were admitted prior to 3-7-2016 will be assessed by the DNS/designee with the Self Administration assessment by 3-31-2016. Their revised care plans will be implemented by the DNS/Designee to reflect their ability and/or desire to Self Administer medications by 3-31-2016.</p> <p>All residents admitted to the facility on or after 3-7-2016 were and will be hereafter, assessed within 72 hours of Admission by the DNS/Designee and on-going as a part</p>		

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F 176	<p>Continued From page 2</p> <p>Interview on 3/1/16 at 11:00 a.m. with registered nurse A revealed: *Any resident who self-administered medications should have had a physician's orders to do so. *If they wanted to self-administer medication they should have had an assessment stating they were able to do so in a safe manner. -That assessment would have been completed prior to self-administration and quarterly thereafter. *Resident 16 had recently returned to the facility from hospice and had been a resident in the facility prior to that hospice stay. *She felt resident 16 was capable of self-administering medications after set-up by the nurse. -She agreed there should have been a physician's order and an assessment for her to do so.</p> <p>Interview on 3/1/16 at 1:40 p.m. with the director of nursing revealed any resident self-administering medications should have had: *A physician's order to self-administer meds. *An assessment stating they were okay to self-administer meds. -That assessment should have been done prior to the resident self-administering meds and quarterly thereafter.</p> <p>Review of the provider's May 2012 Self Administration of Medications policy revealed "In order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and</p>	F 176	<p>of the quarterly Nursing assessment process by the DNS/designee according to their individual RAI schedule. Their individualized interim and comprehensive Care Plans will be updated by the Intra-disciplinary team to reflect the desire and or ability to Self Administer medications.</p> <p>Beginning 3-18-2016, all newly admitted residents medical record will be reviewed within 72 hours by the Intra-disciplinary Team to assure the Self Administration of Medication assessment is completed upon admission.</p> <p>Education will be provided to all Licensed Nursing staff and Medication Aides on 3-25-2016 regarding the definition of Self Administration of Medication, following the corresponding assessment policy and not allowing residents to use medications without the MD order, assessment and individual care plan updated.</p> <p>Audits of 10% of the week's admission records will be completed by the DNS/Designee weekly X 4 weeks, then 10 % of the monthly admissions will be audited X 2 to assure completion of Self Administration of Medication assessments. 10% of the entire facility population will have quarterly audits for the Quarterly/Significant change/Annual requirements of the completion of assessments will be completed by the DNS/Designee X 2.</p>	
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F 176 F 241 SS=E	Continued From page 3 there is a prescriber's [physician] order to self-administer." 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on observation, interview, and record review, the provider failed to respond within an appropriate time frame and manner to call lights for 4 of 19 sampled residents (2, 12, 18, and 19) regardless of their mental status, level of care needed, and staff assigned for care. Findings include: 1. Resident group interview on 3/1/16 at 1:00 p.m. with eight random residents voiced concerns about call lights and four of those residents revealed "Call lights were good when they were good. But when they were bad they were really bad." They stated it was hard to sit and wait from twenty minutes up to an hour or more when you had to use the bathroom. Those residents at the group interview chose not to be identified. Surveyor: 32573 2. Interview on 3/1/16 at 2:00 p.m. with resident 2 revealed: *She was frustrated with staff regarding call lights. *When they came to answer her light they would	F 176 F 241	The DNS/designee will provide the results of both audits to the QAPI committee monthly with a Performance Improvement Plan based on results for the next 3 months and will be revised as recommended by the committee. Resident # 2 was interviewed by the ED and SW on 3-21-16 regarding her concerns with call light response and bathing preferences. Her concerns were listened to and addressed with assigned CNAs On 3-22-2016, she spoke to the DNS and stated that the call light response time had improved but staff needed to let her direct her own care. CNAs were reminded in HUDDLE to respect the wished of each individual resident. Resident # 12 was interviewed by the ED on 3-16-2016. She denied feeling abandoned and isolated by staff and stated that she had not been feeling well during the survey and specifically during the Surveyor interviews. She was admitted to the hospital on 3-5-2016 with Pneumonia and was newly diagnosed with Diabetes Mellitus. She readmitted to the facility 3-8-2016. Since returning to the facility, she has expressed that improvement has been noted in call light response and prompt care when requested.	03/31/16	

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F 241	<p>Continued From page 4</p> <p>say they had to get the aide that worked on her hallway. *They would leave, and it could be up to an hour before someone else came to help her. *She did not know why staff could not just help her regardless of what hallway they worked on.</p> <p>Review of resident 2's 12/24/15 Minimum Data Set (MDS) revealed: *She required extensive assistance with bed mobility, dressing, transfers, personal hygiene, and bathing. *She had a Brief Interview for Mental Status (BIMS) score of fifteen indicating she had no mental or memory problems.</p> <p>Surveyor: 20031 3. Review of resident 12's 1/25/16 MDS revealed: *BIMS score was fifteen 15. (That score indicated she had no mental or memory problems). *"As one of my simple pleasures: please assist me with the set-up of my computer." *"My life's simple pleasure is my computer." *"Involve in activities that do not depend on patient's (resident's) ability to communicate."</p> <p>Interview on 3/2/16 at 8:00 a.m. with resident 12 in her room revealed: *She had been waiting for staff to answer her call light since 7:10 a.m. *She stated an unidentified aide came in just after 7:10 a.m. and took her roommate's blood sugar. That aide did not answer resident her call light at that time. *Another unidentified aide brought her the breakfast menu at 7:30 a.m. When she questioned if that aide could help her the aide replied "I have to go get the aide that works on your hallway."</p>	F 241	<p>Resident #18 – 19 (husband and wife) have expressed very specific wishes that staff do not enter their room unless they are present. Resident 18 has Progress Notes dated 2-21-2016 referencing them "becoming quite upset with room being cleaned in spite of being informed prior by SW and ED". Resident 18 and 19 have been residents at GL Meadowbrook since 3-18-2008.</p> <p>CNA (I) will be counseled on 3-25-2016 about seeing a call light and not responding to it.</p> <p>CNA (F) will be counseled regarding general call light response as part of the job description on 3-25-2016.</p> <p>The Golden Living Dignity Policy was reviewed by the ED, DNS, SW and IDT to assure all residents are treated with dignity and cared for in a dignified and respectful manner. The Call Light Use Policy was reviewed by the ED, DNS, SW and IDT to assure that it addresses responding promptly to the resident's call for assistance.</p> <p>Staff education will be provided to All staff on 3-25-2016 to include treating all residents in a manner and in an environment that maintains and enhances each resident's dignity and respect and of the responsibility of ALL staff to respond to call lights, even if not assigned to the room. Residents will be treated in a</p>		

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F 241	<p>Continued From page 5</p> <p>*The aides would leave, and it could be up to an hour before someone else came to help her.</p> <p>*Most answers given by the staff were "Not my job. Or, I need to get your aide."</p> <p>*She did not know why it had to be certain staff to answer certain call lights.</p> <p>***There are more staff around in the afternoons, but that did not mean the service was any better. They walk around in pairs talking and walk right by my room with my light on. There are fewer night staff and they get more done."</p> <p>*She had been diagnosed with multiple sclerosis at a young age.</p> <p>*She had been a resident of the facility for eight years.</p> <p>*She required total assistance and was physically dependent on the staff.</p> <p>***"Little things such as hot coffee, or checking to see if I would like something to drink besides water (orange juice was her favorite) are big things to me."</p> <p>*All she had was her computer for "interaction with the outside world." She also talked with her friends and family by using a headset with the computer.</p> <p>*She would try and engage the aides when they would feed her or do her care. She stated "it's like trying to pull teeth." "Most of the travelers don't smile, and they can't even make small talk."</p> <p>***"When the facility has socials out in the dining room such as ice cream, the residents in their rooms are not served or offered ice cream."</p> <p>*She had attended her care conferences and staff listen and were polite. But it was "all talk and no action around here."</p> <p>Observation from 8:00 a.m. to 8:30 a.m. of the corridor outside of resident 12's room revealed several staff talking, laughing, and walking by her</p>	F 241	<p>manner that does not allow them to feel invisible or decreases self worth in their "home". Additionally, that emptying of urinals and/or commodes need to be emptied EVERY time a Nursing staff member enters the room not just once a shift. Residents have the right to choose the type of bath they want to receive unless a contraindicated medical condition is present.</p> <p>Education will be provided to the Resident council on 3-30-2016 and to new residents upon admission that the practice of turning off call lights when entering the room is appropriate in accordance to our current policy. However, we should be offering assistance prior to exiting the room unless additional staff assistance is required. It will be iterated that if additional staff are required to complete the request, an agreement from the resident regarding a perceived delay in cares is obtained before leaving the room.</p> <p>The ED/designee will monitor call light response time by completing random audits of the units daily for 2 weeks beginning 3- 28-2016, with the ED providing audit results to the QAPI committee and their recommendations for further monitoring followed.</p>	03/31/16	

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F 241	<p>Continued From page 6 illuminated call light just outside her door.</p> <p>Observation on that same day at 8:30 a.m. revealed certified nurse assistant (CNA) H knocked on resident 12's door to answer her call light. She stated she had been with another resident that took longer for care. When CNA H questioned what resident 12 needed, the resident replied she had wanted help to sit up to look at her computer.</p> <p>Continued interview on that same day at 5:25 p.m. with resident 12 revealed: "I feel invisible and forgotten. Both as a person and as a resident in what is now my home." "If they would just recognize me, or the fact that they have seen my call light. I am okay with that. But when my light is on and they walk by or I can hear them just outside my door I feel ignored." "It's the same 'ol thing of 'I'll get someone' or 'I'll get your aide.'" "Even the nurses don't answer the call lights. I really don't understand why any of the staff who are trained in the healthcare profession cannot answer any resident's call light or concern." Surveyor: 36413</p> <p>4. Observations at the following times indicated resident 19's room his urinal was sitting on a bedside table and needed to be emptied: *2/29/16 at 6:30 p.m. *2/1/16 at 10:00 a.m. *2/1/16 at 5:10 p.m. *3/2/16 at 8:30 a.m. *3/2/16 at 10:00 a.m. *3/2/16 at 2:00 p.m. *3/2/16 at 3:00 p.m.</p> <p>Observation in resident 18 and 19's shared room, and interview on 3/2/16 at 1:00 p.m. with CNA I</p>	F 241			

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F 241	<p>Continued From page 7</p> <p>revealed: *She tried to empty resident 19's urinal and his wife's (resident 18) commode once every shift. *She stated "Their call light was on now, and that was what she probably wanted." *CNA I did not answer the call light at that time. -She walked the other direction.</p> <p>Interview on 3/2/16 at 1:30 p.m. with resident 18 revealed she had her call light on to empty her husband's urinal and to empty her commode. CNA F came in their room and turned off her call light and said she would return. **"They never come back when they shut the light off. So I have to put the light on again." **"She (CNA F) does that all the time, and other ones do it too." **"Call lights can take up to an hour or more to be answered."</p> <p>Interview on 3/2/16 at 2:10 p.m. with director of nursing (DON) revealed she would expect urinals and commodes to be checked and emptied several times per shift.</p> <p>Surveyor: 20031 5. Review of the undated Call Light, Use Of policy revealed: **"Purpose: To respond promptly to resident's call for assistance." **"Procedure: 1. All facility personnel must be aware of call lights at all times. 2. Answer ALL call lights promptly whether or not you are assigned to the resident. 6. Answer call lights in a prompt, calm, courteous manner. 7. Never make the resident feel you are too busy to give assistance; offer further assistance before</p>	F 241			

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F 241	Continued From page 8 you leave the room."	F 241			
F 253 SS=C	<p>Interview on 3/10/16 at 10:00 a.m. with the DON confirmed the above issues with call lights. She stated anyone who completes cares for residents should answer a call light.</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on observation, testing, and interview, the provider failed to maintain the inside and outside of the building in a safe and sanitary condition as evidenced by: *The new vinyl flooring and new mopboards were not completely installed in some places and left exposed concrete. *Random door thresholds between the corridor flooring and the resident room flooring were not installed. *The old vinyl flooring in various staff use closets had been removed, and left an uncleanable unsealed concrete surface. *Three of three noted sharps containers were completely full and needed to be replaced in two of two bathing rooms and one of two soiled utility rooms. *The outside of the building in an alcove north of the generator had a variety of old unused equipment, storage containers, pieces of wood, hospital beds, and was full of debris and leaves.</p>	F 253	<p>The Flooring Contractor is in the process of replacing the flooring in the facility hallways, with thresholds and exposed floor to be covered. The Flooring was ordered on 3-15-2016 and work will commence on 4-11-2016, expecting to be done by the end of April. The Clean linen closet across from room 7 was painted and the mop board was replaced on 3-21-2016. The Vinyl flooring that was exposed to concrete in staff use closets will have new tiles and base cove installed by 3-25-2016. The Sharps containers in both tub rooms and in the soiled utility rooms were emptied on 3-1-2016. Alcove on the South side of the building was cleaned out on 3-22-2016. The wall outside of the maintenance office will be repaired and painted by 3-30-2016.</p> <p>All flooring has been inspected for exposure to cement and covered appropriately as of 3-30-2016.</p>		

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F 253	<p>Continued From page 9</p> <p>This unkept area may create a habitat for rodents and insects.</p> <p>*The outside south wall of the maintenance office had crumbled concrete and holes in it. That hole may create an area for nesting birds or habitat for insects.</p> <p>Findings include:</p> <p>1. Observation and interview on 3/1/16 from 7:30 a.m. to 9:15 a.m. with the maintenance supervisor (MS) revealed:</p> <p>*The clean linen closet across from room 7 had unpainted walls from a repair and the mop board was missing from the juncture of the wall and floor.</p> <p>*The lift closet concrete floor was unsealed and uncleanable.</p> <p>*The threshold was taped with duct tape, electrical tape, or was gone at rooms 22, 40, 41, and 47.</p> <p>*The west medical supply/wound care closet had old glue and tape on the floor. There was no mop board to seal the floor and wall juncture.</p> <p>-Interview with the MS confirmed the above findings.</p> <p>-He stated a commercial contractor had replaced the flooring last fall and they had not returned to complete the job.</p> <p>*The sharps containers in three areas (two resident bathing areas and one soiled utility room) were completely full. Used syringes and vials lay on top of the flip lid.</p> <p>-Interview with the MS revealed if he saw a full container he would replace it with a new one.</p> <p>-He did not know whose responsibility it was to monitor or dispose of the full containers.</p> <p>*The outside area on the south wall of the maintenance office, north of the generator, had</p>	F 253	<p>All sharps containers have been inspected to ensure they are not overfilled on 3-25-2016. All exterior areas of the building were inspected for debris as of 3-25-2016. All exterior walls will be inspected for crumbling concrete and repaired by 3-25-2016.</p> <p>The Night Licensed Nurses will daily inspect every sharps container in the facility and empty any that are at or above the overfill line to maintain them at acceptable levels. The full Sharps containers will be locked and taken to the facility designated secured area.</p> <p>Preventative maintenance tasks will be added to inspect in the following areas:</p> <ul style="list-style-type: none"> • Exposed flooring, including closets (monthly) • Debris buildup outside of the facility (monthly) • Exterior wall deterioration (monthly) <p>Education will be provided to all staff on 3-25-2016 that observation of physical plant concerns must be reported to the Maintenance Director upon discovery and that all staff are responsible for reporting issues regarding condition of the Physical plant.</p>		

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F 253	Continued From page 10 the following: -Four hospital beds. -Snow blower. -An old food warmer. -A large yard storage unit. -An old maintenance cart. -A large trash can. -A few sheets of stainless steel. -Several pieces of various sizes of wood. *Those items were covered and enveloped with a layer of dust, dirt, and leaves. -Interview with the MS confirmed the above finding. He stated he had not had a chance to clean-up that area. -He did not know if those items could be used or were all trash. -He agreed it could harbor insects and rodents and was within direct sight of the area reserved for residents who smoked. *The brick and mortar wall on the south side of the maintenance office had a hole in the top of the mortar about the size of a softball. The mortar around that area had eroded and crumbled. -Interview with the MS confirmed that finding. -He stated he was not aware of the repair needed on that outside wall. -He agreed it could harbor insects and rodents.	F 253	Licensed Nursing staff will be educated on 3-25-2016 about the nightly rounds to observe Sharps containers and the process for removal and storage. Audits of flooring, outside debris, deteriorating exterior walls and overfilled sharps containers will be done weekly X 4 weeks and then monthly X 3 months by the Maintenance Director to ensure compliance. Results will be reported by the Maintenance Director to the monthly QAPI Committee.	03/31/16	
F 280 SS=E	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	F 280	Resident #1 was assessed using the Side Rail Assessment on March 22, 2016 and the continued use of ½ side rails was deemed to be appropriate. His care plan was reviewed and revised on March 21, 2016 to include the continued use of ½ Side rails for positioning enablers.		

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F 280	<p>Continued From page 11</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation, record review, and interview, the provider failed to ensure care plan(s) for: *Six of nine sampled residents (1, 3, 5, 6, 8, and 10) had included problems, goals, and interventions for the use of grab/positioning bars on their beds. *One of one sampled resident (2) who needed a bed bath had it on her care plan. *One of one sampled resident (2) who needed her weight monitored. Findings include:</p> <p>1. Observation from 2/29/16 at 3:45 p.m. through 3/2/16 at 11:00 a.m. revealed residents 3, 5, and 6 had grab/positioning bars on their beds.</p> <p>Review of residents 3, 5, and 6's care plans revealed: *Resident 3's was last revised on 2/11/16. *Resident 5's was last revised on 2/11/16. *Resident 6's was last revised on 1/5/16.</p>	F 280	<p>Resident #3 was assessed by Therapy on 12-2- 2014 and recommended the use of ½ side rails. She was reassessed by nursing personnel on March 22, 2016 and found to be appropriate to have ½ side rails continue to be provided on her bed. Her care plan was reviewed and revised March 22, 2016 to reflect the continued recommendation for ½ side rails as enablers.</p> <p>Resident #5 was assessed by Therapy on 6-2-2015 and the use of ½ side rails was deemed appropriate. He was assessed using the Side Rail Assessment on 6-2-2015 and the use of ½ side rails was deemed to be appropriate for positioning. His care plan was reviewed and revised on 3- 22-2016 to reflect the continued recommendation for ½ side rails as enablers.</p> <p>Resident #6 was assessed using the Side Rail assessment on September 3, 2015 quarterly thereafter and the continued use of ½ side rails was deemed to continue to be appropriate on 3-21-2015 after observation of use by her. Her care plan was reviewed and revised on 3-21-2016 to include the continued use of ½ Side rails for positioning enablers.</p> <p>Resident #8 was assessed using the Side Rail Assessment on 3-2-2016 and the use of ½ side rails was deemed to be inappropriate. Her care plan was reviewed and revised on 3-22-2016</p>		

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F 280	<p>Continued From page 12</p> <p>*None of the above care plans addressed the use of grab/positioning bars while those residents had been in bed.</p> <p>Surveyor: 32573</p> <p>2. Review of resident 2's 1/1/16 care plan revealed: *An intervention initiated 12/30/15 of "monitor weight per physician order, Notify physician of weight gain/loss."</p> <p>Review of resident 2's complete medical record revealed: *There had been no physician order for monitoring weights.</p> <p>Interview during the survey with the director of nursing (DON) revealed: *She would not expect a physician order for weights. -She thought this was automatically populated into the care plan by the computer.</p> <p>3. Interview on 3/1/16 at 2:00 p.m. with resident 2 revealed she had not gotten a bath "in three weeks."</p> <p>Interview on 3/2/16 at 7:30 a.m. with the DON revealed resident 2 got a bed bath when she asked for one. She refused to take a normal bath or shower.</p> <p>Review of resident 2's complete medical record revealed: *She had gotten a bed bath less than three weeks ago. *Her preference for only taking a bed bath had not been on her 1/1/16 care plan.</p>	F 280	<p>during the actual survey to NOT include the use of ½ Side rails for positioning enablers and the physical rails were removed by the Maintenance Director on the same day.</p> <p>Resident #10 was assessed using the Side Rail Assessment on 3-22- 2016 and the continued use of ½ side rails was deemed to be appropriate. Her care plan was reviewed and revised on 3-22-2016 to include the continued use of ½ Side rails for positioning enablers after observation by RN.</p> <p>Resident #2 had the CNA care revised on 3-3-2016 to specify the preferred bed bath. She was interviewed on 3-22-2016 to allow her the opportunity to restate or revise her preferred bathing method. Her comprehensive care plan was revised on 3-7-2016 to reflect her stated preference. Resident was weighed 3-17-2016. Her weight recorded and Dietician notified for further assessment. Care plan interventions for weight plan were revised 3-22-2016. She requests to direct her weight plan. IDT notified on 3-24-2016.</p> <p>All residents that were identified as being at risk for potential weight loss will have their care plan reviewed by the Intra-disciplinary Team by 3-31-2016.</p> <p>All residents remain at risk for care plan accuracy. Each Resident chart and care plan will be reviewed by the IDT within</p>		

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F 280	Continued From page 13 Surveyor: 36413 3. Observation from 2/29/16 at 6:00 p.m. through 3/2/16 at 9:30 a.m. revealed resident 1 had grab/positioning bars on his bed towards the head of the bed. Review of resident 1's 2/29/16 care plan revealed the positioning bars had not been addressed or mentioned on it. Surveyor: 35237 4. Observations from 2/29/16 at 3:45 p.m. through 3/1/16 at 5:30 p.m. revealed residents 8 and 10 had grab/positioning bars on their beds toward the head of the bed. Review of resident 8's 2/29/16 care plan revealed the positioning bars had not been mentioned or addressed on it. Review of resident 10's 3/2/16 care plan revealed the positioning bars had not been mentioned or addressed on it. 5. Interview on 3/1/16 at 1:30 p.m. with the director of nursing revealed: *Positioning bars for residents should have been assessed and documented on their care plans. *They did not have a specific care planning policy. -They used the Resident Assessment Instrument Manual as a reference. *Charge nurses and the interdisciplinary team were responsible for updating resident care plans.	F 280	72 hours of admission. Interim (IPOC) admission care plans will be initiated until the Comprehensive Care plan is developed and completed within 7 days of completion of the Comprehensive assessment according to the RAI process. All licensed nurses and department heads will remain responsible for care plan revision according to changes in resident preference or changes in condition. All staff are responsible for communicating and resident physical care changes or preferences to the Licensed Nurses and/or department heads. All resident care plans will be reviewed throughout the next quarter to assure correct interventions are identified and implemented. The Care Plan Policy and Procedure was reviewed by the Intra-disciplinary team. All CNA care sheets and resident eMAR/eTAR will be considered part of the care plan. Care planning will not include facility protocols or standards of practice but individualized interventions based on the individual resident needs and desires. Education will be provided to all staff regarding communicating resident needs and preferences and Licensed Nurses/department personnel on completion of a care plan. It is an on-going process based on the changing needs and wants of each individual resident on 3-25-2016 and 3-31-2016.		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281			

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F 281	<p>Continued From page 14</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure professional nursing standards were maintained or carried out for:</p> <p>*One of one randomly observed resident's (16) insulin (injectable diabetic medication) administration.</p> <p>*One of one randomly observed resident's (9) medication administration through an enteral feeding tube (tube directly into the stomach or intestine for nutrition and medication).</p> <p>*Two of two sampled residents (10 and 13) who received hemodialysis (procedure used when kidneys no longer work properly) and had access sites that should have been monitored.</p> <p>*Ten of thirteen sampled residents (2, 3, 5, 6, 7, 8, 9, 10, 12, and 13) who had incomplete documentation on their medication and treatment administration records (MAR and TAR). Findings include:</p> <p>1. Observation and interview on 3/1/16 from 8:40 a.m. through 9:05 a.m. with licensed practical nurse (LPN) B revealed: *Resident 16 had two different types of insulin she was to receive that morning. *While LPN B was prepping the insulin pens (pen-like device containing insulin) she: -Applied the needle device to both pens without wiping the rubber seal of the pen with an alcohol wipe first. -Set the Novolog FlexPen to administer eight</p>	F 281	<p>F280 continued</p> <p>Monitoring of care plans will be provided by the DNS/Designee within 72 hours of F 280 continued</p> <p>admission for all new residents. All residents will have audits completed by the DNS/designee quarterly with the completion of each required MDS.</p> <p>Results of these audits will be presented by the DNS/Designee to the QAPI committee monthly and recommendations for further monitoring followed.</p> <p>F281</p> <p>Resident #16 did not have any ill effects from the use of the Insulin pen on 3-1-2016. Her blood sugar level was recorded 228 at 8 am on 3-1-2016. The Blood sugar was recorded at 12 noon on 3-1-2016 as 216. At 5 pm, her Blood sugar was recorded at 253.</p> <p>LPN B received education regarding the use of the Insulin pen by the Director of Clinical Education on 3-2-2016.</p> <p>LPN B completed her Medication Administration Examination on 3- 18-2016. Her in-person competency testing by the Director of Clinical Education will</p>	03/31/16

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F 281	<p>Continued From page 15</p> <p>units of insulin.</p> <p>-Set the Lantus Solostar pen to administer eighteen units of insulin.</p> <p>*She did not prime (process to remove air) either of those insulin pens prior to setting the dose.</p> <p>*During administration of the insulin to resident 16 she held each needle and insulin pen into the resident's skin for about two to five seconds each.</p> <p>*Following administration of those insulins she revealed she:</p> <p>-Had not heard of priming an insulin pen before setting the dose and administering.</p> <p>-Agreed there was a potential for an inaccurate dose to the resident if it had not been given according to the manufacturer's guidelines.</p> <p>-Had not had specific training related to insulin pen administration.</p> <p>Interview on 3/1/16 at 11:00 a.m. with registered nurse (RN) A regarding insulin pen administration revealed the pens should have been:</p> <p>*Cleaned with alcohol prior to attaching the needle to the device.</p> <p>*Primed with two units prior to setting the resident's dose of insulin.</p> <p>*Held into the resident's skin during administration for at least five seconds to make sure the whole dose was administered.</p> <p>Interview on 3/1/16 at 4:50 p.m. with the director of clinical education revealed:</p> <p>*LPN B was a temporary staff nurse that had been working there for one to two weeks.</p> <p>*LPN B had not had completed a medication pass competency or insulin pen competency yet.</p> <p>*She usually had newly hired nurses perform a written test prior to starting medication administration to test their knowledge.</p> <p>-LPN B had not completed that written test.</p>	F 281	<p>Resident #9 did not show any adverse conditions related to the amount of H2O used by RN A to deliver the medications and flushes during the medication pass.</p> <p>Physician Orders were obtained for Resident #9 H2O requirements on 3-2-2016 to be administered before and after medication administration.</p> <p>RN A was counseled on 3-2-2016 regarding the need to provide water prior to and following Medication administration via Enteral feeding tube per Dietician recommendations and a subsequent Physician's order.</p> <p>All residents with enteral feeding tubes present upon admission or placed after admission are at risk for appropriate amounts of H2O used during medication administration. We currently have 1 additional resident who has an enteral feeding tube. His MD orders for H2O flushed before and following medication administration were also received on 3-1-2016.</p> <p>The Enteral Medication Administration policy was reviewed by the DNS/ED/Intra-disciplinary team.</p> <p>Education will be provided to all licensed nursing personnel and the Dietician regarding the specificity of the amount of water used from flushes of the Enteral</p>		

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F 281	<p>Continued From page 16</p> <p>*Following the above observation she had educated LPN B on insulin pens using the Novolog FlexPen competency form.</p> <p>Review of the provider's May 2012 Injectable Medication Administration policy revealed: **"To clean stopper with alcohol pad and allow to air dry (except on pen devices and pre-filled syringes)." *For pen devices "Dial dose as instructed by pen manufacturer." **Remove air bubbles." **Inject medication." -For subcutaneous (applied under the skin), "Inject slowly." -No specific amount of time was mentioned to hold the needle in place.</p> <p>Review of the provider's undated Novolog FlexPen Competency form revealed: **"8. Wipes the rubber seal with alcohol swab." **"9. Removes protective seal from new needle and screws on to pen." **"12. Dials a test dose of 2 units. Holds the pen upright and taps to bring any bubbles to the top." **"13. Presses the INJECT button all the way and checks that insulin has come out of needle. The dial will return to "0" if this occurs. This step may be repeated up to 6 times to ensure priming. If unable to prime after 6 attempts, replaces pen." **"15. Dials in ordered dose (insulin)." **"17. Injects dose, keeping needle at 90 [degree] angle to skin and keeping needle in place for at least 6 seconds with button pushed all the way in and dose at "0"." **"18. Release button after 6 seconds and removes needle."</p> <p>Review of the provider's undated SoloStar pen for</p>	F 281	<p>feeding tube for all residents 3-25 and 3-1-2016.</p> <p>A monthly Physician Order reconciliation process by the DNS/designee will allow on-going monitoring of appropriate H2O flush order for residents who receive medications via enteral tube. This process will in place by 3-31-2016</p> <p>Resident # 10's Clinical Health Record dated 2-16-16 was amended to include her AV fistula on 3-2-2016. An MD order which verified her Dialysis schedule was obtained 3-22-2016. An MD order to check AV fistula site was obtained 3-2-2016.</p> <p>Resident #13 discharged from the facility to home on 3-5-2016.</p> <p>All current residents with dialysis are at risk for emergency concerns with their access site. All residents' orders were reviewed by 3-22-2016 to assure their access site will be observed every shift by a licensed nurse.</p> <p>All newly admitted residents after 3-7-2016 with dialysis will have a chart review within 72 hour of admission to assure the MD order for observation of their access site is present.</p> <p>The monthly Physician Order reconciliation process by the DNS/designee will allow on-going</p>		

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F 281	<p>Continued From page 17</p> <p>Lantus insulin Competency form revealed: ***8. Wipes the rubber seal with alcohol swab." ***9. Removes protective seal from new needle and attaches to pen, keeping push-on needle straight as attaching it." ***12. Dials a test dose of 2 units. Holds the pen up and taps to bring any bubble to top." ***13. Presses the INJECT button all the way and checks that insulin has come out of needle. The dial will return to "0" if this occurs. This step may be repeated twice to ensure priming. If unsuccessful after 3 attempts, replaces needle and attempts priming again. If unable to prime after two needles, replaces pen." ***15. Dials in ordered dose (units)." ***17. Injects dose, keeping needle at 90 [degree] angle to skin and keeping needle in place for 10 seconds." ***18. Releases button after 10 seconds and removes needle."</p> <p>2. Observation and interview on 3/1/16 from 8:15 a.m. through 8:35 a.m. with RN A during resident 9's medication administration through her enteral feeding tube revealed: *She prepared three medications that included: -Two separate tablets by crushing them and putting each of them into plastic medication cups. -One capful of a powder type medication into a larger plastic cup. *She added approximately 5 to 10 milliliters (ml, unit of measurement for liquid) of water to each of those crushed medications and approximately 90 ml of water to the powder medication. *She stated there was no specific amount of water to add to those medications, it was up to the nurse to decide. *During the administration she: -Administered approximately 30 ml of water prior</p>	F 281	<p>monitoring of orders to observe the dialysis access site every shift remains in effect. This process will begin by 3-31-2016.</p> <p>An Ad Hoc QAPI identified issues with documentation for the following: Resident #7-eTAR, Resident #8 eTAR, Resident # 10 eTAR, Resident #3 eTAR, Resident #5 eTAR, Resident #6 eTAR, Resident #2 eTAR, Resident # 9 eTAR, Resident # 13eTAR and Resident # 12 eTAR. We are unable to document the completion of historically scheduled items in the Medical Record.</p> <p>As noted in the Ad Hoc QAPI plan, the PCC Care Management Dashboard report is audited daily by the Charge Nurse prior to the end of each shift and the documentation completed prior to the Licensed Nurse leaving for the day. This daily audit process was initiated on 3-1-2016 and revised on 3-22-2016. The reports are being provided to the DNS/designee and are being reviewed in the daily Clinical Start-Up meetings by the Intra-disciplinary team.</p> <p>Results of the reports/audits will be presented to the QAPI committee by the DNS/designee monthly X 3 months and further committee recommendations followed.</p>	03/31/16	

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F 281	<p>Continued From page 18</p> <p>to the first medication, the specific amount was not measured.</p> <p>-Then gave the first medication in the 5 to 10 ml of water it was mixed with.</p> <p>-Added an unmeasured amount water to the second medication and administered that.</p> <p>*The second medication did not go down the feeding tube well, so she added a little more water to it which was not measured.</p> <p>-She stated the second medication did not mix well, and sometimes needed more water to make it go down the tube better.</p> <p>*She thought 30 ml was the normal amount of water to give before and after administering medications through a feeding tube.</p> <p>*She agreed she had not measured all the water she administered during the above observation.</p> <p>*She confirmed resident 9's MAR, and physician's orders should have specified an amount of water to use for administration of her medications.</p> <p>*The dietitian should have been involved in how much water resident 9 needed.</p> <p>-She would not have been able to know how much each nurse was administering at each medication pass since it was not specified.</p> <p>Review of resident 9's 12/21/15 signed physician's orders revealed no mention of the amount to be used for water flushes related to medication administration through her feeding tube.</p> <p>Interview on 3/1/16 at 1:40 p.m. with the director of nursing (DON) revealed: *Resident 9 should have had directions for the amount of water to be used for medications through her feeding tube listed on her MAR and physician's orders. *It should not have been left up to the nurse to</p>	F 281			

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F 281	<p>Continued From page 19</p> <p>decide the amount of water to use for flushes and with medication administration through a feeding tube.</p> <p>Review of the provider's November 2013 Enteral Tube Medication Administration policy revealed: **2. Crush immediate-release tablets into a fine powder, and dissolve in 5-10 ml of warm water, or prescribed amount." ***12. Put 30 ml of water in syringe and flush tubing using gravity flow." ***13. Pour dissolved/dilute medication in syringe and unclamp tubing, allowing medication to flow by gravity." ***14. Flush with 5 ml of water between each medication." ***16. Flush tubing with 30 ml of water, or prescribed amount."</p> <p>3a. Observation and interview with resident 10 on 2/29/16 at 4:30 p.m. and on 3/1/16 at 5:15 p.m. revealed she: *Was admitted on 12/24/15 and been in the hospital a few times since then. *Went to dialysis on Monday, Wednesday, and Friday every week. *Had a fistula (surgically made access site) for dialysis in her left forearm.</p> <p>Review of resident 10's medical record revealed: *She was initially admitted on 12/24/15 and had two hospitalizations since that time. -Her most recent hospital return was on 2/16/16. *Her diagnoses included end-stage renal (kidney) disease. *Her 12/24/15, 1/27/16, and 2/16/16 Clinical Health Status Assessments did not mention her left arm fistula. *A 1/28/16 Order Summary Report that was</p>	F 281			

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F 281	<p>Continued From page 20</p> <p>signed by the physician on 2/16/16 had not mentioned her Monday, Wednesday, Friday dialysis or her left arm fistula.</p> <p>Review of resident 10's following MARs and TARs revealed: *For February and March 2016 there was no mention of her left arm fistula or checking the site. *In January 2016 her left arm fistula was scheduled to be monitored every shift. -That entry was discontinued on 1/26/16. -There were eighteen of seventy-seven times not initialed as completed prior to 1/26/16.</p> <p>Review of resident 10's 3/2/16 care plan related to her dialysis and left arm fistula revealed: *The date initiated was 2/17/16. *Interventions for that area included: -"Check access site daily fistula/graft/catheter-signs of infection (redness, hardness, swelling, pain, drainage, elevated temperature, body chills)." -"Monitor thrill (feeling) and bruit (sound) daily and document findings; report abnormal findings to physician."</p> <p>Interview on 3/2/16 at 8:00 a.m. with RN A regarding resident 10 revealed: *Her fistula site should have been monitored by the nurse every shift according to their policy. *There should have been an entry on her TAR to check the fistula site every shift, so it would not get missed by the nurse. *She confirmed her current TAR for March 2016 did not have an entry to check her fistula. *She thought that entry did not get added back into her orders when she had returned from the hospital, and it should have.</p>	F 281			

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F 281	<p>Continued From page 21</p> <p>Interview on 3/2/16 at 9:05 a.m. with the DON revealed she expected fistula and dialysis sites to be monitored every shift by the nurses. She agreed resident 10's site had not been monitored according to their policy.</p> <p>Surveyor: 32573 b. Review of resident 13's complete medical record revealed: *He had dialysis every Monday, Wednesday, and Friday. *A 2/16/16 intervention to check his dialysis access site (shunt [opening for fluid exchange] site) daily for signs of infection. *There had not been daily documentation the shunt was checked for infection.</p> <p>Surveyor: 35237 c. Review of the provider's 10/5/15 Dialysis Guideline policy revealed: *"Check fistula for bruit (listening to fistula) or feel for a thrill (by touching the fistula.) This must be done daily, best after dressing is removed." *Daily fistula/graft checks included to "Check for any signs of infection daily, these may appear as redness, hardness, swelling, pain, drainage, and elevated temperature and body chills. Call physician promptly." *For monitoring/compliance the following elements should have been in place for the center to demonstrate satisfactory compliance with the guide: "daily documentation of fistula/site on eTAR/UDA [electronic treatment administration record/user defined assessment]."</p> <p>4. Review of resident 7's TAR from 2/1/16 through 2/28/16 revealed orders for: *Gerisleeves (arm protectors) bilateral (both)</p>	F 281			

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F 281	<p>Continued From page 22</p> <p>arms every day shift. -That had not been initialed as completed one time. *Check air mattress every shift to ensure it was plugged in and functioning. -That had not been initialed as completed two times. *Foley catheter (drain tube inserted into the bladder) care every shift. -That had not been initialed as completed three times.</p> <p>5. Review of resident 8's TAR from 2/1/16 through 2/28/16 revealed orders for: *Wound care to coccyx (tailbone) every day shift. -That had not been initialed as completed one time from 2/22/16 through 2/28/16. *Wound care to right foot every day shift. -That had not been initialed as completed six times from 2/7/16 through 2/23/16. *Bactroban (antibiotic) ointment to right foot ulcer (open area) three times daily. -That had not been initialed as completed for two times from 2/24/16 through 2/27/16. *Offload (remove pressure) right lateral (outer side) foot every shift. That had not been initialed as completed thirteen times. *Must wear oxygen at all times to be checked three times a day. -That had not been initialed as completed twenty-six times. *Titrate oxygen to keep saturation more than 90 percent every shift. -That had not been initialed as completed fourteen times.</p> <p>6. Review of resident 10's TAR from 1/1/16 through 1/26/16 revealed an order to monitor left arm fistula for thrill and bruit every shift. That had</p>	F 281			

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F 281	<p>Continued From page 23 not been initialed as completed eighteen times.</p> <p>Surveyor: 29162 7. Review of resident 3's TAR revealed an order to cough and deep breathe four times daily for prevention of pneumonia. From 2/1/16 through 2/28/16 there had been six times the treatment had not been initialed as having been completed.</p> <p>8. Review of resident 5's TAR revealed orders for: *Hydrocerin cream to bilateral legs at bedtime. From 2/1/16 through 2/28/16 there had been two times the treatment had not been initialed as having been completed. *Oral care after meals and at bedtime. From 2/1/16 through 2/28/16 there had been five times the treatment had not been initialed as having been completed.</p> <p>9. Review of resident 6's TAR revealed orders for: *Passive range of motion in left elbow and the use of an elbow extension brace. From 2/1/16 through 2/28/16 there had been two times the treatment had not been initialed as having been completed. *Oxygen at 2 liters per minutes (flow of oxygen) to keep blood oxygen level at greater than 89 percent. 2/1/16 through 2/28/16 there had been one time the treatment had not been initialed as having been completed.</p> <p>Surveyor: 32573 10. Review of resident 2's TAR revealed it had not been completely filled out. There were twenty-three areas (skin condition review, wound care, catheter care, and skin care) left blank that should have been completed.</p> <p>11. Review of resident 9's TAR revealed it had not</p>	F 281			

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F 281	Continued From page 24 been completely filled out. There were seven areas (dental care, positioning, checking feeding tube placement, skin care) left blank that should have been completed. 12. Review of resident 13's TAR revealed it had not been completely filled out. There were two areas (skin condition review) left blank that should have been completed. Surveyor: 20031 13. Review of resident 12's February 2016 TAR revealed: *Weekly Skin Assessment every day shift every Thursday. Order date 7/25/13. -A skin assessment had not been completed on 2/4/16 and 2/18/16. *Check air bed to ensure that it was plugged in and functioning properly. Order date 7/23/15. -The checks had not been completed thirteen of eighty-seven times in that month. Interview on 3/2/16 at 11:00 a.m. with the DON confirmed all areas of the TAR should have been initialed when the treatment had been provided. If there were no initials, the treatment would be considered not completed.	F 281			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a	F 325	Resident #9 was weighed on March 16, 2016. Her weight was recorded as #177.4. The potential for weight loss were reported to the MD on 3-11-2016. New orders were obtained for 1 scoop of protein powder/120cc water daily through		

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F 325	Continued From page 25 nutritional problem. This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on record review, interview, and policy review, the provider failed to: *Identify significant weight loss for 1 of 2 residents (9) who received tube feeding. *Obtain weights to monitor for weight loss for 2 of 13 sampled residents (2 and 9). Findings include: 1. Review of resident 9's complete medical record revealed: *She had been admitted to the facility on 12/3/15. *She was receiving her feedings through an enteral tube ((tube directly into the stomach or intestine for nutrition and medication). -There had not been any weights recorded in her electronic record or paper chart until 1/15/16. *Her weight recorded on 1/15/16 was 183.8 pounds (lb). *Her next weight was at 181 lb. on 2/18/16. *Her 12/10/15 admission Minimum Data Set (MDS) assessment had her weight at 194 lb. *She had greater than five percent weight loss from 12/10/15 to 1/15/16. -That would be considered a significant weight loss per state regulations and their policy. Review of resident 9's nutrition assessments by the registered dietician (RD) since admission revealed: *The 1/11/16 assessment stated "noting wt. [weight] 11/7/15 194# [pounds], unable to find a	F 325	her feeding tube. On 3-22-2016 she weighed #178.8. Dietician and MD notified of weight gain. Weekly weights will be obtained while the resident is receiving protein powder per MD order. Resident # 2 was weighed 3-17-2016. Her weight recorded and Dietician notified for further assessment. Resident was interviewed by the DNS on 3-22-2016, she stated that she was not concerned about her current weight and did not want to be weighed more frequently than monthly. A note was entered in the medical record. Her care plan interventions for her self directed weight plan were revised 3-22-2016. IDT notified on 3-24-2016. All residents admitted to Golden Living at Meadowbrook are at risk for significant weight loss. Review of the resident chart and care plan within 72 hours after admission will validate that an admission weight has been obtained. The IDT will determine whether a MD order should be obtained for weekly monitoring. All residents will have a monthly weight obtained unless contraindicated or the resident refuses. All residents with significant weight loss/gain will be reviewed weekly and as needed by the Intra-disciplinary team with recommendations provided to the MD. Orders will be included in the Plan of Care.	

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F 325	<p>Continued From page 26</p> <p>more recent wt., staff has been asked to weigh resident."</p> <p>-That above weight was from the hospital before her admission.</p> <p>*She used the electronic record to monitor weights.</p> <p>*The 1/25/16 assessment noted over 5 percent weight loss over the last two months. That was not considered a significant loss due to being over her ideal body weight.</p> <p>-There had been no information if the resident should have been monitored for continued weight loss.</p> <p>-There was no physician's order for her to be on a weight loss diet.</p> <p>-There had been no documentation the physician had been notified of her weight loss.</p> <p>*The 2/29/16 assessment stated "1/15/16 183.8#, 10/18/15 203.6#, triggered for an 11% wt. loss the last 90 days but resident was outside of this facility when the wt. loss occurred."</p> <p>Interview on 3/1/16 at 2:20 p.m. with the dietary manager revealed they had not been notified of any weight loss for resident 9. That should have been reported to them.</p> <p>Interview on 3/1/16 at 3:00 p.m. with the director of nursing (DON) revealed: *Residents should have been weighed at least monthly. *They should have been weighed more often if needed. *She had not known of resident 9's weight loss and would look into it.</p> <p>Interview on 3/1/16 at 5:00 p.m. with the RD revealed: *She had trouble getting weights for residents</p>	F 325	<p>DNS/designee will monitor weight measurements obtained for resident's daily/weekly or monthly during the Clinical Start up meeting starting 3-17-2016. Any noted significant weight changes will be discussed by the Intra-disciplinary team and the MD/Dietician/Responsible party will be notified timely. This process was initiated 3-17-2016.</p> <p>The Weight Monitoring and Weight and Height Measurement Policies were reviewed by the Intra-disciplinary team.</p> <p>Education will be provided to All Nursing staff on 3-24-2016 that includes the definition of a significant weight change, the importance of obtaining an accurate weight when requested to obtain which includes using the same weight scale, only including the appropriate items to be weighed I.E. w/c, O2 tank, same clothing, etc.</p> <p>All Results of recorded significant weight changes will be monitored by the Dietary Services Manager and will be reported to the QAPI Committee monthly by the Dietary Services Manager and recommendations by the committee followed.</p>	3-31-16	

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F 325	<p>Continued From page 27 from the provider.</p> <ul style="list-style-type: none"> *She had asked staff and the director of nursing (DON) to get residents' weights several times. *She was not concerned with the weight loss of resident 9 even though it had flagged as significant. *She expected resident 9 to be weighed at least twice a month, so she could monitor for continued weight loss. *Resident 9 was not being weighed as she had requested. <p>Interview on 3/2/16 at 7:30 a.m. with the DON revealed:</p> <ul style="list-style-type: none"> *The original weight for resident 9 on her MDS was taken from hospital paperwork. *Staff had not weighed her on admission. *The weight on the MDS was not accurate to her knowledge. <p>2. Review of resident 2's complete medical record revealed:</p> <ul style="list-style-type: none"> *A note in her paper chart stated her weights were maintained electronically. *She had no recorded weights in her electronic record. *She had a weight of 82 lb on her 12/24/15 admission MDS. *She was at risk for skin breakdown. *She had chronic pressure ulcers. *Her 2/29/16 care plan had an intervention of monitor weight per physician's order. Notify physician of weight gain/loss. -There was no physician order regarding weight. <p>Interview on 3/1/16 at 5:00 p.m. with the RD regarding resident 2 revealed:</p> <ul style="list-style-type: none"> *She was on nutritional supplements, because she had a weight loss and skin integrity risk. 	F 325			

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F 325	<p>Continued From page 28</p> <p>*There were no weights for the resident. *She had asked several times for her weight. *She needed the resident's weights, so she could monitor her for weight loss.</p> <p>Interview on 3/2/16 at 3:10 p.m. with the DON revealed: *She would not have expected a physician order for weights unless there was a special reason. *She thought the weight intervention on resident 2's care plan probably should not have been on there. *She did not know why resident 2 had not been weighed. *Residents should have been weighed at least monthly.</p> <p>Review of the 2/26/16 Weight and Height Measurement policy, version 2 revealed: *The procedure purpose was to: -Obtain accurate weight and height of each resident. -Maintain constant control of weight changes. -Identify significant change in condition. *Documentation guidelines included "notify the charge nurse or physician of all weight changed of five pounds (or 5%) or more in a 30-day period or ten percent in a 180-day period or per state requirement. *There were no care plan documentation guidelines.</p> <p>Review of the 12/16/15 Weight Monitoring policy revealed: *Weight should have been recorded by nursing department "upon admission, monthly and more often if risk is identified." **"When weight change is significant (five percent in one month, seven and a half percent in three</p>	F 325			

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F 325	Continued From page 29 months, or ten percent in six months) or severe, the licensed nurse should notify the resident's physician and obtain treatment orders if given." *The nurse should also have notified the resident's family or legal representative. *The provider was responsible for notifying the dietician.	F 325			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431	The Medication room refrigerator/ freezer temperature log was within the recommended temperature range for storage of medications throughout the month of February/March 2016 in spite of the observed frost build-up in the freezer compartment. The medication room refrigerator was defrosted on 3-20-2016. The freezer will be defrosted weekly by the DNS/designee following the initial cleaning on 3- 20-2016. Maintenance of the temperature log will continue to be by licensed nursing personnel daily per Storage of Medications policy. Monthly Audits of the freezer being defrosted and the temperature log within acceptable limits will be completed monthly by the consultant Pharmacist beginning 3-31-2016.		

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F 431	<p>Continued From page 30</p> <p>package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, interview, manufacturer's instructions review, and policy review, the provider failed to: *Keep the refrigerator free from frost build-up in one of one medication room. *Secure Fentanyl (government-controlled narcotic pain medication) patches awaiting destruction. *Properly store randomly observed residents' medications to prevent cross-contamination (spreading germs) in one of three medication carts (west) and two of two treatment carts. *Maintain labels for randomly observed residents' prescription medications in two of two treatment carts. *Maintain one of one observed liquid, controlled medication in the refrigerator according to the manufacturer's instructions. Findings include:</p> <p>1. Observation on 3/1/16 at 8:15 a.m. and on 3/2/16 at 9:05 a.m. revealed there was a large amount of frost build-up in the freezer part of the medication refrigerator in the medication room. *Interview at those times with registered nurse (RN) A and D confirmed that finding. *RN A was unsure if there was a system in place to defrost the refrigerator. -She agreed the frost build-up could eventually affect the temperature and the medications that were stored there.</p>	F 431	<p>Results of the temperature log/freezer defrost audits will be presented to the QAPI committee monthly by the DNS/designee and further recommendations of the committee followed beginning 3-30-2016.</p> <p>Education of all Licensed Nursing personnel will be provided on 3-24-2016 regarding the daily requirement to monitor the temperature of the refrigerator and freezer in the Medication room, the weekly cleaning schedule and the appropriate storage of refrigerated medications.</p> <p>No reported misplaced transdermal narcotic patches while awaiting destruction were reported to any facility personnel prior to or during the survey which ended 3-3-2016. No residents were identified during the survey.</p> <p>All residents with MD orders for Transdermal Narcotic Patches are at risk for having their patches misappropriated upon removal. Each resident will continue to have a Controlled Substance Count Record implemented when the medication is received from the Pharmacy.</p> <p>As of 3-24-2016, all residents that have Transdermal Narcotic Patches have had their individual controlled substance</p>		

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F 431	<p>Continued From page 31</p> <p>2. Interview on 3/2/16 at 9:05 a.m. with RN D during the medication room audit revealed: *Fentanyl patches were destroyed by a nurse and a witness by placing them into a sharps container (a box that contained sharp objects such as used needles). *When the sharps container became full it went to the maintenance room. *All staff had access to the maintenance room. *She confirmed there still would have been some Fentanyl medication left in those patches. -They would not have been considered secured in an area where all staff had access to them.</p> <p>Interview on 3/2/16 at 9:23 a.m. with the director of nursing (DON) and RN A regarding Fentanyl patch destruction revealed: *They would have put used Fentanyl patches into the sharps container with a nurse and a witness to destroy them. *They confirmed those full sharps containers were stored in the maintenance room that was not a secured area. *All staff would have had access to those used Fentanyl patches.</p> <p>Review of the provider's 7/2/15 Guidance on Disposal of Transdermal Narcotic Patches policy revealed: *"Transdermal patches containing controlled substances present a unique situation with the potential for abuse, misuse, and diversion, and the substantial amount of controlled medication remaining in the patch after use. The facility's policies must address safe and secure storage, limited access and reconciliation of controlled substances in order to minimize loss or diversion, and provide for safe handling, distribution and</p>	F 431	<p>include signatures by 2 Licensed Nurses with the date and route of destruction noted.</p> <p>The Guidance on Disposal of Transdermal Narcotic Patches was reviewed by the DNS and Consultant Pharmacist on 3-2-2016 which confirmed that the Fentanyl patch should be folded and flushed in a toilet; witnessed and documented by a second licensed provider.</p> <p>Education of all Licensed Nurses regarding destruction of the Transdermal Narcotic Patches will be provided 3-25-2015.</p> <p>Random audits of the documentation of Fentanyl patches destruction will be completed weekly X 2, monthly X 2 by the DNS/designee beginning March 25, 2016.</p> <p>Results of the audits will be reported to the QAPI committee by the consultant Pharmacist monthly with the recommendations of further auditing followed.</p> <p>All unlabeled prescription medications observed during the survey were destroyed 3-2-2016 by RN. All over-the-counter and Topical medications were separated by barrier in each Medication/Treatment cart to prevent cross contamination on 3-11-2016.</p>	

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F 431	<p>Continued From page 32 disposition of the medications." **"In the presence of another licensed [provider name] employee, flush the folded patch down the toilet."</p> <p>3. Observation and interview on 3/2/16 at 9:50 a.m. with the director of clinical education/RN during audit of the east treatment cart revealed: *A large container of Silvadene (prescription burn medication) cream that had been partially used and had no label for a specific resident. *A tube of triamcinolone (TMC, prescription steroid medication) cream that had been opened and had no label for a specific resident. *A bottle of TMC lotion that was opened with a label that was un-readable. *In that same area of the cart were multiple residents' medications that included: TMC, anti-fungal creams and powders, skin cleansers, and wound sprays. -There were no barriers separating each of those medications from one another. -She would have expected them to be separated to create a barrier and prevent cross-contamination.</p> <p>Observation and interview on 3/2/16 at 10:00 a.m. with the director of clinical education/RN during audit of the west treatment cart revealed: *A tube of TMC that was opened with a torn label. It was not possible to identify which resident the medication belonged to. *Another tube of TMC with the label torn off. *A tube of Santyl (prescription wound medication) that was partially used with no label for a specific resident. *A large container of Silvadene cream that was partially used and the label had been torn off. *Over-the-counter medications that were opened</p>	F 431	<p>The opened bottle of Lorazepam oral concentrate was destroyed during the actual survey by an RN and the Consultant Pharmacist on 3- 2-2016.</p> <p>Resident 16 was not using the lorazepam oral concentrate, so the MD was contacted and the order was discontinued on 3-2-2016.</p> <p>Storage of schedule 4 and 5 liquid narcotics that require refrigeration will be maintained in the medication room refrigerator per the Storage of Medications policy.</p> <p>Nightly audits of all medication carts are being completed by the Licensed Nurses. This includes reviewing the scheduled 4 and 5 medications that are liquid to assure appropriate storage. This process was revised 3-2-2016.</p> <p>The Storage of Medication policy was reviewed by the DNS and the Consultant Pharmacist on 3-2-2016. All medication carts will be audited by the Consultant Pharmacist by 3- 31-2016 and will have barriers placed between all powders, creams, lotions, etc.</p> <p>Daily audits of medication carts by the Licensed Nurses will continue to occur with the results provided to the DNS/designee. Any discrepancies in storage identified in the audit will be</p>		

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F 431	<p>Continued From page 33</p> <p>and not labeled for specific residents' use that included: Hydrophor (dry skin medication) ointment, antifungal powders and creams, mentholatum (cough/congestion medication) ointment, and Hibiclens (skin and wound cleaner).</p> <p>-Those medications were not separated from one another.</p> <p>-She would have expected them to be separated by a barrier to prevent cross-contamination.</p> <p>Observation and interview on 3/2/16 at 10:10 a.m. with the director of clinical education/RN during audit of the west medication cart revealed: *Several residents' powders, lotions, and creams were stored together without barriers separating them from one another. *She confirmed those were not stored properly to prevent cross-contamination.</p> <p>4. Observation and interview on 3/2/16 at 10:10 a.m. with the director of clinical education/RN during audit of the west medication cart narcotics drawer revealed: *An opened bottle of Lorazepam (controlled anti-anxiety medication) oral concentrate for resident 16. *On the top of the box of Lorazepam were directions to refrigerate and store at a cold temperature between 36 and 46 degrees Fahrenheit (F). *She confirmed that medication had not been stored in the refrigerator as indicated on the box. *The medication quality could have been affected, and the medication should not be used.</p> <p>5. Interview on 3/2/16 at 1:30 p.m. with the DON and RN A regarding the medication carts, treatment carts, and the medication room</p>	F 431	<p>resolved immediately with follow-up the next business day.</p> <p>Education will be provided to all Licensed Nurses on 3-25-2016 to review the Storage of Medication policy including but not limited to Schedule 4 & 5 liquid narcotics.</p> <p>A culmination of the audit results will be presented to the QAPI committee monthly X 3 months by the DNS/designee and further recommendations for monitoring followed.</p>	03/31/16

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F 431	<p>Continued From page 34</p> <p>revealed:</p> <ul style="list-style-type: none"> *The refrigerator should not have had a build-up of frost. It should have been defrosted quarterly. *They confirmed prescription medications should have been labeled by the pharmacy for specific residents and not maintained for use if there was no label or the label had become un-readable. *Medications for multiple residents including the powders, creams, and antifungals listed above should have had barriers separating them from one another to prevent cross-contamination. *The DON thought the Lorazepam was okay to store at room temperature for thirty days after opened, but she would check the manufacturer's instructions. <p>Interview on 3/2/15 at 2:15 p.m. with the DON and review of the Lorazepam Oral Concentrate instructions for use revealed it should have been stored at a cold temperature between 36 and 46 degrees F. She confirmed they should have kept that medication in the refrigerator as directed.</p> <p>Review of the provider's May 2012 Storage of Medications policy revealed:</p> <p>*Procedures included:</p> <ul style="list-style-type: none"> -"C. All medications dispensed by the pharmacy are stored in the container with the pharmacy label." -"F. Medications labeled for individual residents are stored separately from floor stock medications when not in the medication cart." <p>*Temperatures included:</p> <ul style="list-style-type: none"> -"A. Medications and biologicals are stored at their appropriate temperatures and humidity according to the United States Pharmacopeia [medication making] guidelines for temperature ranges." -"C. Medications requiring refrigeration are kept in 	F 431			

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F 431	Continued From page 35 a refrigerator at temperatures between 36 degrees F and 46 degrees F with a thermometer to allow temperature monitoring." *There was no specific mention of how to store multiple resident's medications to prevent cross-contamination.	F 431	LPN L was incorrect when she revealed to the unidentified surveyor that Resident # 17 was still having symptoms of Clostridium Difficile. No documentation of continued diarrhea is noted in the resident's Medical Record diarrhea X 48 hours prior to 2-29-2016.		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a 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.	F 441	Communication to the MD had been sent on 3-1-2016 to obtain an order to obtain a stool sample. The return communication for the MD was to obtain a sample only if resident continued to have loose stools on 3-2-2016. A MD order to discontinue contact precautions based on the negative lab result was originally received from the MD on re-admission to the facility on 2-5-2016. Therefore, when a stool sample was obtained, the negative lab result was reported on 3-11-2016. Contact precautions were discontinued. CNA H was in her 2nd day of orientation and should have requested assistance from another staff member. CNA H did not return to work and did not receive additional education. CNA G was attempting to follow the posted instructions for the facility tub however the tub had since been replaced. CNA F followed the instructions for tub cleaning as she had been instructed during orientation however; the tub has since been replaced.		

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F 441	<p>Continued From page 36</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237</p> <p>Surveyor: 36413 A. Based on observation, interview, record review, and policy review, the provider failed to ensure two of two whirlpool tubs and one of one shower area were properly cleaned after all residents had used them including one of one randomly observed resident (17) with Clostridium Difficile (C-diff) (a spore bacteria that causes infectious diarrhea). Findings include:</p> <p>Surveyor: 35237 1. Observation and interview on 2/29/16 at 4:30 p.m. with resident 17 in her room revealed: *She was sitting in her wheelchair with her eyes closed and her call light on. *Upon entering the room she stated she was waiting for staff to help her to move a little in her wheelchair, because she was uncomfortable. *She shared the room with another resident. *Her roommate was laying in bed, did not speak, and had a machine for enteral tube feeding (tube going directly into the stomach for nutrition and medication) that was running. *On her roommate's side of the room there was: -A plastic three-drawer container that had items including disposable gloves and gowns in it.</p>	F 441	<p>The Director of Clinical Education provided on-the-spot training to all scheduled CNAs for the tub cleaning procedure on 3-2-2016.</p> <p>The facility had a procedure in place to clean the shower area with bleach after bathing a resident with Clostridium Difficile however the supplies required for use needed to be restocked. Upon awareness by the Maintenance Director, the supply was restocked immediately.</p> <p>CNA C was a contracted CNA and she was terminated from the facility on 3-7-2016 for non-related issues so re-training was not able to be completed.</p> <p>RN D is in her orientation period at the facility. She had not have received training on cleaning the tub.</p> <p>Education by the Director of Clinical Education during the survey included cleaning of the shower area with a 10 % bleach solution following use by a resident with an active diagnosis of C-Diff. The education included the procedure of any resident diagnosed with C-Diff using the shower only as the last resident bathed for that shift and the shower/shower chair being cleaned with 10% Bleach and allowed to dry for 10 minutes.</p> <p>A revision of the Orientation checklist for all CNS was made on 3-22-2016 to</p>		

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F 441	<p>Continued From page 37</p> <p>-A waste basket with a red biohazard (used for potentially hazardous waste) disposable bag.</p> <p>Interview on 2/29/16 at 4:45 p.m. with licensed practical nurse (LPN) L regarding resident 17 revealed she:</p> <p>*Was currently on isolation for C-diff. *Still had symptoms of infection including diarrhea. *Was not on antibiotics at that time.</p> <p>Review of resident 17's medical record revealed: *She: -Had been re-admitted from the hospital on 2/5/16 with a diagnosis of C-diff. -Was on an antibiotic from 2/5/16 through 2/14/16. -Had not been on antibiotics since 2/14/16. -Continued to have incontinent (unable to control) diarrhea. *Her physician had not been updated on her continued diarrhea.</p> <p>Surveyor: 36413 Interview on 3/1/16 at 10:15 a.m. with an anonymous certified nursing assistant (CNA) revealed: *When she comes on shift, the duties of the leaving CNAs were not done. *She was not provided orientation on how to clean the whirlpools or the shower rooms. *There was no bleach cleaner in the shower room.</p> <p>Interview on 3/2/16 at 11:00 a.m. with CNA H revealed: *She had given the first whirlpool bath of the day in the east hallway. *She had not cleaned the whirlpool when she had</p>	F 441	<p>include whirlpool and shower cleaning as well as the care of a C-Diff resident during the bathing process.</p> <p>Resident # 17's CNA care sheet was updated on 3-2-2016 to include the Diagnosis of Clostridium Difficile. Her Care Plan would not have included cleaning instructions of her care equipment as this would be considered a facility standard of practice. She was no longer on antibiotics during the survey and was undergoing re-evaluation of the continued active diagnosis..</p> <p>Contact precautions were discontinued for Resident 17 on 3-11-2016. However, the resident's bathing method remains a shower.</p> <p>The CNA orientation checklists for CNA H, CNA J and CNA K were updated on 3-4-2016 after their education by the Director of Clinical Education was completed for cleaning resident care items, handwashing/hand hygiene policy and isolation policy as noted in the survey.</p> <p>The Cleaning and Disinfection of Environmental surfaces policy was reviewed and appropriate supplies were</p>		

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F 441	<p>Continued From page 38 finished.</p> <p>*This was her first day on the floor, her preceptor had called in sick, so she was working on her own.</p> <p>*She had not received any instruction on cleaning the whirlpool.</p> <p>Interview and observation on 3/2/16 at 11:30 a.m. with CNA G revealed:</p> <p>*She had given the second bath of the day in the east hallway tub room.</p> <p>*She assumed the whirlpool had been disinfected.</p> <p>*She did not clean the tub before she had used the whirlpool for her resident.</p> <p>*She was unclear what the whirlpool cleaning instructions on the wall meant.</p> <p>*There was not a measuring cup in the shower room to measure the disinfectant.</p> <p>*There was about one inch of a clear liquid in an unlabeled spray bottle that she assumed was the disinfectant.</p> <p>-No other disinfectant or bleach concentrate was in the shower room.</p> <p>*She usually did not measure the disinfectant when she cleaned the tub.</p> <p>*She usually did not time the disinfectant, because she was in a hurry.</p> <p>-Instructions were to disinfect for ten minutes.</p> <p>-She could not find a timer, and there was no clock on the wall.</p> <p>Interview and observation on 3/2/16 at 11:40 a.m. with CNA F regarding cleaning of the whirlpool tub revealed:</p> <p>*She filled the whirlpool tub with water to above the chair.</p> <p>-The instructions sheet on the wall gave directions to add water to "one inch below three</p>	F 441	<p>placed in the tub/shower areas on 3-2-2016.</p> <p>The Employee Training on the Infection Control Policy was reviewed by the Director of Clinical Education and the Orientation checklist was revised on 3-22-2016.</p> <p>Education of all staff will be provided on 3-24-2016 regarding The Clostridium Difficile Policy and the implementation of Contact isolation precautions when a resident is identified as having a positive diagnosis. All Nursing staff will be provided with education regarding cleaning of the Tub/Shower when a resident has an active Clostridium Difficile diagnosis.</p> <p>The 4-6-15 Infection Control Program policy will be reviewed by the QAPI committee by 3-31-2016 and any recommendations for current facility process followed.</p> <p>The West Unit tub room seat cushion was replaced on 3-11-2016. Tiles in the chemical dispensing area will be replaced by 3-30-2016. Sink in the housekeeping area was emptied and cleaned on 3-18-2016.</p>		

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F 441	<p>Continued From page 39 tabs."</p> <p>-The whirlpool tub did not have three tabs. *She added disinfectant to the water but would not measure it. *She found the timer in the top cupboard in the back. *She agreed the timer was not used to keep track of the recommended ten minutes for disinfectant.</p> <p>Interview on 3/2/16 at 12:10 p.m. with the director of clinical education revealed she had just reviewed whirlpool cleaning with CNAs. She was unable to provide documentation of that education.</p> <p>Interview on 3/2/16 at 12:25 p.m. with the director of nursing (DON) revealed: *The instructions posted on the east hall whirlpool room were not for the new whirlpool. -The whirlpool had been replaced five or six months ago. *The manufacturer's recommendations for the new tub included: -Remove each impeller cap (part of the tub's jets) and clean individually. -Take a long handled brush and thoroughly clean the jet casings. *No instructions were posted in the west shower room with the old tub that was still being used.</p> <p>Interview on 3/2/16 at 2:00 p.m. with CNA C regarding cleaning a whirlpool tub revealed she did not clean the shower any differently when a resident had C-diff.</p> <p>Interview on 3/2/16 at 2:15 a.m. with RN D revealed: *She would have cleaned the shower chair with the same disinfectant, without bleach, for all</p>	F 441	<p>Cups and drinks in the West tub room were disposed of on 3-1-16 and the beverage rings were cleaned on 3-4-2016.</p> <p>All resident use areas will be inspected for exposed floors and non-cleanable surfaces and repaired by 3-30-2016. All resident care areas were inspected for personal beverages and disposed of on 3-1-2016.</p> <p>Education on the importance of not having personal beverages in resident care areas will be provided to all staff on 3-25-2016.</p> <p>The auditing of the condition of shower/tub chairs, non-cleanable surfaces, and the housekeeping sink will be completed monthly X 3 by the Maintenance Director.</p> <p>Results of the audits will be presented monthly to QAPI committee by the ED/designee and further recommendations for monitoring followed.</p>	03/31/16	

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F 441	<p>Continued From page 40</p> <p>residents including those with C-diff. *She agreed there was usually not any bleach disinfectant in the shower rooms.</p> <p>Interview on 3/2/16 at 2:20 p.m. with CNA E revealed she did not clean the shower chair any differently when a resident with C-diff used the shower chair.</p> <p>Interview on 3/2/16 at 3:15 p.m. with the infection control licensed practical nurse (LPN) revealed the director of clinical education RN did all the teaching for shower and whirlpool cleaning. *She did not have documentation of the audits for staff-cleaning whirlpools. *She denied observing staff cleaning whirlpools.</p> <p>Interview on 3/2/16 at 3:40 p.m. with CNA F revealed she did not use bleach when cleaning the shower chair after a resident with C-diff had used it.</p> <p>Interview on 3/2/16 at 4:00 p.m. with the DON revealed: *She agreed resident 17 was still having diarrhea and symptomatic of C-diff. *Her expectation had been residents with C-diff could use the shower as long as it had been cleaned appropriately using a bleach product. *Her expectation was the CNAs would have used the bleach disinfectant to clean the shower area after a resident with a C-diff infection had used it. *Residents with C-diff usually showered last on their bath days.</p> <p>Surveyor: 35237 Interview on 3/2/16 at 4:10 p.m. with the DON revealed: *They used the Centers for Disease Control</p>	F 441			

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F 441	<p>Continued From page 41</p> <p>(CDC) guidelines for infection control practices. *Residents with C-Diff were expected to be on contact precautions. *She did not think there was a specific policy related to C-Diff, but she would look for it.</p> <p>Surveyor: 36413 Review of the provider's undated CNA Orientation checklist did not include shower or whirlpool cleaning.</p> <p>Interview on 3/2/16 at 4:35 p.m. with the DON revealed her expectation would have been to include whirlpool and shower cleaning with the CNA Orientation checklist.</p> <p>Surveyor: 35237 Review of resident 17's bathing report from 2/6/16 though 3/2/16 revealed she had received five showers from three different CNAs.</p> <p>Review of resident 17's 3/2/16 care plan revealed: *She had bowel incontinence. *She required staff assistance with personal care and transfers. *For transfers she used a Hoyer (sling type of equipment used to move a person from one place to another) lift, and she used a wheelchair to move around. *For her C-diff infection the interventions included: -"Follow contact precautions." -"Monitor vitals signs as needed." -"Provide adequate nutrition." -The goal was the infection will resolve without complication and had a target date for 5/12/16. *In the C-diff focus area there was no specific mention of:</p>	F 441			

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F 441	<p>Continued From page 42</p> <ul style="list-style-type: none"> -Monitoring her diarrhea. -What products should have been used to clean her care equipment after use. -If she had been on antibiotics or what her treatment was. <p>Interview on 3/2/16 at 5:00 p.m. with the environmental services district supervisor related to residents with a C-diff infection revealed:</p> <ul style="list-style-type: none"> *Housekeeping staff attended a morning stand-up meeting to find out about new infections for any residents. *The communication was not always good between nursing and housekeeping when an infection was found at other times of the day. *Housekeeping staff were not responsible for the cleaning of the whirlpool tub or shower chair. *Nursing staff were responsible for cleaning of resident care equipment. *Housekeeping staff was aware that bleach products were to be used for cleaning with a resident with a C-diff infection. <p>Interview and record review on 3/3/16 at 8:00 a.m. with the infection control nurse of the CNA care sheet for resident 17 revealed:</p> <ul style="list-style-type: none"> *That sheet was updated by RN A, and there was no record kept of previous versions. *The current sheet had been last updated on 2/29/16. *There was no mention of the resident's current C-diff infection, or she was on contact precautions. -She confirmed those areas should have been addressed on the care sheet to make sure the CNAs had been aware of them. *She was scheduled for showers on Thursday and Sunday in the morning. -Six other residents were scheduled on either 	F 441			

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F 441	<p>Continued From page 43</p> <p>Thursday or Sunday to shower or use the whirlpool tub in the afternoon.</p> <p>*There was no instruction to shower any known resident with C-diff at the end of the day or as the last resident for showers.</p> <p>Surveyor: 36413 Review of the provider's 12/1/14 Cleaning and Disinfection of Environmental Surfaces policy revealed in units with C-diff, to use a 1:10 dilution (one part bleach to 9 parts water) of household bleach for routine environmental disinfection.</p> <p>Review of the provider's 1/1/14 Employee Training on Infection Control policy revealed: *All staff and personnel should have completed orientation and training on preventing the transmission of healthcare associated infections. *Contracted and agency personnel were required to participate in facility-specific infection control orientation and training before having direct contact with residents.</p> <p>Review of the provider's CNA Orientation Checklist for CNA H, CNA J, and CNA K revealed dates and signatures were omitted by the director of clinical education. That checklist indicated areas to be done during orientation for: *Cleaning resident care items policy. *Handwashing/hand hygiene policy. *Isolation precautions.</p> <p>Review of the provider's August 2014 Clostridium Difficile policy revealed: *Residents with diarrhea associated with C-diff infection would be placed on contact isolation. *Health care workers would wear gloves and gowns upon entering the room and would remove gloves and gowns prior to exiting the room.</p>	F 441			

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F 441	<p>Continued From page 44</p> <p>*Resident still having symptoms (diarrhea) would be placed in a private room.</p> <p>*The primary reservoirs for C-diff were infected people and surfaces. Spores could persist on resident-care items and surfaces for several months and were resistant to common cleaning and disinfection methods.</p> <p>*There were no directions for disinfecting the whirlpool bathtub or shower chair after bathing a resident with C-diff.</p> <p>Review of the provider's 4/6/15 Infection Control Program policy revealed: ""An infection control program is designed to provide and maintain a safe, sanitary, and comfortable work environment and to help prevent the development or transmission of disease or infection will be established for all facilities." ""Management shall inform affected employees whenever special infection control precautions are required." ""Management will orient employees to infection control procedures by using the Infection Control Manual and will reorient employees annually in infection control procedures."</p> <p>Surveyor: 20031 B. Based on observation, testing, and interview, the provider failed to maintain: *A sanitary and clean work environment in the west tub room. *The seat cushion of the tub chair in the west whirlpool room was torn and damaged. *The wall and floor of the chemical dispensing area for housekeeping had damaged and missing tiles. *The handsink for the chemical dispensing area clean and available for use.</p>	F 441			

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F 441	<p>Continued From page 45</p> <p>Findings include:</p> <p>1. Observation and interview on 3/1/16 from 3:30 p.m. to 4:30 p.m. with the maintenance supervisor (MS) revealed the following in the west bathing room: *A cup of what appeared to be coffee on the counter next to the whirlpool tub. There was also a bottle of pop inside the cabinet next to the tub. That bottle of pop was intermingled with resident care items in that cabinet. There were also old semisolid rings of liquid debris on top of the cabinet that appeared to be from food or liquids. -Interview with the MS confirmed that finding. -He stated staff were aware their drinks and snacks were to be kept in the staff break room. *The formed foam rubber seat cushion for the west whirlpool tub was broken and was missing a ten inch by three inch portion of foam rubber. -Interview with the MS confirmed that finding. -He stated he was not aware of the damaged condition of the seat cushion.</p> <p>2. Observation and interview with the district housekeeping supervisor and MS on 3/1/16 at 4:30 p.m. of the chemical dispensing/housekeeping area by the maintenance office revealed: *The gypsum board finished walls and tile floor throughout the area had deteriorated, was damaged, and was no longer in a cleanable condition. -Interview with the district housekeeping supervisor and MS confirmed those findings. -The MS stated the provider was slowly fixing the floors throughout the facility. -He stated he was not aware when that area was to be redone. *The handsink was blocked for immediate use by</p>	F 441			

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F 441	Continued From page 46 carts and supplies. The handsink had a rubber squeegee stored in the basin. That handsink was also dirty and stained from what appeared to be cleaning of paint brushes. -Interview with the district housekeeping supervisor and MS at the time of the observation confirmed those findings. -The district housekeeper stated the floors, walls, and handsink had been in that condition since she had been with the contracting company for about three years.	F 441		
F 466 SS=C	483.70(h)(1) PROCEDURES TO ENSURE WATER AVAILABILITY The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply. This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on policy review and interview, the provider failed to ensure the 1/27/04 water outage contract for potable water was in good standing with the local Coca-Cola bottling company. There was no contract or listed specific source for non-potable water. Findings include: 1. Review of the undated Water Outage policy revealed: **If the water outage is expected to be lengthy, request temporary use of water tanker from local sources such as: -National Guard -Local businesses	F 466	The Contract for emergency water supply was revised with the appropriate facility name on 3-7-2016. There are no other water contracts	

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F 466	<p>Continued From page 47 -Local water department." *"During an emergency, water will be supplied to the facility by trucks from the source listed in this section. This source will deliver emergency water supply for resident consumption to the facility..."</p> <p>Review of the 1/27/04 letter from the local Coca-Cola bottling company was in reference to Meadowbrook Manor owned by Beverly Enterprises. The provider was now owned by Golden LivingCenters, and the name was now Golden LivingCenter-Meadowbrook. There was no letter or dated communication between any source for non-potable water.</p> <p>Interview on 3/3/16 at 10:00 a.m. with the executive director revealed he had not contacted any of the sources on the list. He was not aware the Coca-Cola letter was over ten years old.</p>	F 466	<p>The contract for the Emergency Water Supply will be reviewed annually for accuracy.</p> <p>Executive Director will audit the contract annually and report findings to QAPI Committee each January.</p>	03/31/16
F 520 SS=F	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>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.</p> <p>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 action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require</p>	F 520	<p>A QAPI Committee meeting will be held on 3-30-2016 and will address weight loss and infection control procedures.</p> <p>All other issues identified during the survey of 2-29-2016 will be discussed during the QAPI meeting on 3-30-2016 as well.</p>	

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F 520	<p>Continued From page 48</p> <p>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.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on record review, interview, and policy review, the provider failed to ensure an effective quality assurance (QA) program had been maintained to identify concerns within the facility and to develop and implement corrective action for issues including infection control and weight loss. Findings include:</p> <p>1. Review of the provider's QA meeting notes from May 2015 through January 2016 revealed: *The type, number of, and total infections had been documented monthly. *Increase or decrease in infections was noted monthly. *Vaccinations for residents and staff had been noted. *No other areas of concern had been documented. *Corrective actions and monitoring for the above issues had not been documented.</p> <p>There had been no QA available that had identified problems in the areas of weight loss or monitored infection control procedures for residents with infectious diseases. Refer to F325 and F441.</p>	F 520	<p>and all issues identified through this survey will continue to be monitored per the 2567 POC timelines until all issues are resolved. If plans put in place are not effective in sustaining compliance, issues will have new PIPs developed and will be monitored through the QAPI Committee.</p> <p>Ad Hoc QAPI will be held as needed for immediate planning and resolution of issues.</p> <p>Education will be provided for all staff on 3-24-16 regarding the QAPI Committee structure and purpose.</p> <p>The Executive Director will ensure the monthly QAPI Committee occurs, and that all PIPs are followed through to successful completion.</p> <p>Golden Living Centers District QAPI Committee randomly reviews the facility QAPI meeting minutes and provides feedback and recommendations for further analysis and for PIP as necessary. The facility review was last completed in January 2016 with the next review of March data to occur in April 2016.</p>	03/31/16
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F 520	<p>Continued From page 49</p> <p>Interview on 3/2/16 at 2:00 p.m. with the director of nursing (DON) revealed:</p> <ul style="list-style-type: none"> *The QA committee had planned on looking at falls, pain, and pharmacy issues soon. *The committee was at the beginning stages of a real Quality Assurance and Performance Improvement (QAPI) program. *Not much QA had been done before she had taken the position over 6 months ago. *The QA program was still in its first steps. *Meetings had been held monthly with the required staff members. *Meetings would be held more often if issues were brought up. *Staff were just learning how to participate. *They did not have a process for corrective actions in place yet. *She had been trying to get departments to be more cohesive in identifying QA concerns. <p>Review of the provider's August 2014 QAPI Committee Guideline policy revealed:</p> <ul style="list-style-type: none"> **"The facility conducts Performance Improvement Projects (PIPs) to examine and improve care or services in areas identified as opportunities for improvement (OFIs)." *PIPs should have been selected for areas that were important for the services unique to the facility. *Compliance would be monitored by: <ul style="list-style-type: none"> -Monthly meetings held and documented. -Special QAPI or Ad Hoc (for a specific area or concern) meetings conducted as needed to address OFIs in between monthly meetings. -PIPs developed and implemented for OFIs. 	F 520		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435051	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2016
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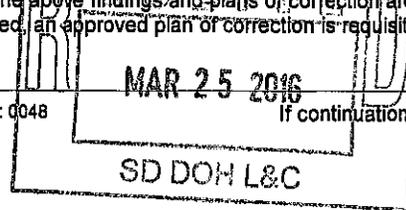
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MEADOWBROOK	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 ARROWHEAD DR RAPID CITY, SD 57702
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 20031 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted from 2/29/16 through 3/3/16. Golden LivingCenter-Meadowbrook was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies upon correction of the deficiencies identified at K018, K027, K029, K038, K050, and K062 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	<p><i>*Addendums noted with On asterisk per 3/28/16 per email K018 with facility administrator. CHRIS DROHTEL</i></p> <p>Rooms 9, 37 and 48 either had resident education about placing items in front of the door or had Velcro placed on the door and door stop to keep door in place on 3-2-2016.</p> <p>All resident rooms were inspected on 3-5-2016 to ensure nothing was blocking the doors from closing.</p>	
K 018 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by:</p>	K 018	<p>On 3-23-2016, an informational flyer was delivered to each resident room notifying residents that they couldn't place items in front of the door. Additionally, at the April resident council, we will bring this up to the residents to explain why this is prohibited.</p> <p>Staff will be educated on 3-25-2016 about checking for items placed in front of doors.</p> <p>Audits of resident rooms to ensure no items are placed in front of doors will be done X 4 weeks and then monthly X 3 months by the Maintenance</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE ADMINISTRATOR (X6) DATE 3/24/16

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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 018	<p>Continued From page 1 Surveyor: 20031 Based on observation and interview, the provider failed to ensure the swing path was not obstructed to close and latch three random resident room doors (9, 37, and 48). Findings include:</p> <p>1. Random observation from 2/29/16 through 3/1/16 revealed: *Resident room 9's door was blocked open with a trash can and Kleenex box. *Resident room 37's door was blocked open with a trash can. *Resident room 48's door was blocked open with a walker. Interview with the maintenance supervisor at the time of the above observations confirmed those findings. He stated he was not aware nothing could impede the closing of a door.</p> <p>Interview on 3/2/16 at 2:00 p.m. with the executive director revealed he had no policy on blocking open doors. The facility followed the LSC guidelines for policies.</p> <p>This deficiency affected all residents in two of two resident room corridors of the building.</p>	K 018	<p>Director to ensure compliance. Results will be reported to the monthly QAPI Committee.</p> <p><i>[REDACTED]</i></p> <p>CHV/SDDO/HJEL</p> <p>*Results will be reported to the monthly QAPI committee by the maintenance director. CHV/SDDO/HJEL</p>	*3/31/16 CHV/SDDO/HJEL
K 027 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 10-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.6. Swinging doors are not required to swing with egress and positive</p>	K 027		

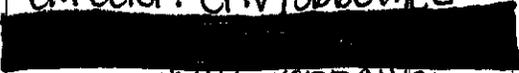
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K 027	Continued From page 2 latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation, testing, and interview, the provider failed to maintain one of one set of self-closing smoke barrier doors (between the dining room and resident room corridors) would not close and latch under the power of their self-closers. Findings include: 1. Observation on 3/1/16 at 9:30 a.m. revealed a set of twenty-minute rated self-closing doors between the dining room and the resident room corridors. Testing of those doors, upon release from the magnetic hold open devices, revealed they would not close and latch at the top of the frame. The left door would hit against the right door, and it would not close and latch. Interview with the maintenance supervisor at the time of the observation and testing confirmed that finding. He stated he was not aware those doors would not latch at the top. He revealed the testing of doors was on the monthly fire drill form. He stated staff would watch to see if the doors closed. He could not verify if staff checked the doors to see that they also latched into the frame. This deficiency affected two of two common areas (dining room and nurses station) where any and all residents and guests could gather. NFPA 101 LIFE SAFETY CODE STANDARD	K 027	K027 The Smoke barrier doors between dining room and the resident room corridors were fixed on 3-1-2016. All other smoke barrier doors with automatic closure were checked to ensure proper closing on 3-4-2016. Checking smoke barrier doors with automatic closures will be placed on the monthly preventative maintenance schedule. Audits of the preventative maintenance logs to ensure smoke barrier doors with automatic closures have been checked for operation will be done monthly X 6 months by the Executive Director to ensure compliance. Results will be reported to the monthly OAPI Committee. *by the executive director. [REDACTED]	*3/31/16 CIV/SDDOHT/EL
K 029 SS=D	One hour fire rated construction (with 0 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When	K 029		

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K 029	Continued From page 3 the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation, testing, and interview, the provider failed to maintain proper separation of hazardous areas for one of two (north) ninety minute rated self-closing doors (kitchen pantry) would not close and latch into the frame. Findings include: 1. Observation on 3/1/16 at 8:35 a.m. revealed the north door of the kitchen pantry would not close and latch into the frame. The room was over 100 square feet in area. Interview with the maintenance supervisor at the time of the observation and testing confirmed that condition. He stated he was not aware the door was not latching into the frame. He stated he had a monthly preventive maintenance program for checking doors but could not verify if that door closed or not. The deficiency affected one of several hazardous areas in the building required to be provided with self-closing and latching doors. NFPA 101 LIFE SAFETY CODE STANDARD	K 029	K029 The Kitchen pantry door was corrected so it latched on 3-1-2016. All other 90 minute rated self-closing doors were inspected for proper closure on 3-23-2016. Checking 90 minute self-closed door will be placed on the monthly preventative maintenance schedule monthly. Audits of the preventative maintenance logs to ensure smoke barrier doors have been checked for operation will be done monthly X 6 months by the Executive Director to ensure compliance. Results will be reported to the monthly QAPI Committee. *by the executive director. CKV/SDDOHH/EL	
K 038 SS=E	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by:	K 038	 *CKV/SDDOHH/EL	

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K 038	Continued From page 4 Surveyor: 20031 Based on observation and interview, the provider failed to maintain two of four resident room corridors clear and unobstructed. The north and south corridors were blocked with lifts, wheelchairs, carts, and a coffee/water bar by the front desk. Findings include: 1. Observation on 2/29/16 at 4:00 p.m. revealed the following unattended items in the north and south corridors: *Four wheelchairs. *Three lifts. *Two medical carts. *One utility cart. *One coffee/water bar that measured approximately four feet long and sixteen inches wide. Those items blocked emergency access through the corridors. Those items also blocked access to full and continuous use of the handrails by residents. Interview on 3/3/16 at 9:50 a.m. with the administrator and director of nursing revealed they were aware staff stored resident use items in the corridors. They were not aware the coffee/water bar restricted access in the corridor. The administrator stated he did not have a specific policy for storage in the corridors. He stated they would have followed the LSC guidelines. This deficiency affected all residents in two of two resident room corridors of the building.	K 038	K038 Coffee/water bar was moved into the dining room on 3-4-2016. Wheelchairs, lifts, medical carts, and utility cart were moved to other locations on 2-29-2016. All other hallways that residents use for transportation were checked to ensure there was nothing impeding their movement on 3-1-2016. Staff will be educated on 3-25-2016 that items not in use in the past 30 minutes must be removed from the hallway. Additionally, all items in use must be placed on the North side of the hallway so that one side is always free from obstacles along the handrails. Audits of each hallway to ensure it is free of unused items and all items in use are along the North side will be done on both the day and evening shift daily X 1 week then weekly X 4 weeks and then monthly X 3 months by the Lunch [redacted] to ensure	*3/31/16 CHRISTOPHER
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		

**managers on duty CHRISTOPHER*

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K 050	<p>Continued From page 5</p> <p>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Surveyor: 20031</p> <p>Based on document review and interview, the provider failed to ensure fire drills were conducted at least once per shift per quarter for one of three quarters (last quarter of 2015). Findings include:</p> <p>1. Document review of the fire drill records from 3/11/15 through 12/31/15 revealed an evening drill had not been conducted during the months of October, November, and December 2015. Two daytime drills and one overnight drill had been completed for that quarter.</p> <p>Interview on 3/1/16 at 9:00 a.m. with the maintenance supervisor revealed he was not aware he had not conducted an evening drill for the last quarter of 2015. He was aware a drill must be conducted once per shift per quarter.</p> <p>Review of the undated fire plan policy revealed "At a minimum, fire drills will be conducted quarterly on all occupied shifts. This may be accomplished by conducting fire drills each month on rotating shifts."</p>	K 050	<p>compliance. Results will be reported to the monthly QAPI Committee. <i>*by the executive director. CHV/SDDOHH/EL</i></p> <p><i>[REDACTED]</i></p> <p><i>*CHV/SDDOHH/EL</i></p> <p>K050</p> <p>The quarter has expired and a fire drill on evenings could not be completed for the fourth quarter of 2015. All fire drills for the first quarter of 2016 have been completed.</p> <p>Fire drills will be completed quarterly and prn on each shift as initiated by the Maintenance Director starting 3-31-2016..</p> <p>Education of all staff will be provided on 3-25-2016 regarding the importance of fire drills.</p> <p>Audits of fire drills will be done monthly X 3 months by the Executive Director to ensure compliance. Results will be reported to the monthly QAPI Committee. <i>*by the executive director. CHV/SDDOHH/EL</i></p>	<i>*3/31/16</i> <i>CHV/SDDOHH/EL</i>

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K 050	Continued From page 6 This deficiency could potentially affect all occupants of the building.	K 050	[REDACTED]	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 20031 Based on document review and interview, the provider failed to ensure the automatic sprinkler system was maintained in accordance with National Fire Protection Association (NFPA) 25. Review of the maintenance records revealed one of three (July, August, and September 2015) quarterly inspections for the dry pipe and wet pipe sprinkler system was not performed on the sprinkler system. Findings include: 1. Document review of the fire sprinkler inspection reports for 2015 revealed an annual inspection had been completed by a commercial service. Interview on 3/1/16 at 9:00 a.m. with the maintenance supervisor (MS) revealed he conducted the quarterly testing for the sprinkler system. He was aware of the quarterly testing requirements and had been trained by the former MS how to do the quarterly testing for the sprinkler system. The MS stated he was unaware he had not completed the quarterly testing for the third period of 2015. The MS stated that period was a time of transition from the old MS to himself, and he must have missed the quarterly inspection.	K 062	<i>*CHV/SDDOHT/EL</i> K062 The quarter has expired and a quarterly inspection for the third quarter of 2015 can not be completed. All quarterly inspections since the third quarter of 2015 have been completed. <i>*3/31/16</i> <i>CHV/SDDOHT/EL</i> A new vendor has been approved that will complete quarterly and annual inspections of the sprinkler system. Audits will be added to the preventative maintenance log to ensure these inspections are done timely. Audits of inspections will be done quarterly X 3 by the Executive Director to ensure compliance. Results will be reported to the monthly QAPI Committee. <i>*by the executive director.</i> <i>CHV/SDDOHT/EL</i>	

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K 062	Continued From page 7 This deficiency could potentially affect all occupants of the building.	K 062		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10668	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/03/2016
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NAME OF PROVIDER OR SUPPLIER
GOLDEN LIVINGCENTER - MEADOWBROOK

STREET ADDRESS, CITY, STATE, ZIP CODE
**2500 ARROWHEAD DR
RAPID CITY, SD 57702**

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S 000	Compliance/Noncompliance Statement Surveyor: 29162 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/29/16 through 3/3/16. Golden LivingCenter - Meadowbrook was found not in compliance with the following requirement: S130.	S 000		
S 130	44:73:02:07 Food Service Food service shall be provided by a licensed facility or food service establishment that is inspected by a local, state, or federal agency. The facility shall meet the safety and sanitation procedures for food service in §§44:02:07:01, 44:02:07:02, and 44:02:07:04 to 44:02:07:95, inclusive, the Food Service Code. In addition, a mechanical dishwasher shall be provided in all facilities of 17 beds or more. The facility shall have the space, equipment, supplies, and mechanical systems for efficient, safe, and sanitary food preparation if any part of the food service is provided by the facility. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 20031 Based on observation and interview, the provider failed to maintain the following areas of the kitchen and/or pantry clean and sanitary: *Floors; *Walls; *Ceilings; *Beverage area in the dining room. Findings include: 1. Observation and interview on 3/1/16 from 1:15 p.m. to 2:30 p.m. with the dietary manager (DM) of the kitchen and pantry revealed:	S 130	S130 *Addendums noted with an asterisk per 3/29/16 per telephone with facility DM. The wall beneath the 3 compartment sink will be patched and deep cleaned by 3/30/16. Ceiling in the kitchen and dry storage were cleaned on 3-14-2016 and were painted by 3-30-2016. Floors under the refrigerators and freezers were deep cleaned on 3-14-2016. The floor directly behind the flat top grill was cleaned 3-14-2016 and a drip pan was replaced on 3-18-2016. The beverage cabinet in the dining room was cleaned and the caulking was repaired on 3-23-2016. On 3-21-2016, the rest of the kitchen, dry storage, dishwasher room and beverage serving area were inspected to ensure other cleaning issues not covered by these survey findings were not present. Beverage serving counter was added to the daily cleaning schedule. Areas under equipment and 3 compartment sink area were added to the weekly cleaning schedule. Ceilings were added to the monthly cleaning schedule.	3/31/16 MRS DDOHJEL

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

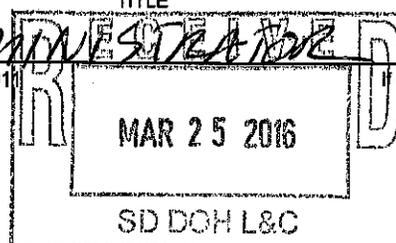
TITLE

(X6) DATE

STATE FORM

6899

22991



Continuation sheet 1 of 3

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10668	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/03/2016
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MEADOWBROOK	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 ARROWHEAD DR RAPID CITY, SD 57702
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 130	<p>Continued From page 1</p> <p>*The wall directly beneath the three compartment sink was damaged. There were holes ranging in size from coin half dollars to paper dollars. The entire area also needed a deep cleaning. -Interview with the DM confirmed those findings. -She stated maintenance and contractors had to dig up a water line beneath the floor in the kitchen. -She stated they had not repaired the wall since the work was completed approximately a month ago.</p> <p>*The white ceilings throughout the kitchen and pantry area were dull from grease and cooking vapors. Those ceilings now appeared to be an off-white color. The kitchen ceiling had splatters of various colors of dried liquid debris throughout the kitchen. The ceiling in the pantry was also damaged and had peeling tape and texture. -Interview with the DM confirmed those findings. -She stated the ceiling had not been painted since she had been at the facility for three years.</p> <p>*The floors under the larger reach-in coolers and freezers in the pantry needed a deep clean. There was a build-up of dirt, lint, and debris of unused single-service cups, napkins, and small kitchen utensils. The floor directly behind the flat top grill of the stove had a puddle of old grease. Closer observation revealed the grease drip pan for the flat top grill had a leak and would drip onto the floor. -Interview with the DM confirmed those findings. -She stated they would deep clean under the coolers and freezers in the pantry about twice a year. -But she may need to make it quarterly. -She stated the grease on the floor behind the stove had been cleaned two days ago. -She was unaware the drip tray had a leak and was dripping the used grease on the floor.</p> <p>*The beverage cabinet in the dining room had</p>	S 130	<p>Audits of inspections will be done weekly X 3 and then monthly X 3 by the Executive Director to ensure compliance. Results will be reported to the monthly QAPI Committee.</p> <p>Compliance will be achieved March 31, 2016</p>	<p><i>by the executive director.</i> <i>MP/SDDOH/EL</i></p>

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10668	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MEADOWBROOK		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 ARROWHEAD DR RAPID CITY, SD 57702		
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S 130	Continued From page 2 soiled drawers and spilled coffee inside the cabinet. The caulking between the cabinet and the wall itself was embedded with lint and food debris and needed a deep clean. -Interview on 3/3/16 at 8:00 a.m. with the district housekeeping supervisor confirmed that finding. -She was unaware whose duty it was to keep that specific area clean. -Continued interview at 8:30 a.m. revealed the district housekeeping supervisor had spoken with the DM. The DM told her it was a shared duty between kitchen staff and housekeeping to clean those areas. Interview on 3/3/16 at 10:00 a.m. with the executive director revealed he had done a walk-through a few days earlier and confirmed the above conditions of the kitchen, pantry, and beverage area.	S 130		