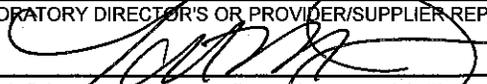


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/25/2016
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F 000	<p><i>*Addendums noted with an asterisk per 3/24/16 per telephone with facility administrator.</i></p> <p>Surveyor: 32572 A Minimum Data Set (MDS) focus health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/24/16 through 2/25/16. Fountain Springs Healthcare was found not in compliance with the following requirements: F221, F241, F246, F278, F280, F281, F356, and F441.</p>	F 000		
F 221 SS=E	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, record review, interview, and policy review, the provider failed to ensure: *One of one sampled resident (2) had a physician's order and completed assessments for the use of a seat belt. *Two of two sampled residents (4 and 8) with a lipped mattress (built up edges) had been assessed for appropriate need without the potential use as a restraint. Findings include:</p> <p>1. Observation and interview on 2/24/16 at 10:25 a.m. with certified nursing assistant (CNA) A in resident 2's room revealed he was asleep in his wheelchair. There was a seat belt secured around his waist.</p>	F 221	<p>Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.</p> <p>F221</p> <p>1. Resident #2 has an order for his seatbelt and a current physical device assessment completed. The MDS from 8/17/15 and 2/3/16 have been modified to reflect the restraint. Residents #4 and #8 have a physical device assessment completed on their lipped mattress and their care plans have been updated. All residents with lipped mattresses have a seat belt secured around their waist.</p>	<i>*3/17/16</i> <i>LAISSDOH/EL</i>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 3/17/16
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	<p>Continued From page 1</p> <p>Interview at the above time with CNAA revealed resident 2 was unable to remove the seat belt.</p> <p>Observation on 2/24/16 at 10:57 a.m. in resident 2's room revealed he was sitting in his wheelchair with a seat belt secured around his waist. The surveyor asked resident 2 to remove the seat belt. There was no response from resident 2.</p> <p>Interview on 2/24/16 at 3:15 p.m. with CNAs G and H in resident 2's room revealed he was unable to remove the seat belt.</p> <p>Review of resident 2's medical record revealed: *There was no order for a seat belt on the 1/30/16 physician's current orders. *The current care plan with a 6/12/15 revision date revealed: -Focus: "I have a seat belt per MD (physician) orders/family request r/t (related) my hx (history) of multiple falls." -Interventions: "Assure seat belt is in place when in w/c (wheelchair). I use my seatbelt to keep from falling out of my w/c. Release seatbelt per policies and procedures." *The 8/17/15 significant change and the 2/3/16 quarterly Minimum Data Set (MDS) assessments were coded for: -No restraint usage. -Brief Interview for Mental Status assessment had not been completed. -Cognitively impaired. *The 8/10/15 Physical Device Assessment revealed: -Seatbelt will be used in w/c to prevent resident from falling forward, sliding out of w/c. -Type: Restraint. -The device is utilized for fall prevention. -The resident was unable to demonstrate the</p>	F 221	<p>physical device assessment completed and their care plans have been updated.</p> <p>2. Administrator, DON and IDT have reviewed the policy on restrictive devices such as seat belts and lipped mattresses. Facility has decided to use the physical device assessment for all residents with lipped mattresses. The Director of Nursing (DON) or designee will educate all staff by March 25,2016 on the restraints to include: release of restraints, assessment of restraints, and care planning restraints. The DON or designee will educate the MDS staff on coding of restraints on the MDS by March 25,2016.</p> <p>3. DON or designee will audit all residents with restraints and lipped mattresses monthly for proper documentation. This audit will be monthly for 3 months. DON or designee will audit all residents with restraints 3 times weekly to ensure that restraint is released per policy. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to Quality Assurance Process Improvement (QAPI) by the DON for review and recommendations of continuation/discontinuation.</p> <p><i>KLASDDOHT/EL</i></p>		

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F 221	<p>Continued From page 2</p> <p>ability to appropriately utilize the device. -The resident was not able to remove the device upon command. *There were no other Physical Device Assessments found in his medical record.</p> <p>Interview on 2/25/16 at 10:00 a.m. with the director of nursing (DON) and MDS nurse regarding resident 2 confirmed: *The seatbelt was considered a restraint. *He was unable to self-release the seat belt on command. *The 8/17/15 and 2/3/16 MDS assessments had been coded incorrectly.</p> <p>Interview and record review on 2/25/16 at 12:02 p.m. with the DON regarding resident 2 revealed: *An initial order for a seatbelt while up in w/c to protect from fall/accidents was dated 5/21/09. *The last Physical Device assessment had been completed on 8/10/15. *Her expectations would have been for quarterly Physical Device assessments to have been completed.</p> <p>Surveyor: 32355 2. Observation on 2/24/16 at 10:10 a.m. of resident 8's bed revealed a lipped mattress.</p> <p>Review of resident 8's medical record revealed: *An admission date of 12/4/15. *Diagnoses of second lumbar vertebra fracture (lower back), osteoporosis (weak bones), chronic pain, anxiety, and depression. *She had a Brief Interview for Mental Status (BIMS) score of 15. That score had indicated she was alert and oriented to time, place, and person. *She had required staff assistance to transfer from one location to another and in/out of her</p>	F 221			

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F 221	<p>Continued From page 3 bed.</p> <p>*No documentation or assessment to support the use of a lipped mattress.</p> <p>Review of resident 8's 12/4/15 comprehensive care plan revealed: *She had a history of falls related to transferring herself without staff assistance. *The lipped mattress had not been identified as: -An intervention to help decrease her falls. -Helpful in identifying edge boundaries of the mattress.</p> <p>3. Observation on 2/24/16 at 10:35 a.m. of resident 4's bed revealed a lipped mattress.</p> <p>Review of resident 4's medical record revealed: *An admission date of 1/19/16. *Diagnoses of chronic congestive heart failure, urinary tract infection, high blood pressure, and fractured left wrist. *She had a BIMS score of 13. That score indicated she had no memory problems. *She had required staff assistance to transfer from one location to another and in/out of her bed. *She had fallen at home and broken her left wrist. *She was working with the therapy department for strengthening. Her goal was to return home. *No documentation or assessment to support: -She had any falls since her admission. -The purpose of a lipped mattress.</p> <p>Review of resident 8's 1/19/16 comprehensive care plan revealed: *She had a focus area of fall prevention. *The lipped mattress had not been identified as: -A preventative intervention for safety. -Helpful in identifying edge boundaries of the</p>	F 221			

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F 221	<p>Continued From page 4 mattress.</p> <p>Interview on 2/24/16 at 2:15 p.m. with resident 4 revealed: *She confirmed her goal was to return to her previous level of independence and return home. *She had noticed her bed had a "different kind of edge." *No one had discussed with her why she had required the use of that type of mattress. *She did not have that type of mattress at home. *The lipped mattress had hindered her some when getting in and out of bed, but not enough to talk to anyone about it.</p> <p>Interview on 2/24/16 at 2:20 p.m. with registered nurse (RN) F revealed: *She had been aware resident 4 had a lipped mattress. *She could not identify the purpose for the lipped mattress. *When a resident was admitted to a room with that type of mattress on the bed it would not have been exchanged for a regular mattress. *She agreed the lipped mattresses could be a safety risk for a resident who was more independent and able to transfer in and out of bed without assistance. *To her knowledge the lipped mattresses had not been identified as a potential restraint or safety risk.</p> <p>Interview on 2/24/16 at 2:30 p.m. with occupation therapist D revealed: *She had been working with resident 4 to increase her strength and independence. *She had been aware the resident had a lipped mattress. *She had not been able to identify the purpose of</p>	F 221		
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F 221	Continued From page 5 that lipped mattress. *She stated "The mattresses are probably used as a fall prevention." *The therapy department did not recommend what type of mattresses the residents should use. *She agreed the lipped mattresses could be considered a safety risk for a more independent resident. Random observations from 2/24/16 through 2/25/16 revealed sixty-three out of eighty-three mattresses currently being used by the residents had lipped edges. Interview on 2/24/16 at 2:40 p.m. with the DON revealed: *She confirmed the provider used quite a few lipped mattresses. *She could not identify the purpose for using that many lipped mattresses. *She had not considered those mattresses to be a safety risk or a type of restraint for an independent resident. *She agreed there should have been documentation in the residents' charts to support the use of a lipped mattress. Request for a Physical Device policy revealed: *A piece of paper with no title nor date. *Physical Restraint: "any manual method or physical or mechanical device, material, or equipment attached or adjacent to the individual's body that he/she cannot remove easily and that restricts freedom of movement or normal access to his/her body."	F 221			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241			

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F 241	<p>Continued From page 6</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, and policy review, the provider failed to ensure dignity was maintained for one of ten sampled residents (2) during: *One of two personal care observations by two of four certified nursing assistants (CNA) (A and B). *Two of two meal observations in two of four dining rooms (Miller and Main). *Two of two random observations in resident 2's room. Findings include:</p> <p>1. Observation on 2/24/16 from 11:10 a.m. through 11:19 a.m. in the Miller dining room regarding resident 2 revealed: *His food and drinks had been placed in front of him. *Certified nursing assistant (CNA) B sat down beside him. *CNA B would put a spoon full of blended food into his mouth, then take the spoon and wipe the remainder of the food from his lips, and put the food back into his mouth. This process continued throughout the meal.</p> <p>2. Observation on 2/24/16 at 11:55 a.m. with CNA A and B in resident 2's room revealed: *In front of resident 2, CNA A turned to the surveyor and stated "He is kind of ornery today." *Resident 2 had a large amount of mucus on the</p>	F 241	<p>F241</p> <p>1. No immediate action could be taken for residents #2. Residents are being treated with dignity and respect. All residents are at risk.</p> <p>2. Administrator, DON and IDT have reviewed the policy on resident dignity and respect. DON or designee will educate all staff by March 25, 2016 on resident's dignity and respect. CNAs A and B have had 1:1 education completed on resident dignity and respect during meal times and personal cares.</p> <p>3. DON or designee will audit 5 meal services a week to watch for staff interaction with residents during meals to ensure that residents are treated with dignity and respect. DON or designee will audit 5 episodes of care per week to ensure that residents are treated with dignity and respect: to include having staff discuss what cares they are providing. These audits will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the DON for review and recommendations of continuation/discontinuation.</p> <p> *LA/SDDOW/EL</p>	<p>*A/15/16 LA/SDDOW/EL</p> <p>*Some audits will include resident 2 and CNA's A and B. LA/SDDOW/EL</p> <p>*the monthly. LA/SDDOW/EL</p>

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F 241	<p>Continued From page 7</p> <p>front of his shirt. CNA B: -Took a paper towel and wiped the mucus off of his shirt. -Took the same paper towel and wiped his mouth with it. *CNAs A and B then proceeded to: -Transfer resident 2 from his wheelchair to the bed. -Performed personal care with him. -Repositioned him on his back. *During the above observations CNAs A and B had not informed resident 2 what they were doing nor visited with him throughout the personal care.</p> <p>3. Observations on 2/24/16 at 10:15 a.m. and 4:20 p.m. in resident 2's room revealed at: *10:15 a.m. he had been sitting in his wheelchair with no activity going on. *4:20 p.m. he had been sitting in his wheelchair with the room lights off, the curtain 3/4 way pulled, and his roommate had been watching television on the roommate's side of the room.</p> <p>Interview on 2/25/16 at 10:00 a.m. with the DON regarding the above observations revealed her expectations would be for the CNAs: *Not to have wiped food with a spoon from the resident's mouth. *To remove excess food from a resident's mouth using a napkin. *To visit with him during cares. *To not make comments about him. *To explain what tasks would be done while performing personal care. *To engage him in some sort of activity.</p> <p>Review of the provider's revised March 2013 Resident Rights and Dignity for all Nursing Procedures policy revealed:</p>	F 241			

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F 241	Continued From page 8 **For any procedure that involves direct resident care, follow these steps: -Introduce yourself to the resident if he/she is unfamiliar with you, or if he/she may not recognize you due to memory loss. -Explain the procedure to the resident." Review of the provider's undated Assistance with Meals policy revealed: **Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. -Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity. -Keeping interactions with other staff to a minimum while assisting residents with meals." Surveyor: 32572 4. Observation in the main dining room on 2/25/16 at 8:15 a.m. revealed two unidentified CNAs talking to each other and not the residents. One of the CNAs was sitting at the table for those who require dining assist. She was assisting resident 3 with his breakfast. The other CNA was across the room at the juice machine. Interview on 2/25/16 at 9:18 a.m. with the director of nursing (DON) confirmed she would have expected the staff to have been talking with the residents and not each other across the room.	F 241			
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be	F 246			

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F 246	Continued From page 9 endangered. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Surveyor: 29354 Based on observation, interview, and policy review, the provider failed to ensure resident call lights were accessible in order to meet the residents' needs for two of ten sampled residents (2 and 6). Findings include: 1. Observation on 2/24/16 at 10:45 a.m. in resident 6's room revealed: *She had a diagnosis of a hip fracture and used a wheelchair. *She had been on isolation precautions. *Her husband was in the room visiting with her. *Licensed practical nurse (LPN) I had gone into the room to check on her medications. *Her husband requested for LPN I to place her call light where she could reach it. *LPN I picked up the call light from the floor behind the bed. He then: -Untangled the call light. -Clipped the call light to the right side of her wheelchair. Surveyor:32572 2. Observation on 2/24/16 at 8:10 a.m. revealed resident 2 had been removed from the Miller Place dining room and pushed into his room by an unidentified CNA. He was seated in his wheelchair at the end of his bed. His call light was attached at the head of his bed. He was unable to reach his call light.	F 246	F246 1. No immediate action can be taken for residents #2 and #6. Residents have their call lights within reach. All residents are at risk. 2. DON or designee will educated all staff by March 25, 2016 on call lights and ensuring that all residents have their call lights in reach. 3. DON or designee will audit all residents 5 times weekly to ensure that residents have their call light in reach. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the DON for review and recommendations of continuation/discontinuation.	*A/15/16 LA/SDDO/H/EL *the monthly LA/SDDO/H/EL	

*including residents 2 and LA/SDDO/H/EL

[Redacted] LA/SDDO/H/EL

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F 246	Continued From page 10 Observation on 2/25/16 at 8:30 a.m. revealed resident 2 sitting in his wheelchair in his room. He was seated at the foot of the bed with the call light attached at the head of his bed. He was unable to reach his call light. Surveyor: 29354 Interview on 2/25/16 at 10:00 a.m. with the director of nursing revealed her expectations were for all residents to have access to their call light. Review of the provider's revised June 2015 Answering the Call Light policy revealed: *"When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. *Some residents may not be able to use their call light. Be sure you check these residents frequently."	F 246			
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278			

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F 278	<p>Continued From page 11</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, record review, and resident assessment instrument manual, the provider failed to ensure the Minimum Data Set (MDS) assessment had been completed accurately for seven out of eleven sampled residents (2, 3, 4, 6, 7, 8, and 11). Findings include:</p> <p>1. Review of resident 4's medical record revealed: *An admission date of 1/19/16. *Diagnoses of chronic congestive heart failure (CHF), urinary tract infection (UTI), high blood pressure, and fractured left wrist.</p> <p>Review of resident 4's 1/19/16 Patient Health Summary revealed: *The physician ordered Diflucan 100 milligrams (mg) everyday for a urinary tract infection. *She had a fall on 12/28/15 with a major injury to her left wrist.</p>	F 278	<p>F278</p> <p>1. Resident #4's MDSs from 1/26/16 and 2/16/16 have been modified. Resident #7's MDSs from 1/21/16 and 1/28/16 have been modified. Resident #8's MDS from 1/5/16 has been modified. Resident #2's MDSs from 8/17/15 and 2/3/16 have been modified. Resident #6's MDS from 2/14/16 has been modified. Resident #3's MDS from 10/14/2016 has been modified. No immediate action could be taken for Resident #11's missed comprehensive assessment. Resident 11 has an updated care plan.</p> <p>2. Administrator, DON and IDT have reviewed the policy on accurate and timely assessments. DON or designee will educate MDS nurses on completing MDSs accurately to the resident's condition and on setting correct assessments by March 25, 2016.</p> <p>3. DON or designee will audit 5 residents per week to ensure that they have the correct assessments set and that their last 2 MDSs were accurate. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the Administrator for review and recommendations of continuation/discontinuation.</p> <p>*LA/SDDO/H/EL</p>	<p>*1/15/16 LA/SDDO/H/EL</p> <p>*the monthly LA/SDDO/H/EL</p>

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F 278	<p>Continued From page 12</p> <p>Review of resident 4's 1/26/16 admission MDS assessment revealed: *Section I, Musculoskeletal, I4000 other fracture, had not been coded. *Section J, Fall History on Admission/Entry or Reentry revealed: -J1700A "Did the resident have a fall any time in the last month prior to admission/reentry?" had been inaccurately coded as a 9 "unable to determine." -J1700B "Did the resident have a fall any time in the last 2-6 months prior to admission/entry or reentry?" had been inaccurately coded as a 9 "unable to determine." -J1700C "Did the resident have any fracture related to a fall in the 6 months prior to admission/entry reentry." had been inaccurately coded as a 9 "unable to determine." -J1800 "Has the resident had any falls since admission/entry or reentry or prior assessment, whichever is more recent?" had been inaccurately coded as a "no." -J1900C had not been coded to support the resident had a fall with a major injury prior to admission. *That assessment coded her to be healthier than she was.</p> <p>Review of resident 4's 2/16/16 30 day MDS assessment revealed: *Section I, Active Infections, I2300 urinary tract infection (UTI) within the last 30 days had not been coded. *Section J, Musculoskeletal, I4000 other fracture, had not been coded. *That assessment coded her to be healthier than she was.</p>	F 278		
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F 278	<p>Continued From page 13</p> <p>2. Review of resident 7's medical record revealed:</p> <ul style="list-style-type: none"> *An admission date of 1/14/16. *Diagnoses of CHF, respiratory failure (poor air movement through the lungs), chronic obstructive pulmonary disease (lung disease), UTI, fractured right wrist and humerus. *She had required the use of oxygen continuously at 3 liters per minute (LPM). *She had been admitted with a stage II (shallow opening of the skin) pressure ulcer on her sacral (bony area of rectum) area. <p>Review of resident 7's 1/21/16 admission MDS assessment revealed:</p> <ul style="list-style-type: none"> *Section J1900C had not been coded to support the resident had a fall with a major injury prior to admission. *Section M, Skin Condition, was not coded to support she had a stage II pressure ulcer. *That assessment coded her to be healthier than she was. <p>Review of resident 7's 1/28/16 14 day MDS assessment revealed:</p> <ul style="list-style-type: none"> *Section O, Special Treatments, Procedures, and Programs, O0100C oxygen therapy had not been coded. *That assessment coded her to be healthier than she was. <p>3. Review of resident 8's medical record revealed:</p> <ul style="list-style-type: none"> *An admission date of 12/4/15. *Diagnoses of urinary retention, pneumonia (lung infection), asthma (disease of the lungs), Type II diabetic (uncontrollable sugar levels in the blood), anxiety, and depression. *She had required the use of oxygen continuously 	F 278		
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F 278	<p>Continued From page 14 at 1 LPM.</p> <p>Review of resident 8's 1/5/16 30 day MDS assessment revealed: *Section 0, Special Treatments, Procedures, and Programs, O0100C oxygen therapy had not been coded. *That assessment coded her to be healthier than she was.</p> <p>Interview on 2/25/16 at 10:30 a.m. with the MDS assessment nurse confirmed the above assessments had all been coded incorrectly.</p> <p>Surveyor: 29354 4. Review of resident 2's 8/17/15 significant change and 2/3/16 quarterly MDS assessments revealed Section P, Restraints, PO110 had not been checked indicating he had not used a restraint. Refer to F221, Finding 1.</p> <p>5. Review of resident 6's 2/14/16 MDS assessment revealed: *Section J, Health Conditions, J1700 had been marked yes indicating she had a fall any time in the last month prior to admission or reentry. *Section J1800 "Has the resident had any falls since admission/entry or reentry or the prior assessment" had been coded no. *Section J1900 had not been coded to support the resident had a fall with a major injury prior to admission. *The resident appeared to be healthier than she was.</p> <p>Review of resident 6's medical record revealed: *An admission date of 10/15/15. *She had a fall on 2/1/16 that resulted in a hip</p>	F 278		

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F 278	<p>Continued From page 15 fracture.</p> <p>*The 2/8/16 hospital discharge summary revealed a discharge diagnosis of acute fall from wheelchair, resulting in a right hip fracture.</p> <p>Interview on 2/25/16 at 10:00 a.m. with the MDS nurse regarding resident 2 and 6's MDS coding revealed both were coded incorrectly.</p> <p>Surveyor: 32572</p> <p>6. Review of resident 3's 10/14/15 quarterly MDS assessment revealed:</p> <p>*Section I, Active Infections, I2300 urinary tract infections (UTI) within the last 30 days, had not been checked.</p> <p>*Section M, Pressure Ulcers, M0300 stated the resident had one stage 1 (intact skin over a bony area) pressure ulcer.</p> <p>Review of resident 3's medical record revealed:</p> <p>* A 10/13/15 nursing note to the physician stating "Resident notes as having a stage 2 wound left medial heel and right lower gluteal. Resident notes as having a UTI. Ordered 10/9/15 encourage fluids. 10/8/15 Cipro [antibiotic] po [by mouth] bid [twice a day] X [for] 10 days."</p> <p>*A urinalysis completed on 10/9/15 revealed a positive UTI.</p> <p>*A 10/8/15 physician's order stating:</p> <ul style="list-style-type: none"> -Cipro 250mg (milligram) po BID X 10 days. -Doxycycline (antibiotic) 100mg po BID X 10 days. -Do Not Hospitalize. -UA [urinalysis] (reflux to culture) [if the urine sample meet the criteria of an UTI diagnoses a culture is initiated] today. <p>*Review of the Weekly Wound Documentation forms revealed:</p> <ul style="list-style-type: none"> -10/7/15 a pressure ulcer on his left heel 2.6 	F 278		
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F 278	<p>Continued From page 16 (centimeters, unit of measurement) cm X 3.8 cm, unstageable, with no drainage. -10/14/15 a pressure ulcer on the right gluteal fold (buttock fold) 2.0 cm X 1.2 cm. This area was not staged. This area had no drainage. -10/14/15 a pressure ulcer on the left medial heel, 2.4 cm X 3.8 cm. It had not been staged, and it had no drainage.</p> <p>7. Review of resident 11's medical record revealed: *He was admitted on 1/29/16. *He had MDS assessments completed on: -1/23/16 a Medicare-5 day/DRA (discharge return anticipated), that was not a comprehensive assessment. -2/5/16 a Medicare-5day, that was not a comprehensive assessment. -2/12/16 a Medicare-14 day, that was not a comprehensive assessment. -2/26/16 a Medicare-30 day, that was not a comprehensive assessment.</p> <p>Interview on 2/24/16 at 3:50 p.m. with the MDS coordinator confirmed a comprehensive assessment had not been completed on this resident. She confirmed a comprehensive assessment drove the care plan for resident needs and should have been completed.</p> <p>Review of the RAI manual, Version 1.13 on page 2-17 revealed "A comprehensive assessment includes the completion of both the MDS and the CAA process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident's status has occurred or a significant correction to a prior comprehensive assessment is required."</p>	F 278			

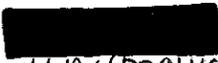
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F 278	Continued From page 17 *On page 1-8 of the RAI manual, MDS 3.0, Version 1.13 revealed "An accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [interdisciplinary team] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment." Interview on 2/24/16 at 3:50 p.m. with the MDS assessment coordinator confirmed the MDS reflected the current status of the resident at that time period. The MDS coordinator stated they used the RAI manual, Version 1.13 as a manual for completion of the MDS assessments.	F 278			
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			

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F 280	<p>Continued From page 18</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: 32572 Based on observation, interview, record review, and policy review, the provider failed to ensure resident care plans reflected the current status for eight of ten sampled residents (2, 3, 4, 5, 6, 7, 8, and 10). Findings include:</p> <p>1. Observation and interview on 2/24/16 at 10:30 a.m. revealed CNA (certified nursing assistants, A and B) used the EZ Lift Stand-aid in transferring resident 3 from a lying position in bed to sitting in his high-back wheelchair. During this transfer the resident did not place his feet on the foot plate, he kneeled on the knee pad. The CNAs stated that was their usual practice.</p> <p>Review of the 2/23/16 Care Sheets (used by the CNA staff to know how to care for residents) revealed resident 3 was to have been transferred using the "easy st" (EZ stand).</p> <p>Review of resident 3's medical record revealed: *The 10/8/15 care plan for "Hygiene/ADL's</p>	F 280	<p>F280</p> <p>1. The care plans for residents # 3,5,10,2,6,8, and 4 have been updated to reflect the resident's current plan of care and the C.N.A. care sheets have been updated to reflect what is on the care plan. Resident #7 expired on 3/5/2016 so her care plan and C.N.A. care sheet cannot be updated. All resident care plans and C.N.A care sheets have been reviewed and updated as needed to reflect their current plan of care.</p> <p>2. Administrator, DON and IDT have reviewed the policy on care planning the resident's current plan of care. DON or designee will educate all staff on care plans, C.N.A. care sheets, and keeping them up to date with the resident's current plan of care by March 25, 2016. to ensure the care plans reflect the resident status.</p> <p>3. DON or designee will audit 10 care plans per week to check that it accurately reflects the resident's current plan of care. DON or designee will audit the C.N.A. care sheets weekly for accuracy. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the DON for review and recommendations of continuation/discontinuation.</p> <p> *LATSDDOHH/EL</p>	<p>*A/15/16 LATSDDOHH/EL</p> <p>The unit managers will be responsible to ensure the care plans reflect the resident status. LATSDDOHH/EL</p> <p>*the monthly LATSDDOHH/EL</p>

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F 280	<p>Continued From page 19</p> <p>[activities of daily living, bathing, dressing, eating, transferring] / Skin" focus area had an intervention of "Hoyer lift for transfers."</p> <p>*The 10/5/15 care plan for "Mobility/Fall Prevention: Mobility via staff propelled wheelchair. Staff assist of 2 or hoyer lift for transfers" focus area. One of the interventions listed was "Hoyer lift for transfers."</p> <p>Review of resident 3's 1/11/16 laboratory result revealed he had a positive Methicillin Resistant Staphylococcus Aureus (MRSA, difficult to treat infection).</p> <p>Interview on 2/25/16 at 10:04 a.m. with nurse manager J confirmed the CNA care sheet was incorrect and it would "be corrected today." She was not aware the resident did not bear weight during the transfer using the EZ stand.</p> <p>Review of the provider's revised July 2015 Mechanical Lift policy revealed the policy was "To lift and move a resident safely without causing injury to staff or resident."</p> <p>Review of the 1/12/16 care plan revealed a focus area of "Currently being treated for UTI [urinary tract infection] prophylaxis." There was no mention he was MRSA positive and what actions needed to be taken with this infection.</p> <p>2. Observation and interview on 2/24/16 at 11:45 a.m. with CNA C revealed resident 5: *Used a trapeze over his bed to assist with movement. *Transferred with the assist of one unidentified CNA and one unidentified physical therapy assistant. During that transfer the staff had</p>	F 280			

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F 280	<p>Continued From page 20</p> <p>applied a gait belt and he was assisted to a standing position. He used a walker and a transfer disk (lazy susan type round device) to complete the transfer.</p> <p>Review of the 2/24/16 CNA care sheet revealed resident 5 was to have been transferred with a slide disk transfer board. He was also to have "TTWB-LLE" (toe-touch weight bearing on left lower extremity).</p> <p>Review of the 12/8/15 care plan revealed: *A focus area of "Hygiene/ADL's/Skin" stating the resident was "unable to sit." The interventions did not reveal he used a trapeze on his bed to assist with bed mobility. It did not indicate his limited weight bearing status. *A focus area of Mobility/Fall Prevention: -"I can ambulate. -I require staff assistance to ambulate. -I use a walker, crutches, or wheelchair for mobility." The interventions did not indicate he used a gait belt, walker, and transfer disk for transferring. It also did not indicate he used a trapeze for bed mobility. It did not indicate his limited weight bearing status.</p> <p>Interview on 2/25/16 at 9:00 a.m. with nurse manager K confirmed the care sheets were not correct and the care plan did not reflect the current resident status. She would update those today.</p> <p>3. Review of resident 10's medical record revealed the 2/24/16 care plan focus area of "Nutritional Status: On a NAS [no added salt] /1500cc [specific unit of measurement for liquids] fluid restriction" diet.</p>	F 280		

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NAME OF PROVIDER OR SUPPLIER FOUNTAIN SPRINGS HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 WESLEYAN BLVD 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 280	<p>Continued From page 21</p> <p>Review of the 2/23/16 CNA care sheet did not indicate she was on a fluid restriction.</p> <p>Review of the provider's revised August 2014 Care Planning policy revealed: *"Individual, resident-centered care planning be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence." *"Care planning is constantly in process; it begins the moment the resident is admitted to the facility and doesn't end until discharge or death."</p> <p>Interview on 2/25/16 at 9:18 a.m. with the director of nursing confirmed the CNA care sheet were "real time," meaning they were to have been current and up to date.</p> <p>Surveyor: 29354 4. Observation on 2/24/16 at 11:55 a.m. with CNAs A and B in resident 2's room revealed they transferred him without a gait belt from the wheelchair to the bed. They placed their arms under his arms, grabbing a hold of his pants, and then lifting him.</p> <p>Observation on 2/24/16 at 3:15 p.m. with CNAs G and H in resident 2's room revealed they transferred him with a gait belt from the bed to the wheelchair in the same manner as above.</p> <p>Review of the care plan revealed: *Revised 4/24/14: Hygiene/ADLs (activities of daily living)/Skin: I transfer with the hoyer (mechanical lift for total lift). *Revised 6/12/15: Mobility/Fall Prevention: Transfer with hoyer lift.</p>	F 280			

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F 280	<p>Continued From page 22</p> <p>Review of resident 2's 2/24/16 CNA care sheet revealed to "transfer with assist of 2."</p> <p>Interview on 2/25/16 at 8:15 a.m. with the Minimum Data Set (MDS) nurse regarding resident 2 revealed: *The CNA care sheets were "worksheets" for the staff to use. *Nurse managers J and K updated the CNA care sheets. *Information on the care plan should have been carried over to the CNA care sheets. *Resident 2 was to be transferred with the hooyer lift. *The information on the CNA care sheet was incorrect regarding how to transfer resident 2. *It had been "universal" on deciding how to transfer a resident. It had involved physical therapy and reviewing safety measures for each resident. *Anyone could update the care plan.</p> <p>Interview on 2/25/16 at 8:45 a.m. with the DON, MDS nurse, nurse managers J and K regarding resident 2 revealed: *"What was on the care plan was how the resident should have been transferred." *All agreed: -The care plan had not been consistent with the CNA care sheets. -CNAs A, B, G, and H had transferred him incorrectly.</p> <p>5. Observation and interview on 2/24/16 at 8:10 a.m. with licensed practical nurse I regarding resident 6 revealed she had been on isolation precautions (special precautions to prevent the transmission of serious illnesses).</p>	F 280		
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F 280	<p>Continued From page 23</p> <p>Random observations on 2/24/16 revealed staff members putting on masks, gowns, and gloves before entering resident 6's room.</p> <p>Review of resident 6's medical record revealed she had been admitted on 2/14/16 with hospital discharge diagnoses of pneumonia and positive for MRSA (methicillin resistant staph aureus) (bacterial infection) in her sputum.</p> <p>There was no documentation on resident 6's care plan she had been on isolation precautions.</p> <p>Review of the 2/24/16 CNA care sheet revealed "Current Issues/Falls/Interventions: Resp (respiratory)/Contact Isolation."</p> <p>Interview on 2/25/16 at 8:15 a.m. with the MDS nurse regarding resident 6 revealed: *She confirmed isolation procedures were not on the care plan. *Nurse managers J and K completed all of the admissions and updated the care plans after admission. *Her expectations would have been for isolation procedures to be on the care plan.</p> <p>Interview on 2/25/16 at 8:45 a.m. with the DON, MDS nurse, and nurse managers J and K regarding resident 6 revealed: *They agreed isolation procedures had not been on the care plan. *Nurse manager K had done resident 6's admission and had not added isolation procedures to the care plan. *Isolation procedures should have been added to the care plan. Surveyor: 32355</p>	F 280		
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F 280	<p>Continued From page 24</p> <p>6. Observation on 2/24/16 at 10:10 a.m. of resident 8's bed revealed: *A lipped (built-up edges) mattress. *Two quarter (1/4) sized grab bars placed at the head of her bed.</p> <p>Review of resident 8's medical record revealed: *An admission date of 12/4/15. *Diagnoses of second lumbar vertebra fracture (lower back), osteoporosis (weak bones), chronic pain, anxiety, and depression. *She had required staff assistance to transfer from one location to another and in/out of her bed.</p> <p>Review of resident 8's 12/4/15 comprehensive care plan revealed: *She had a history of falls related to transferring herself without staff assistance. *No documentation to support the use of a lipped mattress or grab bars.</p> <p>7. Observation on 2/24/16 at 10:35 a.m. of resident 4's bed revealed: *A lipped mattress. *Two 1/4 sized grab bars placed at the head of her bed.</p> <p>Review of resident 4's medical record revealed: *An admission date of 1/19/16. *Diagnoses of chronic congestive heart failure, urinary tract infection, high blood pressure, and fractured left wrist. *She had required staff assistance to transfer from one location to another and in/out of her bed.</p> <p>Review of resident 8's 1/19/16 comprehensive care plan revealed no documentation to support</p>	F 280			

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F 280	<p>Continued From page 25 the use of a lipped mattress or grab bars.</p> <p>8. Observation on 2/24/16 at 10:39 a.m. of resident 7's bed revealed two 1/4 sized grab bars placed at the head of her bed.</p> <p>Review of resident 7's medical record revealed: *An admission date of 1/14/16. *Diagnoses of congestive heart failure, respiratory failure (poor air movement through the lungs), chronic obstructive pulmonary disease (lung disease), UTI, fractured right wrist and humerus. *She had required staff assistance to transfer from one location to another and in/out of her bed.</p> <p>Review of resident 7's 1/16/16 comprehensive care plan revealed no documentation to support the use of grab bars.</p> <p>Interview on 2/25/16 at 10:35 a.m. with the DON and MDS assessment nurse confirmed the lipped mattresses and grab bars should have been identified on all of the above care plans.</p> <p>Review of the provider's August 2014 Care Planning policy revealed: *"Individual, resident-centered care planning be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence." *"Care planning is constantly in process; it begins the moment the resident is admitted to the facility and doesn't end until discharge or death." *"Interventions act as the means to meet the individual's needs." *"Each department supplies information and input</p>	F 280			

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F 280	Continued From page 26 into all areas of the care plan as they obtain information." *"It is the responsibility of all direct care members to familiarize themselves with the care plans and review them routinely for changes."	F 280	F281 1. Resident #7 expired on 3/5/2016. All residents with pressure ulcers have been audited to ensure they have the appropriate documentation, MD orders, and MD notification. All residents who use oxygen have been audited to ensure they have appropriate orders and documentation on the TAR. All Residents are at risk.	*4/15/16 LA/SDDO/HJEL	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, record review, policy review, guideline review, and job description review, the provider failed to ensure: *One of three sampled residents (7) with two facility-acquired stage II pressure ulcers (shallow opening of the skin) were monitored and assessed in a timely manner. *Physician's orders were followed for one of five sampled residents (7) requiring the use of oxygen. Findings include: 1. Review of resident 7's medical record revealed: *An admission date of 1/14/16. *Diagnoses of congestive heart failure, respiratory failure (poor air movement through the lungs), chronic obstructive pulmonary disease (COPD) (lung disease), urinary tract infection (infection in the bladder), fractured right wrist and humerus. *She had been admitted with a stage II (shallow opening of the skin) pressure ulcer on her sacral	F 281	2. Administrator, DON, and IDT have reviewed the policy for monitoring and assessing skin concerns and following MD orders for oxygen. DON or designee will educate all nursing staff on the procedure for monitoring and assessing identified skin concerns and following oxygen administration orders by March 25, 2016. 3. DON or designee will audit all residents with pressure ulcers weekly for appropriate documentation, MD orders, and MD notification. DON or designee will audit all residents with oxygen for appropriate orders and documentation weekly. These audits will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the Administrator for review and recommendations of continuation/discontinuation.  *LA/SDDO/HJEL	*4/15/16 LA/SDDO/HJEL	

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F 281	<p>Continued From page 27 (bony area of rectum) area. *The wound nurse had been monitoring and assessing that pressure ulcer weekly.</p> <p>Observation on 2/24/16 at 10:45 a.m. with certified nursing assistant (CNA) C while providing personal care to resident 7 revealed: *The resident had been assisted to the bathroom. *After the resident had completed going to the bathroom CNA C assisted her to stand up for perineal (area between both thighs) care. *During perineal care the surveyor observed two open areas. One of those open areas was located on her left buttock and the other open area had been on her right buttock. *Both of those open areas were over bony prominences and appeared to be stage II level pressure ulcers. *No open area had been observed on her sacral area.</p> <p>Interview on 2/24/16 at that time with CNA C revealed: *She had been: -Aware the resident had two open areas on her bottom. -Instructed by the nurse to apply a special protective cream to those open areas. *She was not sure how long the resident had those open areas.</p> <p>Review of the resident 7's nursing progress notes from 1/14/16 through 2/22/16 revealed: *On 1/14/16 she had been admitted with a stage II pressure to her sacral area. *On 2/15/16 "Small odd shaped open area to the coccyx. Bilat [bilateral] buttocks excoriated [open], red and blanchable." *No documentation to support:</p>	F 281		
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F 281	<p>Continued From page 28</p> <p>-The doctor or wound nurse had been notified of those excoriated areas.</p> <p>-The pressure ulcer to her sacral area had been healed.</p> <p>Review of resident 7's 2/15/16 comprehensive evaluation of skin inspection and risk factors form confirmed:</p> <p>*She continued to have an open area to her sacral area.</p> <p>*She had two new red and excoriated areas on her left and right buttocks.</p> <p>Review of resident 7's February 2016 treatment assessment record revealed:</p> <p>*No documentation to support:</p> <p>-A separate treatment for those red and excoriated areas had been obtained.</p> <p>-The nursing staff had continued to monitor and assess those red and excoriated areas after 2/15/16.</p> <p>-When the sacral area had been healed.</p> <p>Review of resident 7's 2/19/16 weekly wound documentation form revealed:</p> <p>*The wound nurse had assessed the resident's pressure ulcer to her sacral area.</p> <p>*No documentation to support:</p> <p>-She had observed or assessed for any excoriated areas to the left or right buttocks.</p> <p>-Those red and excoriated areas had been healed.</p> <p>2. Observation on 2/25/16 at 8:50 a.m. with the wound nurse while assessing resident 7's bottom revealed:</p> <p>*She confirmed:</p> <p>-The open area to the resident's sacral area had been healed.</p>	F 281			

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F 281	<p>Continued From page 29</p> <p>-The resident had two new open areas located on her left and right buttocks.</p> <p>Interview on 2/25/16 at that time with the wound nurse revealed:</p> <p>*The resident had not always been cooperative with changing positions as recommended.</p> <p>*She had assessed the resident's bottom on 2/19/16.</p> <p>*She could not recall observing any red or excoriated areas to the resident's bottom during that observation.</p> <p>*She stated:</p> <p>-"Since I did not see anything, I'm sure they were healed."</p> <p>-"The resident had the right treatment for those types of wounds to heal quickly."</p> <p>-"Those types of wounds can develop quickly."</p> <p>*She would have only monitored, assessed, and documented on pressure ulcers.</p> <p>*The nursing department had been responsible for assessing and monitoring all other types of wounds or skin issues.</p> <p>*Those stage II pressure ulcers would have been documented as new areas of concern as of 2/25/16.</p> <p>*She could not provide documentation upon request from the surveyor to support:</p> <p>-The nursing department had notified her of those red and excoriated areas on 2/15/16.</p> <p>-The stage II pressure ulcers had been observed by the nursing department prior to her assessment on 2/25/16.</p> <p>Interview on 2/25/16 at 9:30 a.m. with the director of nursing (DON) revealed:</p> <p>*She had not been aware of the new open areas to the resident's bottom.</p> <p>*She would have expected the nursing</p>	F 281		
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F 281	<p>Continued From page 30</p> <p>department to have:</p> <ul style="list-style-type: none"> -Notified the physician and wound nurse of the red and excoriated areas on 2/15/16. -Continue to monitor those two new areas of concern. -Identified and documented when those two areas had healed or worsened. -Identified, assessed, and documented on the new stage II pressure ulcers to her buttocks prior to the surveyor's observation on 2/24/16. <p>*The wound nurse should have documented her observation and assessment of those red and excoriated areas on 2/19/16.</p> <p>Review of the provider's February 2014 Prevention of Pressure Ulcers policy revealed:</p> <p>***The facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family, and addressed.</p> <p>***Immediately report any signs of a developing pressure ulcer to the supervisor.</p> <p>***Routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown.</p> <p>3. Observation on 2/24/16 at 10:39 a.m. of resident 7 revealed she had been using oxygen.</p> <p>Review of resident 7's medical record revealed:</p> <ul style="list-style-type: none"> *Diagnoses of CHF, respiratory failure, and COPD. *On 1/14/16 the physician had ordered her to use oxygen continuously at 3 liters per minute (LPM). <p>Review of resident 7's 2/3/16 physician's orders confirmed she required the use of oxygen at 3</p>	F 281			

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F 281	<p>Continued From page 31 LPM continuously.</p> <p>Review of resident 7's January 2016 through February 2016 medication assessment record revealed: *On 2/16/16 the physician had ordered "Titrate O2 (oxygen) to keep saturation at least 90% (percent) with rest and activity. O2 at 3 LPM at night (or higher if needed to keep sat at least 90%) every shift." *No documentation by the nursing department to support the resident had been using oxygen prior to 2/16/16.</p> <p>Interview on 2/25/16 at 10:45 a.m. with the DON and MDS assessment nurse confirmed: *The nursing department had not been documenting the use of oxygen for resident 7 until 2/16/16. *There should have been documentation to support the resident had been using oxygen since her admission on 1/14/16.</p> <p>Review of the provider's undated Charge Nurse Job Description revealed "Monitor medication passes and treatment schedules to assure that medications are being administered as ordered and that treatments are provided as scheduled."</p> <p>Review of the provider's undated Notification of Change in Resident Health Status Guideline revealed: "The facility will consult the resident's physician, nurse practitioner or physician assistant, when there is a need to alter treatment significantly (i.e. a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment)."</p> <p>Review of Patricia A. Potter and Anne Griffin</p>	F 281			

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F 281	Continued From page 32 Perry, Fundamentals of Nursing, 8th Ed., Pages 4, 305, and 850, St. Louis, Mo, 2013, revealed: *Page 4: "The Standards of Practice describe a competent level of nursing care. The nursing process is the foundation of clinical decision making and includes all significant actions taken by nurses in providing care to patients." *Page 305: "The health care provider (physician or advanced practice nurse) is responsible for directing medical treatment. Nurses follow health care providers' orders unless they believe the orders are in error or harm patients." *Page 850: "The dosage or concentration of oxygen is monitored continuously. Routinely check the health care provider's orders to verify that the patient is receiving the prescribed oxygen concentration."	F 281	F356 1. No immediate action could be taken for the missed nurse staffing postings. The facility is posting nurse staffing daily. All residents are at risk. 2. Administrator or designee will educate DON and nursing staff responsible for posting on ensuring that posting is completed daily by March 25, 2016. 3. Administrator or designee will audit staffing posting 5 times per week to ensure that it is posted and accurate. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the Administrator for review and recommendations of continuation/discontinuation.	*4/15/16 LAISDDO/H/EL	
F 356 SS=D	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format.	F 356	 *LAISDDO/H/EL	*the monthly LAISDDO/H/EL	

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F 356	<p>Continued From page 33</p> <p>o In a prominent place readily accessible to residents and visitors.</p> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation and interview, the provider failed to ensure the twenty-four hour nursing staff information was posted and reflected the actual staffing that was on duty to provide the basic care needs to all eighty-three residents. Findings include:</p> <p>1. Random observations on 2/24/16 at 8:00 a.m. through 2/25/16 revealed no posting of nursing staffing information.</p> <p>Interview on 2/25/16 at 10:45 a.m. with the administrator confirmed the staffing had not been posted at the nurses station as she thought. Eighteen months of past postings were requested. REview of those postings revealed the last posting had been in August 2015. The administrator agreed the staffing should have been posted at the nurses station. She also agreed the past postings were for Monday through Friday and not for the weekends. The administrator confirmed there was no policy regarding staff postings, but they "followed state</p>	F 356			

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F 356 F 441 SS=E	Continued From page 34 and federal regulations." 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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 356 F 441	F441 1. Rooms # 221,231, 342, and 349 have had the resident personal items identified, labeled, dated, and separated appropriately. Room #342 since has been cleaned and soap has been replaced. No immediate action could be taken for CNAs A, B, and E. No immediate action could be taken for Residents #3 and 12. All residents personal items have been identified, labeled, dated, and separated appropriately. All residents with catheters have a privacy storage bag on their bed and wheelchairs. All residents are at risk. 2. Administrator, DON and IDT have reviewed the policies on storage of personal items, hand hygiene and appropriate placement of catheter bags when in bed or chair. DON or designee will educate all staff resident's personal items storage, handwashing, gloving, catheter storage, and cleaning spigot by March 25, 2016. 3. DON or designee will audit 5 resident rooms per week to check that resident items are identified, labeled, dated, and separated appropriately, 5 instances of resident care for appropriate handwashing and gloving techniques, and 5 residents with catheters to ensure that their catheters are being stored and transported appropriately. This audit will be done weekly for 4 weeks and then monthly for two months. Audit will be brought to QAPI by the DON for review and	<i>*4/15/16 LA/SDDOHWEL</i>	

**CNAs A, B, and E will receive one on one education on infection control procedures before 4/15/16. LA/SDDOHWEL*

**Some of the audits will include CNAs A, B, and E along with residents 1, 2, 3, and 12. LA/SDDOHWEL*

**monthly LA/SDDOHWEL*

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F 441	Continued From page 35 This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Surveyor: 29354 Based on observation, interview, and policy review, the provider failed to ensure: *Resident personal care items were stored separately in four of four resident rooms (221, 231, 342, and 349). *Proper handwashing and glove use observed during three of seven sampled residents (1, 2, and 3) personal care by three of three certified nursing assistants (CNA) A, B, and E. *Proper placement of a urinary catheter bag (assists with emptying the bladder) for two of two observed residents (3 and 12) who had a catheter. Findings include: 1. Observation on 2/24/16 at 10:10 a.m. in room 221 revealed a sink. On the: *Left side of the sink: -Was a small pink container with a tooth brush and two combs. -There were pieces of hair on the toothbrush. -The items were not marked or dated. *Right side of the sink: -Was a small pink container with a toothbrush, a brush with hair in the bristles, and a comb with pieces of hair. -The items were not marked or dated. *There was no identification indicating which items on the sink belonged to each resident in the shared room.	F 441	recommendations of continuation/discontinuation.  *LAP/SDD/STJ/EL	

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F 441	<p>Continued From page 36</p> <p>2. Observation on 2/24/16 at 10:15 a.m. in room 231 revealed a sink. On the:</p> <p>*Left side of the sink:</p> <ul style="list-style-type: none"> -Was a small pink container. In the pink container was a dirty toothbrush with hair. -Was a small tube of tooth paste with the cap laying beside it. -A small covered glass with a straw. <p>*Right side of the sink :</p> <ul style="list-style-type: none"> -Was a small pink container. In the pink container was a toothbrush and comb with hair. *The items were not marked or dated. *There was no identification indicating which items on the sink belonged to each resident in the shared room. <p>Observation and interview on 2/24/16 at 10:25 a.m. with certified nursing assistant (CNA) A in room 231 revealed:</p> <ul style="list-style-type: none"> *The left side of the sink was resident 2's supplies and the right side of the sink was the roommate's items. *She then took the unmarked, covered drinking glass with straw from the left side of the sink and placed it on the right side of the sink. *She confirmed: -The residents' personal items were not marked. -The unmarked, covered drinking glass with straw that she moved to the right side of the sink had been placed on the wrong side of the sink. <p>Surveyor: 32355</p> <p>3. Observation on 2/24/15 at 7:45 a.m. in room 342 revealed:</p> <ul style="list-style-type: none"> *The room had been shared by two residents. *The left side of the sink had: -Been covered with several areas of brown colored stains. The stains appeared to be from some type of liquid. 	F 441			

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F 441	<p>Continued From page 37</p> <p>-A used bar of soap laying directly on the counter top. That bar of soap was covered with brown colored stains and had been unmarked.</p> <p>-Two unmarked toothbrushes laying directly on the counter top and next to the bar of soap.</p> <p>*The right side of the sink had two unmarked toothbrushes laying directly on the counter top.</p> <p>*There was no identification indicating which items on the sink belonged to each resident in the shared room.</p> <p>4. Observation on 2/24/15 at 8:00 a.m. in room 349 revealed:</p> <p>*The room had been shared by two residents.</p> <p>*The left side of the sink had:</p> <p>-Two unmarked toothbrushes. One toothbrush had been placed inside of a drinking glass. The top of the toothbrush had been resting up against the wall underneath used towels. The other toothbrush had been laying directly on the counter top.</p> <p>-An unmarked denture cup.</p> <p>*On the right side of the sink was a tube of toothpaste laying directly next to a hair brush. That hair brush had been unmarked and contained several gray colored hairs.</p> <p>*There was no identification indicating which items on the sink belonged to each resident in the shared room.</p> <p>Surveyor: 29354 Interview on 2/25/16 at 10:00 a.m. with the director of nursing (DON) and the Minimum Data Set (MDS) nurse revealed:</p> <p>*Resident personal care items should be labeled with their names.</p> <p>*Their expectations were to identify which supplies belong to an individual resident.</p>	F 441			

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F 441	<p>Continued From page 38</p> <p>Review of the provider's December 2013 Care and Storage of Resident Toothbrushes policy revealed: *"To assist in the prevention of the spread of infection by assuring resident toothbrushes are kept clean and stored in the resident's personal area. -Toothbrushes will be stored in a non-communal area such as a holder, top drawer of resident's bedside table in emesis basin, or in a plastic bag away from other personal care items such as razors, hairbrushes, etc. -Toothbrushes will be replaced as they become worn. -If a toothbrush is found to be left out in the resident's bathroom or on top of a nightstand or other area where the sanitation is questionable, the toothbrush will be discarded and replaced with a new one."</p> <p>Surveyor: 32355 5. Observation on 2/24/15 at 11:30 a.m. of CNA E providing personal care including toileting for resident revealed the CNA missed two opportunities for hand washing during that time. She did not wash her hands between glove use.</p> <p>Interview on 2/24/15 at that time with CNA E confirmed that had been her normal practice when providing personal care for residents.</p> <p>Interview on 2/25/16 at 10:45 a.m. with the DON revealed: *She would have expected the CNA to have washed her hands or used hand gel before and after glove use. *She agreed: -The above process had not been performed in a sanitary manner.</p>	F 441		

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F 441	<p>Continued From page 39</p> <p>-That process had created the potential for cross contamination of bacteria from one resident to another.</p> <p>Surveyor: 29354</p> <p>6. Observation on 2/24/16 from 11:55 a.m. through 12:10 p.m. of CNAs A and B in resident 2's room revealed:</p> <p>*CNA B pushed resident 2 into his room.</p> <p>*Without washing their hands, CNAs A and B put on gloves.</p> <p>*Resident 2 had a large amount of mucus on the front of his shirt. CNA B:</p> <p>-Took a paper towel and wiped the mucus off of his shirt.</p> <p>-Took the same paper towel and wiped his mouth with it.</p> <p>*Without washing her hands or changing her gloves, she assisted CNA A to transfer resident 2 from the wheelchair to the bed.</p> <p>*CNA B removed his pants.</p> <p>*CNA A removed his brief and takes cleaning wipes from a package and began to wipe fecal matter from his buttock area.</p> <p>*CNA B discarded the soiled brief into the garbage.</p> <p>*CNA A and B then placed a clean brief on him and repositioned him on his back.</p> <p>*CNA A:</p> <p>-Removed her soiled gloves and placed them on the resident's over-bed table.</p> <p>-Covered him with a blanket.</p> <p>*CNA B removed her gloves and went into his bathroom. She returned with a mattress.</p> <p>*CNA A:</p> <p>-Used the bed control to lower the bed and then placed the mattress on the floor.</p> <p>-Went over to the over-bed table, took the soiled gloves and discarded them into the garbage.</p>	F 441			

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F 441	<p>Continued From page 40</p> <p>*CNA A and B had not washed their hands nor used hand gel before and after glove usage.</p> <p>Interview on 2/25/16 at 10:00 a.m. with the DON and MDS nurse regarding resident 2 confirmed their expectations would have been for the CNAs to have washed their hands or used hand gel before and after glove usage.</p> <p>Surveyor 32572 7. Observation on 2/24/16 at 10:30 a.m. revealed resident 3 laying in bed. CNA A and B were going to assist with personal cares. CNA A missed four opportunities to perform hand hygiene. *She did not remove her soiled gloves prior to applying a clean incontinent product and touching the resident's clothing. *She removed her gloves and went into the hallway to obtain the EZ stand without performing hand hygiene. *She touched the residents hair brush and brushed his hair without performing hand hygiene. *She bagged the garbage up in the room, and pushed the resident out of the room. She then removed the garbage, came back into the room, and washed her hands.</p> <p>Surveyor 29354 Review of the provider's May 2014 Hand Hygiene in the Healthcare Setting guidelines revealed: *"Hand Washing with soap and water or Alcohol Based Hand Rub will always be performed at the following times: -Before and after assisting a resident with personal care. -Upon and after coming in contact with a resident's intact skin (lifting a resident). -Before and after assisting a resident with</p>	F 441			

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F 441	<p>Continued From page 41</p> <p>toileting (hand washing with soap and water). -After contact with a resident's mucous membranes and body fluids or excretions. - After removing gloves."</p> <p>8. Observation on 2/24/16 at 2:00 p.m. of resident 12 revealed he had been laying down in bed. The uncovered urinary catheter bag was laying on the floor next to the bed.</p> <p>Observation and interview on 2/24/16 at 2:45 p.m. through 2:50 p.m. with CNA G revealed: *He had gone into resident 12's room. *Upon leaving the room he told the surveyor he had gone into the room to see if resident 12 had needed anything. *Observation at 2:50 p.m. in resident 12's room revealed the resident remained in bed. The uncovered urinary catheter bag was laying on the floor next to the bed.</p> <p>Interview on 2/25/16 at 10:10 a.m. with the DON regarding resident 12 revealed her expectations would have been for the foley catheter bag to not be on the floor. The urinary catheter bag should have had a cover over it and attached to the bed.</p> <p>Surveyor: 32572</p> <p>9. Observation on 2/24/16 at 10:30 a.m. revealed resident 3 had been laying in his bed. The bed had been lowered to the floor with a floor mat beside it. The resident's uncovered catheter bag was lying on the floor with the spigot (a valve from which the urine is emptied from the bag) laying on the floor. Staff elevated the bed to provide care. CNA A picked up the bag and placed it on the bed with the spigot touching the bedding. She noted the spigot was not in the appropriate place and then placed it in the holder. She did not clean the</p>	F 441			

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F 441	<p>Continued From page 42</p> <p>spigot prior to placing it in the holder. The resident was gotten up and placed in his high-back wheelchair. The catheter bag was placed under the seat of his wheelchair. The spigot again was touching the floor. The resident was propelled into the hallway and then to the dining room on Miller place.</p> <p>Observation on 2/24/16 at 11:50 a.m. of resident 3 in the dining room. The uncovered catheter bag remained under the seat of the wheelchair with the spigot dragging on the floor.</p> <p>Interview on 2/25/16 at 9:18 a.m. with the director of nursing confirmed she would have expected: *The catheter bag to have been placed in a bag when on the bed. *The catheter bag to have been placed in a bag when on the wheelchair. *The spigot to have been cleaned prior to replacing into the holder.</p> <p>Review of the provider's revised November 2014 Urinary Catheter Care policy revealed: *The policy was "The purpose of this procedure is to prevent catheter-associated urinary tract infections." *"Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag." *"Be sure the catheter and tubing and drainage bag are kept off the floor."</p> <p>Review of the provider's revised July 2013 Infection Control - Inservice policy revealed: *The policy was "To assure that staff has access to new information and procedures concerning the control of infections." *"To review basic infection control policy and</p>	F 441		

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F 441	Continued From page 43 procedures with all staff annually."	F 441		