

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/21/2016
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NAME OF PROVIDER OR SUPPLIER PRAIRIE VIEW HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 401 SOUTH FIRST AVENUE POST OFFICE BOX 68 WOONSOCKET, SD 57385
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F 000	<p><i>*Addendums noted with asterisk per 5/16/16 per telephone with facility emergency permit holder and DON. JVE/SPD/HLE</i></p> <p>INITIAL COMMENTS</p> <p>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/19/16 through 4/21/16. Prairie View Healthcare Community was found not in compliance with the following requirements: F157, F279, F281, F309, F314, F323, F329, F371, F372, F441, and F514.</p>	F 000	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.	
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); 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); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p>	F 157	<p>F157</p> <p>1. The physician for resident 1 has been notified of the incident that occurred on 3/15/16.</p> <p>2. All residents are at risk.</p> <p>3. The Director of Nursing (DON) will educate all nurses no later than 5-14-16 on the requirement for notifying the</p>	5-19-16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Kayla Evans	TITLE Admin, eph	(X6) DATE 5/10/16
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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 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on record review and interview, the provider failed to ensure there was documentation the physician was contacted in a timely manner for one of one sampled resident (1) in the special care unit (SCU) with regard to using physical restraints and anti-anxiety medication. Findings include: 1. Review of resident 1's medical record revealed: *She was admitted to the SCU on 9/21/15. *She had diagnoses for: -Alzheimer's disease with behavioral disturbance. -Osteoporosis (weakened bones). -Elevated cholesterol. -Underactive thyroid. -High blood pressure. -Overactive bladder. -Impaired glucose tolerance (higher than normal blood sugar). -Attention or concentration deficit. -Major depressive disorder, recurrent and severe without psychotic features. *Her 3/29/16 quarterly Minimum Data Set assessment revealed: -A Brief Interview for Mental Status score of three out of fifteen indicating severe cognitive impairment (ability to think clearly and make decisions). -She exhibited behaviors of rejection of care one	F 157	physician with any changes of condition. Those not in attendance at education session will be educated prior to their first shift worked. 4. The DON or designee will audit four medical charts per week to ensure there is documentation of physician notification for any changes of condition. Audits will continue for four weeks and then monthly for three months. Audits will be discussed by the DON in monthly Quality Assurance Process Improvement (QAPI) for review and recommendations of continuation/discontinuation of audit.	

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F 157	<p>Continued From page 2 to three days a week.</p> <p>Review of resident 1's medication administration record (MAR) revealed she was administered lorazepam (anti-anxiety medication) 0.5 milligrams (mg) via intramuscular injection (a shot into the muscle [IM]) on 3/15/16. No time was documented on the MAR.</p> <p>Review of registered nurse (RN) L's interdisciplinary progress note regarding resident 1 on 3/15/16 at 8:45 p.m. revealed: *She became physically and verbally abusive to staff. *No nonpharmacologic (non-medication) interventions were documented. *Two certified nursing assistants (CNA) held onto each arm as an IM injection of lorazepam 0.5 mg was administered by the RN. *There was no documentation the physician was notified of the incident.</p> <p>Interview on 4/21/16 at 10:30 a.m. with the director of nursing (DON) revealed: *The physician was in the facility on rounds on 3/16/16 and likely would have been notified at that time. *She could not provide documentation that any notification of the physician had occurred. *It was her expectation the physician was to have been notified and documented of any change in a resident's status including the need to have been restrained and administered an injection.</p> <p>Policies concerning physician notification were requested on 4/21/16 from the DON. There were no policies received before the end of the survey.</p> <p>Review of Patricia A. Potter and Anne Griffin</p>	F 157		

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F 157	Continued From page 3 Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, pp. 357-358, revealed: *"Nurses communicate information about patients [resident] to help team members make appropriate decisions about patient care. *A registered nurse makes a telephone report when significant events or changes in a patient's condition have occurred."	F 157			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on record review, interview, observation, and policy review, the provider failed to accurately	F 279	F279 1. Resident 7's plan of care has been updated to reflect weight loss and Resident 10's smoking care plan has been updated. 2. All residents are at risk. 3. The DON will educate the Interdisciplinary Team (IDT) no later than 5-14-16 on ensuring plans of care are updated timely to reflect resident's current health care, dietary, activities and psychosocial needs/status. 4. The DON or designee will audit four plans of care per week to ensure the plan of care reflects the current care needs and status of the resident. Audits will continue for four weeks and then monthly for three months. Audits will be discussed by the DON at monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit.	5-19-16	

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F 279	<p>Continued From page 4</p> <p>revise the care plan for:</p> <p>*One of one sampled resident (7) who had severe weight loss (greater than ten percent [%] in six months).</p> <p>*One of one sampled resident (10) who smoked cigarettes.</p> <p>Findings include:</p> <p>1. Review of resident 7's medical record revealed:</p> <p>*She had been admitted on 6/2/04.</p> <p>*Her weight on the following dates were:</p> <p>-4/18/16: 111.5 pounds (lb).</p> <p>-4/12/16: 112.5 lb.</p> <p>-3/31/16: 114 lb.</p> <p>-3/24/16: 115.5 lb.</p> <p>-3/17/16: 117.0 lb.</p> <p>-3/3/16: 118.5 lb.</p> <p>-2/22/16: 121.0 lb.</p> <p>-1/28/16: 123.5 lb.</p> <p>-12/28/15: 127.0 lb.</p> <p>-11/5/15: 132.0 lb.</p> <p>-11/2/15: 133 lb.</p> <p>*She had lost a total of 21.5 lb or 16.2% of her total body weight from 11/2/15 to 4/18/16.</p> <p>*A weight loss of greater than 10% in six months was considered severe weight loss.</p> <p>Review of resident 7's revised 4/4/16 care plan revealed:</p> <p>*"I will maintain my weight between 120-125 [lb]."</p> <p>*"Weigh me weekly with baths."</p> <p>*There was no documentation regarding her weight loss.</p> <p>Review of the consultant registered dietitian's (RD) progress notes from 1/11/16 through 4/12/16 regarding resident 7 revealed:</p> <p>*On 4/12/16:</p>	F 279		

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F 279	<p>Continued From page 5</p> <p>-Weight was 112.5 lb. -She had lost 4.5 lb in one month. -She was on the nutritional risk list for monthly RD review. *On 3/21/16: -Weight was 117 lb. -She had lost 4 lb in one month. -She was on the nutritional risk list for monthly RD review. -An appetite stimulant had been started. *On 1/11/16: -Weight was 126.5 lb. -She had lost 4.5 lb from the last quarter. -She was on the nutrition intervention program (increased calories without increased food volume).</p> <p>Interview on 4/19/16 at 4:40 p.m. with the director of nursing (DON) regarding resident 7's weight loss revealed: *She acknowledged resident had lost a significant amount of weight. *Weights were not kept current on the care plan, and those weights should have been updated. *It had been the responsibility of each department to have kept the care plan current. *Dietary department staff had been responsible for updating the nutritional section that included the weight loss.</p> <p>Interview on 4/20/16 at 10:10 a.m. with the DON and the dietary manager regarding resident 7's weight loss revealed: *Both agreed the weights were not kept current on the care plan, and the weight loss needed to have been documented on it. *Each member of the care team was responsible for updating and revising the care plan as needed.</p>	F 279		

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F 279	<p>Continued From page 6</p> <p>Review of the provider's 11/6/15 Care Plan Updates policy revealed: *For non-safety care plan changes it is the expectation that the care plan is updated within 24 hours by the appropriate department." *An example of a non-safety updates had included a food dislike. *That above policy had not included when to have updated the care plan for weight loss. *The department director was responsible for making the changes to the care plan.</p> <p>Review of the provider's 11/6/15 Care Plans-Comprehensive policy revealed: *The individualized comprehensive care plan included measurable objectives (goals) to meet the resident's medical, nursing, mental, and psychological needs. *The comprehensive care plan was based on a thorough assessment. *That above assessment was ongoing, and the care plans were revised as: -Information about the resident changed. -Resident condition changed.</p> <p>2. Review of resident 10's medical record revealed he had: *Been admitted on 4/13/16. *Diagnoses that had included nicotine dependence.</p> <p>Review of the 4/13/16 admission physician's progress note for resident 10 revealed "He does smoke at least a pack [cigarettes] per day."</p> <p>Review of the 4/18/16 smoking or E-cigarette assessment for resident 10 revealed he:</p>	F 279			

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F 279	<p>Continued From page 7</p> <ul style="list-style-type: none"> *Smoked cigarettes. *Smoked ten or greater times per day. *Smoked in the morning, afternoon, evening, and at night. *Was able to light his own cigarette safely. *Had not needed the provider to store his lighter and cigarettes. <p>Review of the 4/13/16 short-term care plan for resident 10 revealed:</p> <ul style="list-style-type: none"> *He was a smoker. *The care plan had no documentation regarding what, when, where, or how he smoked. *The care plan had no documentation regarding where his lighter was to have been stored. <p>Interview and observation on 4/20/16 at 3:30 p.m. with resident 10 revealed he:</p> <ul style="list-style-type: none"> *Smoked cigarettes multiple times per day. *Had been a smoker for many years, and he rolled his own cigarettes. *Kept his lighter in his front left pocket of his shirt at all times. <p>Interview on 4/21/16 at 9:30 a.m. with the administrator and the nurse consultant regarding resident 10 revealed:</p> <ul style="list-style-type: none"> *The short-term care plan needed to have been more detailed on his smoking. *That above care plan had not included information on where his lighter was to have been stored. <p>Review of the provider's revised April 2016 Smoking Policy Residents policy revealed:</p> <ul style="list-style-type: none"> *Any smoking-related privileges, restrictions, and concerns were to have been noted on the resident's individual care plan. *The care plan was to have indicated how the 	F 279			

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F 279	Continued From page 8 smoking materials were to have been stored. Review of the provider's 11/6/15 Care Plans-Preliminary policy revealed it was to have ensured the resident's immediate care needs were met and maintained.	F 279			
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: 29354 Based on record review, interview, and policy review, the provider failed to follow professional standards for the pronouncement of death for two of two sampled residents (6 and 11). Findings include: 1. Review of resident 6's medical record revealed she had died on 4/19/16. The 4/19/16 at 13:44 (1:44 p.m.) progress notes stated "Unable to obtain BP [blood pressure] at this time. Resident passed at 1307 [1:07] p.m." Interview on 4/21/16 at 10:00 a.m. with the director of nursing (DON) regarding resident 6 revealed: *Her expectations would have been for the nurse to not document "resident passed." *She used Perry and Potter and the South Dakota Board of Nursing as her professional standard references. Surveyor: 32331	F 281	F281 1. No correction can be made to Resident 6 and 11's documentation entered at the time of their death. 2. All residents are at risk. 3. The Administrator and DON have reviewed the policy on appropriate documentation by the licensed nurse at the time of death and will educate all nurses on policy no later than 5-14-16. Those not in attendance at education session will be educated prior to their first shift worked. 4. The DON or designee will review the documentation at time of death for all residents who die each week. Audits will continue for four weeks and then monthly for three months. Audits will be discussed by the DON at monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit.	5-19-16	

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F 281	<p>Continued From page 9</p> <p>2. Review of resident 11's medical record revealed she had: *Died on 2/7/16. *On 2/7/16 at 10:15 p.m. registered nurse (RN) L's progress note stated: "Called _____ [son's number] and spoke to _____ [son's spouse] and told her that resident was gone. _____ [son's spouse] stated she would call family and notify them. Hospice was called and _____ [resident's physician] fax sent a fax to notify him of death." *On 2/7/16 at 10:20 p.m. a fax had been sent by RN L to the resident's physician with the following word documented "Expired [died]."</p> <p>Interview on 4/21/16 at 11:05 a.m. with the DON and the Minimum Data Set coordinator regarding resident 11 revealed: *Both agreed the physician needed to have been called regarding no respiration, no heart beat, and no blood pressure. *Both agreed the charge nurse that had documented the death of the resident had done so without proper diagnosis from the resident's physician. *The DON confirmed making a diagnosis was not within the scope of practice for a nurse.</p> <p>Surveyor: 29354</p> <p>3. Review of the provider's undated At Death of Resident policy revealed: "Information to be charted in nurses notes: No breath sounds, pulse or blood pressure."</p> <p>Review of a letter dated 8/4/14 from the South Dakota Board of Nursing revealed "A licensed nurse can not pronounce death."</p> <p>Surveyor: 32331 Review of Patricia A. Potter and Anne Griffin</p>	F 281		

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F 281	Continued From page 10 Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, p. 306, revealed, "Under the law practicing nurses must follow standards of care, the guidelines of professional organizations, and the written policies and procedures of employing institutions."	F 281			
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 34030 A. Based on observation, interview, and record review, the provider failed to assess, develop, and implement interventions for pain management for one of one sampled resident (2) with uncontrolled pain during the resident's dressing change. Findings include: 1. Observation on 4/20/16 at 10:00 a.m. of resident 2's dressing change to her pressure ulcer on her coccyx with registered nurses (RN) C and N revealed: *RN N performed the dressing change while RN C assisted with the positioning of the resident. *The resident was repositioned two to three times during the dressing change. *She grimaced and called out when she was repositioned.	F 309	F309 1. Resident 2 was seen by her Hospice provider at time of survey and pain medication was adjusted. Resident 2 is now deceased. No correction action can be taken for Resident 2, 6 and 11's care plans as all residents are deceased. 2. All residents are at risk. 3. The Administrator, DON, Medical Director and IDT have reviewed the policy on pain management and reviewed the cited deficiency. The Administrator, DON, Hospice Provider and IDT have reviewed the Hospice policy on education and collaboration of plans of care. Education will be provided no later than 5-14-16 to all direct care staff on Hospice services and pain management. Those not in attendance at the education session will be educated prior to their first shift worked. *Education was provided to all staff on pain on 5/10/16. JVE/SDD/H/L 4. The DON or designee will audit four resident cares, including any resident on Hospice care, each month to ensure resident's pain management is adequate and will ensure all resident's on Hospice care have an integrated plan of care.	5-19-16	

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F 309	Continued From page 11. Interview immediately after the above observation with RN C regarding resident 2 revealed: *She had assessed the resident for pain one half hour before the dressing change, and she had appeared comfortable. *She had not received extra pain medication prior to the scheduled dressing change. *She thought the resident's discomfort was due to repositioning her, and not the dressing change itself. Review of resident 2's medical record revealed: *She had been admitted on 8/4/12 and was placed on hospice care on 12/30/15 with the goal to keep her comfortable. *Her diagnoses included arthritis with generalized pain and a stage four pressure ulcer (an injury to the skin and underlying tissue caused by pressure, usually over a bony area). -The pressure ulcer started as a peri-rectal abscess on 6/15/15. -She was then admitted to the hospital for twelve days for treatment of the abscess. -She was readmitted on 6/26/15 with a pressure ulcer to her coccyx. *She had a daily dressing change to her pressure ulcer. *There was no documentation from 2/24/16 up to 4/20/16 nursing pain assessments had been done before or after her dressing changes. *A nurse's note written by RN C from the day of the observed dressing change on 4/20/16 stated "Resident noted to moan when repositioning to prepare for dressing change, no s/s [sign or symptom] of pain noted while performing dressing change." Review of resident 2's 3/16/15 annual Minimum	F 309	Audits will be weekly for four weeks and then monthly for three months. Results of the audits will be discussed by the DON at monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit. <i>*The DON or designee and MDS nurse will review nurses notes and do walking rounds to identify and respond to residents with pain. JVE/SPDOH/EL</i>		

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F 309	<p>Continued From page 12</p> <p>Data Set (MDS) assessment revealed: *A Brief Interview for Mental Status score (BIMS) of six out of fifteen indicating moderately impaired thinking and judgement. *Her behaviors included refusing cares, verbal and physical. *She was independent in her functioning.</p> <p>Review of resident 2's 4/12/16 quarterly Minimum Data Set (MDS) assessment revealed: *A BIMS assessment had been performed by staff. *The resident had been unable to complete it, indicating severe cognitive impairment. *She had pain and showed it by facial grimacing and moaning. *She had received scheduled pain medication.</p> <p>Review of resident 2's medication administration record for April 2016 showed: *Her scheduled pain medication was a fentanyl (a narcotic) pain patch that delivered continuous medication. *Her as needed (PRN) pain medication consisted of: -Tylenol: none had been given for that month. -Morphine (a narcotic pain medication) to be given every hour PRN. It was used twice in April on 4/2/16 and 4/6/16.</p> <p>Review of resident 2's current 4/19/16 care plan revealed: *She had chronic pain due to arthritis. *Interventions were: -"11/2/15, I know nurse will assess for pain prior to dressing changes and provide pain medication..." -"1/7/16, morphine/ativan/atropine as ordered for comfort."</p>	F 309		

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F 309	<p>Continued From page 13</p> <p>*There was no documentation about the dressing change nor any interventions for pain control before the dressing change was done.</p> <p>Interview on 4/21/16 at 11:00 a.m. with RN O regarding the dressing change on resident 2 revealed: *She said "ow" for everything." *She "holds her breath when she's having pain." *When asked what she would do if she noticed the resident having pain during a dressing change, she had no response.</p> <p>Interview on 4/21/16 at 1:40 p.m. with the director of nursing services and the administrator regarding resident 2 revealed: *They did not believe she was having pain during the dressing change. *The hospice nurse came to see the resident last night to reassess her for pain at their request. *Per the hospice note, hospice came per the request of the facility due to "state surveyors being there." *They stated hospice had recommended: -The dose of the resident's fentanyl be increased. -To use the PRN Morphine more often as needed. *They confirmed no routine pain assessments had been done by the provider. *A policy had been requested from the provider, none was provided by the time of exit.</p> <p>B. Based on record review, interview, and policy review, the provider failed to combine the hospice plan of care with the provider's plan of care to specify who was responsible for care for three of three sampled hospice residents (2, 6, and 11). Findings include:</p>	F 309		

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F 309	<p>Continued From page 14</p> <p>1. Review of resident 2's medical record revealed an admission date of 8/4/12. Hospice care had started on 12/30/15.</p> <p>Review of resident 2's current 4/19/16 provider's care plan revealed: *It was located in a care plan binder. The hospice agency's care plan was located in the resident's chart along with the hospice visitation notes. *The provider's care plan revealed: -The resident started hospice on 12/29/15. -"Hospice to evaluate and to help keep comfortable." -"See hospice care plan in resident chart 1/26/16." *No documentation was made on the provider's care plan to indicate who was responsible for what care the resident was to have received. Surveyor: 29354</p> <p>2. Review of resident 6's medical record revealed: *On 1/27/16 she had been placed on hospice services with diagnoses of dementia due to Alzheimer's disease, and adult failure to thrive. *The 2/2/16 significant change Minimum Data Set (MDS) assessment was marked for hospice services. *The 2/2/16 care plan revealed: -1/11/16: Hospice ordered. -1/21/16: Started on hospice. *There was no further documentation on the care plan regarding hospice services.</p> <p>Interview on 4/20/16 at 10:00 a.m. with the MDS registered nurse regarding resident 6 confirmed and revealed: *They had received a physician's order for hospice services on 1/22/16. *Hospice services had begun on 1/27/16.</p>	F 309			

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F 309	<p>Continued From page 15</p> <ul style="list-style-type: none"> *The hospice care plan was located in the resident's chart. *The care plan was located in a seperate binder. *The resident did not have an integrated care plan with hospice. *Any resident who had been receiving hospice services did not have an integrated care plan. *The resident's care plan had been updated on 2/2/16 when the MDS significant change assessment had been completed. *She agreed hospice information should have been written on the resident's care plan. *The staff would not know what hospice services were provided by looking at the 2/2/16 care plan. <p>Surveyor: 32331</p> <p>3. Review of resident 11's medical record revealed:</p> <ul style="list-style-type: none"> *On 12/31/15 she had been placed on hospice services with a terminal diagnosis of Alzheimer's disease. *The 1/12/16 significant change MDS assessment was marked for hospice services. *The above assessment had included she had: <ul style="list-style-type: none"> -Pain present, almost constantly. -That pain was coded as moderate. <p>Review of resident 11's revised 2/5/16 care plan revealed:</p> <ul style="list-style-type: none"> *On 12/29/15: <ul style="list-style-type: none"> -Under the discharge planning focus "Hospice to evaluate and to help keep comfortable." -Under the mental health focus "Hospice comfort care." *Under the activity focus "Hospice and staff 1:1 [one-to-one]." *Under the religion focus "Visits w/ [with] hospice chaplain." *The resident had chronic (persisting for a long time) pain related to gout (severe pain, redness, 	F 309		

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F 309	<p>Continued From page 16 and tenderness in joints). -The above pain was located in multiple areas. -Interventions included medications and laboratory tests as ordered, fentanyl patch (a narcotic pain medication) increased, and to have reported signs and symptoms of pain to the charge nurse. *There was no further documentation on the care plan for hospice services for pain or any other areas. *The care plan had not: -Addressed why she was on hospice. -Identified all the services hospice provided to the resident. -Identified how pain management was achieved. -Identified what care was to have been provided by the provider and by hospice.</p> <p>Further review of resident 11's medical record revealed the hospice care plan was separated from the provider's care plan.</p> <p>Interview on 4/21/16 at 10:05 a.m. with the MDS coordinator regarding resident 11 revealed: *They had received a physician's order for hospice services on 12/29/15. *Hospice services had begun on 12/31/15. *She did not have an integrated care plan with the hospice care plan, and that was an area that "could be improved." *The hospice care plans were always placed in the residents' charts, and the provider's care plans were placed in a separate binder. *Any resident who had been receiving hospice services did not have an integrated care plan.</p> <p>Interview on 4/21/16 at 11:05 a.m. with the director of nursing (DON) and the MDS coordinator regarding resident 11 revealed they</p>	F 309			

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F 309	<p>Continued From page 17</p> <p>confirmed she had needed to have the hospice care plan integrated with the provider's care plan.</p> <p>Surveyor: 29354 Interview on 4/21/16 at 10:00 a.m. with the DON regarding the integration of resident's care plans with hospice care plans revealed: *She had been unaware the resident's care plans should have been integrated with the hospice care plans. *She confirmed they did not have integrated hospice care plans.</p> <p>Surveyor: 32331 Interview on 4/21/16 at 2:05 p.m. with hospice registered nurse K regarding the integration of resident care plans with hospice care plans and staff training revealed: *Her main goals for hospice had included resident's pain level and comfort. *She was unaware of any hospice training to staff. *She had been unaware the residents' care plans had not been been integrated with the residents' hospice care plans. *She confirmed there needed to have been integrated care plans with hospice care plans. *It was the responsibility of the provider to integrate the care plan provided by the hospice agency into the provider's care plan.</p> <p>Interview on 4/21/16 at 2:35 p.m. with the administrator regarding the above revealed: *There had needed to have been integrated care plans with hospice care plans. *Hospice training online for all staff had been mandatory on the provider's Care to Learn program in May 2015. *Hospice training was important for all staff to</p>	F 309		

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F 309	Continued From page 18 have been provided for care for those residents on hospice. Review of the provider's revised 6/20/13 Hospice Services Agreement revealed: *Hospice was to have provided appropriate training to the provider's personnel who were providing care to residents receiving hospice services. *Hospice gave the provider a copy of the resident's plan of care. -That plan of care specified the resident's services that were provided. -The provider agreed to comply with the hospice plan of care. *There was to have been coordination of care between the provider's staff and hospice services. Review of the provider's 11/6/15 Care Plans-Comprehensive policy revealed an individualized comprehensive care plan would have been developed to meet each resident's medical, nursing, mental, and psychological needs.	F 309			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314	F314 1. The sling was removed from under Resident 2 at the time of survey. 2. All residents are at risk. 3. The Administrator, DON and IDT have reviewed the policy on pressure ulcers/skin care prevention and reviewed the cited deficiency. Staff education on policy and cited deficiency review will be	5-19-16	

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F 314	<p>Continued From page 19</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, record review, and manufacturer's instructions review, the provider failed to ensure appropriate use of an air mattress for one of one sampled resident (2) with a stage four pressure ulcer (full thickness loss of skin exposing bone, tendon, or muscle due to an injury caused by unrelieved pressure). Findings include:</p> <p>1. Observation on 4/20/16 at 10:00 a.m. of resident 2 during a dressing change to her pressure ulcer revealed: *She was on an Invacare microair mattress that was used to relieve pressure and to prevent skin breakdown. *A lift sling had been left underneath her.</p> <p>Interview on 4/20/16 at 10:35 a.m. with registered nurse C and the director of nursing (DON) regarding resident 2 revealed: *They both agreed the sling should not have been left under the resident as it prevented the mattress from working correctly. *There was no policy or procedure for use of the lift sling or the air mattress. *They would have used the manufacturer's instructions.</p> <p>Interview on 4/20/16 at 11:10 a.m. with certified nursing assistant (CNA) P regarding the sling lift under resident 2 revealed: *She had used it to transfer the resident back to bed around 9:00 a.m. *She would usually leave it underneath the resident until she got her up again at lunch time.</p>	F 314	<p>provided to all direct care staff no later 5-14-16. Those not in attendance at education session will be educated prior to their first shift worked.</p> <p>4. The DON or designee will audit four residents each week to ensure the slings are not left under a resident when not in use. Audits will continue for four weeks and then monthly for three months. Audits will be discussed by the DON at monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit.</p> <p><i>*An in-service was provided to direct care staff on air-bed mattresses on 5/10/16. JVE/SDDOHH/EL</i></p>	

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F 314	<p>Continued From page 20.</p> <p>*She was unaware it was not to have been left under the resident, especially with the use of the air mattress.</p> <p>Review of resident 2's medical record revealed: *She was admitted on 8/4/12 and was placed on hospice care on 12/30/15 with the goal to keep her comfortable. *Her diagnoses included arthritis with generalized pain and a stage four pressure ulcer on her coccyx. -The pressure ulcer started as a peri-rectal abscess on 6/15/15. -She was then admitted to the hospital for twelve days for treatment of the abscess. -She was readmitted on 6/26/15 with a pressure ulcer to her coccyx. *She had a daily dressing change to the pressure ulcer. *Her 4/12/16 Braden scale (an assessment for skin care problems) was a score of twelve, indicating she was at high risk for a pressure ulcer.</p> <p>Review of resident 2's 3/16/15 annual Minimum Data Set (MDS) assessment revealed: *Her Brief Interview for Mental Status assessment (BIMS) revealed a score of six, which is moderately impaired thinking and judgement. *Her behaviors included refusing cares, verbal and physical. *She was independent in her functioning.</p> <p>Review of resident 2's 4/12/16 quarterly MDS assessment revealed: *Her BIMS was performed by staff as the resident was unable to complete it. -She was severely impaired in her thinking and</p>	F 314		
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F 314	<p>Continued From page 21 judgement. *She required total assistance of one to two staff members to turn in bed and to get up out of bed. *She needed a mechanical lift for all transfers.</p> <p>Review of resident 2's current 4/19/16 care plan revealed: *She used an air mattress. There was no information on the type of mattress that was currently being used. *No information on what should not have been placed between the top of the air mattress and the resident, to be effective in preventing further skin break down.</p> <p>Review of a 2/22/16 On Duty Roster for staff working that day provided by the DON revealed: *A hand written note: "[Resident's name] new air mattress-sheet and bed pad only when she is in bed." The DON stated "This is what we are supposed to use" [on the resident's air mattress].</p> <p>Review of an undated CNA's Skin Care Plan also provided by the DON revealed "Sheet and bedpad only on air mattress" [for resident 2].</p> <p>Review of the undated Microair mattress User Manual revealed: *It was what was provided when the manufacturer's instructions were requested. *There was no documentation on what was to have been used or not been used on top of the air mattress to ensure it's effectiveness.</p> <p>Interview on 4/21/16 at 11:25 a.m. with the DON regarding the type of linen to have been used under resident 2's air mattress revealed she was told verbally by the Microair mattress company representative for optimal use to only put a sheet</p>	F 314			

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F 314	Continued From page 22 and a bed pad on top of the mattress. Review of a March/April 2016 article provided before the survey exit revealed: *It was from an article in Wound Care Advisor "FAQs [frequently asked questions] about support surfaces." **"Support surfaces are consistently recommended for the prevention and treatment of pressure ulcers." **"Choose clothing, linens, and incontinence pads that are compatible with the support surface." **"Studies show that excess linens and incontinence pads interfere with support surface therapy...which leads to decreased effectiveness."	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, testing, interview, and policy review, the provider failed to ensure: *One of one portable electric countertop warmer in the main dining room was not accessible to residents with cognitive impairment with the potential of being burnt. *Storage of chemicals in a secure location for two	F 323	<p>F323</p> <p>1. The electric countertop warmer has been moved when it is not in use so that it is not accessible to residents. The chemicals are now secured when not in use and the flooring strip was repaired at the time of survey.</p> <p>2. All residents are at risk.</p> <p>3. The Administrator, DON, Dietary Manager, Maintenance Director and IDT have reviewed the policy on safety risks and hazards, as well as, reviewed the cited deficiency. All staff will be educated no later than 5-14-16 on their role in identifying risks and hazards. Those not in attendance at education session will be educated prior to their first shift worked.</p> <p><i>*A new policy on electric counter top warmer was developed. All dietary staff were educated on 5/11/16 on the policy.</i></p>	5-19-16

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F 323	<p>Continued From page 23 of two housekeeping carts by two of two housekeeping staff (F and J). *In the center of the main dining room there was not an even flooring strip. Findings include:</p> <p>1. Observation on 4/19/16 at 9:30 a.m. in the main dining room revealed on a table: *One uncovered electric countertop warmer partially filled with water. *That electric countertop warmer was plugged in. *The sides of that warmer were still warm when touched.</p> <p>Interview and testing at the same time with cook A regarding the above revealed: *The electric countertop warmer was always plugged into an outlet located behind a table. -That warmer was stored in the main dining room. *The only time that warmer was not plugged in was when: -The water well was drained from the warmer by the drain valve every other day and replaced with new water. -The water well was delimed each week. *The electric countertop warmer was used for maintaining the hot foods at breakfast. -It was not usually used at the noon and evening meals. *It was started by turning a dial knob located on the front left side of the unit. -That knob went as high as ten. -The dial was always turned up to ten when it was turned on. *It contained several gallons of water. -That water was used to heat the foods placed in a steam table pan in the warmer. *The dial had been turned to the off position at approximately 9:00 a.m. that morning after the</p>	F 323	<p>4. The Administrator or designee will conduct walking rounds of the facility four times a week at random times to ensure chemicals are securely stored, the countertop warmer is not accessible to residents and to ensure there are no other safety hazards present. Audits will continue for four weeks and then monthly for three months. Audits will be discussed by the Administrator at monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit.</p> <p><i>*The electric countertop warmer will be used during breakfast only. The dietary aid will remove the electric countertop warmer from the dining room when breakfast is done.</i></p> <p><i>JVE/SDDO/H/EL</i></p>	
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F 323	<p>Continued From page 24</p> <p>last resident had been served.</p> <p>*Testing of the water in the warmer with the provider's non-digital thermometer revealed a temperature of 103 degrees Fahrenheit (F).</p> <p>Interview on 4/19/16 from 9:35 a.m. through 10:00 a.m. with the dietary manager regarding the above revealed:</p> <p>*The electric countertop warmer was used only at breakfast and for special occasions at the evening meal.</p> <p>*It was always plugged in except for cleaning.</p> <p>*Residents with cognitive impairment could have been in the dining room area without staff present.</p> <p>*She confirmed when the warmer was turned on the dial was always turned up to ten or at the highest setting.</p> <p>*When the warmer was turned on the highest temperature of the water was 140 degrees F to 200 degrees F.</p> <p>*It had always been located on the table in the main dining room since she had started seven months ago.</p> <p>*She was not aware of any residents that had received burns from that warmer.</p> <p>Interview on 4/19/16 at 10:30 a.m. with the dietary manager regarding the above revealed:</p> <p>*She was unable to locate a manual on the warmer.</p> <p>*A similar product's information off the internet revealed it maintained food temperatures in excess of 140 degrees F.</p> <p>Observation, testing, and interview at 11:08 a.m. with the dietary manager regarding:</p> <p>*The electric countertop warmer: -The dial was in the off position.</p>	F 323			

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F 323	<p>Continued From page 25</p> <p>-The warmer was plugged into the wall. -The dial was then turned up to high or "10" on the dial. -The indicator light on the unit next to the dial turned an orange color. *The provider's non-digital thermometer that had been used earlier that morning at 9:30 a.m. to test the water in the warmer was tested for accuracy using an ice water bath. -It read 24 degrees F in an ice water bath indicating it was registering eight degrees low. *The thermometer should have registered 32 degrees F, in freezing temperature. *The temperature of the water taken earlier that morning at 9:30 a.m. in the warmer's water well was recalculated at eight degrees less or 95 degrees F. -The above recalculation was an adjusted reading of that thermometer. *She had not calibrated that thermometer for "a long time." *The electric countertop warmer was turned on at 5:30 a.m. each morning by the cook and kept uncovered. *That warmer had food placed in it from 7:00 a.m. to 7:15 a.m. each morning with breakfast served at 7:30 a.m.</p> <p>Observation, testing, and interview from 11:18 a.m. through 11:23 a.m. with the dietary manager regarding the above revealed: *At 11:18 a.m. testing using the above thermometer: -Of the temperature of the water in the warmer's water well was 123 degrees F (adjusted). *At 11:23 a.m. testing: -Of the temperature of the water in the warmer's water well was 138 degrees F (adjusted). *The dietary manager confirmed the water</p>	F 323		

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F 323	<p>Continued From page 26</p> <p>exceeded 120 degrees F within ten to fifteen minutes after the warmer had been turned on at 11:08 a.m.</p> <p>Surveyor: 29354 Interview on 4/19/16 at 11:55 a.m. with the director of nursing (DON) regarding meal time supervision in the main dining room revealed: *There was usually a staff member present in the dining room during the meal times. *She had been the DON since 2009, and there had been no residents burnt from the electric countertop warmer. *They had an open breakfast for the past three years. *She confirmed over one-half of the residents were cognitively impaired that used that dining room. *She confirmed they did not have a policy for meal supervision.</p> <p>Surveyor: 32331 Interview on 4/19/16 at 11:55 a.m. with the dietary manager regarding the electric countertop warmer revealed: *That was a safety concern. *An unattended resident could get burnt with the electric countertop warmer. *There was no manual available on the electric countertop warmer.</p> <p>Interview on 4/19/16 at 12:10 p.m. with dietary assistant B regarding the electric countertop warmer revealed: *She had been employed in the kitchen for approximately five years. *The electric countertop warmer in the dining room had been plugged in and in the same location for the past four years with no changes in</p>	F 323			

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F 323	<p>Continued From page 27 its location.</p> <p>Interview on 4/19/16 at 12:15 p.m. with registered nurse C revealed: *She was the charge nurse. *Over half of the residents in the facility were cognitively impaired. *A nurse came into the main dining room each morning at approximately 7:15 a.m. *The certified nursing assistants started bringing residents into the dining room at around 6:45 a.m. *Breakfast each morning was scheduled to start at 7:30 a.m. *She was unaware of any residents that had been burnt from the electric countertop warmer.</p> <p>Interview on 4/19/16 at 4:30 p.m. with the maintenance supervisor regarding the electric countertop warmer revealed he: *Agreed the warmer was a safety concern for residents that were cognitively impaired. *Confirmed the provider had no manual on the warmer.</p> <p>Interview on 4/21/16 at 8:50 a.m. with the administrator regarding the above revealed: *All staff were responsible for the safety of the residents. *Dietary staff would have been responsible for monitoring of their equipment for safety of the residents that included the electric countertop warmer.</p> <p>Review of the provider's undated Specifications on the Countertop Warmer revealed: *It was portable. *Utilized for wet and dry applications. *Fit one full pan, two half pans, or three one-third size steam table pans.</p>	F 323			

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F 323	<p>Continued From page 28</p> <p>Surveyor: 29354</p> <p>2. Observation and interview on 4/20/16 at 8:40 a.m. and again at 9:16 a.m. with housekeeper J revealed:</p> <ul style="list-style-type: none"> *There were several assorted spray bottles hanging on the edges of the housekeeping cart. *The spray bottles contained chemicals such as Vindicator (cleaner/disinfectant), toilet bowl cleaner, and window cleaner. *The spray bottles had not been secured. *They were to take the housekeeping carts into the rooms with them. *They were not to leave the housekeeping carts unattended. *At 9:16 a.m. housekeeper J had left the housekeeping cart unattended while he had been inside cleaning the beauty shop. *At the same time three residents had walked by the unattended housekeeping cart. <p>Observation and interview on 4/20/16 at 9:55 a.m. with housekeeper F regarding the second housekeeping cart revealed:</p> <ul style="list-style-type: none"> *There were several spray bottles hanging on the edges of the housekeeping cart. *The spray bottles contained chemicals. *They were to take the housekeeping carts into the rooms with them. *They were not to leave the housekeeping carts unattended. *If the housekeeping cart was not being used it was to have been placed in a locked room. *The spray bottles on the housekeeping cart was not secured. <p>Interview on 4/21/16 at 8:40 a.m. with the maintenance supervisor regarding the above housekeeping carts revealed his expectations</p>	F 323		

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F 323	<p>Continued From page 29</p> <p>were: *For the housekeepers to keep the housekeeping cart within their view at all times. *To never leave a housekeeping cart unattended.</p> <p>Observation on 4/21/16 from 9:45 a.m. through 9:50 a.m. in the south wing revealed: *At 9:45 a.m. an unattended housekeeping cart with several spray bottles of chemicals hanging on the edges of the housekeeping cart was located outside a public bathroom. *At 9:48 a.m. the maintenance supervisor stood outside the public bathroom, looked at the unattended housekeeping cart, looked over at the surveyor, and then knocked on the bathroom door. *At 9:50 a.m. housekeeper F came out of the public bathroom with paper towels in her hands and began to push the housekeeping cart away from the area.</p> <p>Interview on 4/21/16 at 10:35 a.m. with the administrator and the nurse consultant regarding the housekeeping carts revealed: *Their expectations were to never have a housekeeping cart left unattended. *They had residents who were cognitively impaired in areas where the carts were used.</p> <p>Review of the provider's revised December 2013 Storage of Chemicals policy revealed "Cleaning carts will be directly supervised when in use and will be locked in an area not accessible to residents when not in use."</p> <p>3. Observation from 4/19/16 at 12:05 p.m. through 4/20/16 at 3:15 p.m. in the main dining room revealed: *A four foot long by one and one-half inch wide</p>	F 323		

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F 323	<p>Continued From page 30</p> <p>board extended four feet from the wall. *At the distal end of the board the corner protruded up by one-half inch high by four inches long and was not flush with the remaining flooring. *Several residents were observed walking past the above area during that time frame.</p> <p>Surveyor: 32331 Observation and interview on 4/20/16 at 3:15 p.m. with the maintenance supervisor revealed: *The above board should have been flush with the floor. *Resident 7 was legally blind and had a history of being a high fall risk. *That resident's table was located approximately one foot from that board. *He agreed that board could be a tripping hazard for residents in the dining room.</p> <p>Surveyor: 29354 Interview on 4/21/16 at 8:40 a.m. with the maintenance supervisor regarding the above board revealed the protruding board could have been a trip hazard for anyone walking over it.</p> <p>Interview on 4/21/16 at 10:35 a.m. with the administrator and the nurse consultant regarding the above board revealed: *It could have been a trip hazard for anyone walking over it. *They did not have a preventative maintenance policy.</p> <p>4. Review of the provider's revised January 2014 Safety and Supervision of Residents policy revealed: *They strived to make the environment as free from accident hazards as possible.</p>	F 323		

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F 323	Continued From page 31 *Resident safety, supervision, and assistance to prevent accidents were facility-wide priorities. *Safety risks and environmental hazards were identified on an ongoing basis. *Employees should have been trained and in-serviced on potential accident hazards, how to identify and report accident hazards, and to prevent avoidable accidents. *They would implement interventions to reduce accident risks and hazards. *Resident supervision was a core component of the systems approach to safety. *Certain resident risk factors and environmental hazards included: -Falls. -Unsafe wandering. -Electrical safety. -Water temperatures.	F 323			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329	F329 1. Resident 1's Haldol has been discontinued. 2. All residents are at risk. 3. The DON will educate nurses no later than 5-14-16 on ensuring a diagnosis is obtained for use of psychotropic medication and that if a medication is not used for 60 days it should be discontinued. Those not in attendance at education session will be educated prior to their first shift worked. 4. The DON or designee will audit four residents taking psychotropic medications to ensure there is an appropriate diagnosis	5-14-16	

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F 329	<p>Continued From page 32</p> <p>drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on observation, record review, interview, and policy review, the provider failed to ensure a psychotropic (mood altering) medication had been administered with appropriate diagnosis and reason for use for one of two sampled residents (1) receiving a psychotropic medication. Findings include:</p> <p>1. Random observations from 4/19/16 though 4/21/16 of resident 1 revealed she was in her room or in the activity/dining room in the special care unit (SCU). During those observations she had not displayed any episodes of anxiety, agitation, or increased behaviors.</p> <p>Review of resident 1's medical record revealed: *She was admitted to the SCU on 9/21/15. *She had diagnoses for: -Alzheimer's disease with behavioral disturbance. -Attention or concentration deficit. -Major depressive disorder, recurrent and severe without psychotic features. *Her 3/29/16 quarterly Minimum Data Set assessment revealed: -A brief interview for mental status score (BIMS) of 3 out of 15 indicating severe cognitive impairment.</p>	F 329	<p>*and if medication has been used within the last 60 days for order to remain active. Audits will be weekly and will continue for four weeks and then monthly for 3 months. Audits will be discussed by the DON at monthly QAPI meetings for review and recommendations for continuation or discontinuation of audits. JVE/SDDOHH/EL</p>	

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F 329	<p>Continued From page 33</p> <p>Review of resident 1's undated care plan revealed: *Staff were to redirect, reorient, and reapproach as needed. *No additional nonpharmacological behavior interventions were documented on the care plan.</p> <p>Review of resident 1's physician's orders for the following medications revealed: *On 11/30/15 an order for lorazepam (for anxiety) 0.5 milligrams (mg) scheduled by mouth (po) three times a day. *On 2/3/16 an order for lorazepam 0.25 mg po as needed (prn) every six hours. *On 2/17/16 an order for lorazepam 0.5 mg by intramuscular (IM) injection prn three times a day. *On 3/21/16 an order for Haldol (antipsychotic) 2 mg by IM injection prn and to be repeated every thirty minutes. It was not to exceed 10 mg in twenty-four hours.</p> <p>Review of resident 1's medication administration record (MAR) from 1/1/16 through 4/19/16 for prn medications revealed she: *Had received one dose of prn lorazepam by mouth in February 2016, none in March 2016, and none from 4/1/16 through 4/19/16. *Had received no prn doses of lorazepam via intramuscular injection in February 2016, had four doses in March 2016, and had none from 4/1/16 through 4/19/16. -The diagnosis given for use was agitation, increased anxiety, and increased behaviors. -It was documented she had calmed down following the doses given on 3/11/16, 3/14/16, and 3/15/16. *Was given Haldol 2 mg twice by IM injection on 3/21/16 following an elopement.</p>	F 329	 <p>*JVE/SDDOH/EL</p>	

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F 329	<p>Continued From page 34</p> <p>*No diagnosis was given for the use of the Haldol.</p> <p>Review of resident 1's consultant pharmacist's documentation revealed:</p> <p>*On 3/11/16 the increase in prescribed lorazepam was noted along with a concern regarding the potential for increased falls with the medication.</p> <p>*On 4/18/16 no recommendations were made for her medication profile.</p> <p>Telephone interview on 4/21/16 at 11:30 a.m. with the consulting pharmacist revealed he:</p> <p>*Had not documented any recommendations for the Haldol.</p> <p>*Felt he would not address the Haldol since:</p> <ul style="list-style-type: none"> -She had a diagnosis of dementia with behaviors. -She had a BIMS (cognitive assessment) score of six out of fifteen with the 9/27/15 admission Minimum Data Set assessment. -A BIMS score of six indicated severe cognitive impairment. <p>Interview on 4/21/16 at 10:30 a.m. with the director of nursing revealed:</p> <p>*She had not located documentation of a diagnosis given at the time the Haldol was prescribed.</p> <p>*She felt the diagnosis of dementia with behaviors was appropriate for the use of Haldol.</p> <p>*The physician had ordered on 3/21/16 the resident was to be admitted to a behavioral health unit in Sioux Falls or Yankton.</p> <ul style="list-style-type: none"> -Both facilities were unable to admit her on 3/21/16. -No documentation was found regarding further mental health services follow-up. <p>Review of the provider's November 2011 Box Warning Medications policy and procedure</p>	F 329		

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F 329	Continued From page 35 revealed "Nursing facility staff, prescribers, and pharmacists should be familiar with [black] box warnings [Haldol] for any medication used in a nursing home resident and assure that these medications are used and monitored appropriately."	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Surveyor: 32331 Based on observation, testing, interview, manufacturer's instructions, record review, and policy review, the provider failed to ensure sanitary conditions were maintained for the following areas: *The kitchen: -Sanitizing food counters and carts. -Expired and undated food. -Scoop handles in two of two Thick and Easy thickening product containers. *The dining room: -Cleaning of one of one electric countertop	F 371	F371 1. All outdated and opened and not dated food items were discarded at the time of survey. The scoop handles in the Thick and Easy have been removed. No immediate corrective action could be taken for counter sanitization deficient practice and offending staff members were educated at time of survey. The water in the countertop warmer was changed and is changed daily. The kitchenette stove burner pans were replaced and the stove's interior has been cleaned. The ice packs were removed from the kitchenette's freezer and discarded. No immediate correction could be taken for transportation of room tray with partially uncovered silverware. Staff were educated on ensuring all surfaces are covered at the time or survey 2. All residents are at risk. 3. The Dietary Manager and RD have reviewed the policy on kitchen sanitation and reviewed the deficient practice cited. The Dietary Manager will educate kitchen staff on proper kitchen sanitation, including cleaning of countertops, warmers and storage of food items. The Administrator will educate staff on	5-19-16 *by 5/11/16 JVE/SDD/HCL

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F 371	<p>Continued From page 36 warmer.</p> <p>*The 100 wing kitchenette: -Cleaning four of four burner pans and the interior floor of the stove. -Storing one of twelve sampled resident's and other unmarked residents' ice packs with food in the refrigerator's freezer.</p> <p>*The special care unit (SCU): -Unmarked residents' ice packs stored with food in the refrigerator's freezer.</p> <p>*The 100 wing: -Uncovered silverware on a room tray for one of one sampled resident (8) for one of two observed meals.</p> <p>Findings include:</p> <p>1a. Observation on 4/19/16 in the kitchen from 8:38 a.m. through 9:18 a.m. revealed: *A five pound (lb) container approximately one-eighth full of opened and undated egg salad. -That container was marked on the side with a typed label "Enjoy by 4/3/16." *Opened, bagged, and undated: -Approximately 1.5 lb diced turkey. -Approximately three-fourth full 5.0 lb bag of shredded cheese. -Five sausage links. -One lb sliced Swiss cheese. *The above condition of the meats, poultry, and eggs made them potentially hazardous if used. *Two opened eight ounce containers of Thick and Easy thickening product had the scoop handles in the thickener.</p> <p>Interview on 4/21/16 at 8:30 a.m. with the dietary manager confirmed and revealed she agreed: *The egg salad needed to have been dated and not kept beyond the use by date. *The diced turkey, shredded cheese, sausage</p>	F 371	<p>cleanliness of kitchenette stove, ensuring ice packs are not stored in freezer with food items, and ensuring silverware is covered at during room tray transportation. Education will occur no later 5-14-16. Those not in attendance at education session will be educated prior to their first shift worked.</p> <p>4. The Administrator or designee will audit kitchen sanitization, including counter top cleaning, water in warming oven, stove cleanliness, food tray delivery to ensure required items are covered and storage and labeling of food each week. Audits will continue for four weeks and then monthly for three months. Audits will be discussed by the Administrator at monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit.</p>		

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F 371	<p>Continued From page 37</p> <p>links, and sliced Swiss cheese needed to have been dated when opened. *Potentially hazardous foods included meats, poultry, and eggs. *The scoop handles in the Thick and Easy thickening product containers needed to have been stored away from the product.</p> <p>b. Observation and interview on 4/19/16 at 4:45 p.m. with dietary assistant (DA) E in the kitchen regarding cleaning counters and carts revealed: *She obtained: -A dry cloth and wet it with water from the two-compartment sink. -She wiped the food preparation counter and a three-tiered cart with that cloth. -Placed that cloth into a laundry basket in the main dining room. *That was how she usually cleaned and sanitized the counter and the cart.</p> <p>Observation on 4/20/16 at 11:15 a.m. through 11:55 a.m. with cook D in the kitchen revealed: *She wiped: -Two food preparation counters with a wet cloth from a bucket containing suds. -Returned that same wet cloth to the bucket. -She sprayed that area she had just wiped down with Redi San RTU (Ready to Use) Hard Surface Sanitizer. -Immediately wiped the sanitizer from the food preparation counter with a dry cloth. -Left that cloth used for wiping the sanitizer next to the can opener. *She then wiped a three-tiered cart with the same wet cloth from the bucket containing suds. -Left that wet cloth on top of the cart and moved the cart to the food serving area next to the steam table.</p>	F 371		

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F 371	<p>Continued From page 38</p> <p>*At 11:32 a.m. she placed the lids from the steam table on top of that same above wet cloth. -At 11:50 a.m. she moved that same wet cloth from the cart to the serving counter window next to the container holding the cleaned silverware. *During the above observation the wet sanitizing cloth remained next to the can opener.</p> <p>Interview on 4/20/16 at 11:55 a.m. with cook D and the dietary manager revealed both agreed: *The wet cloth should not have been left on the cart and placed on the serving counter. *Confirmed that wet cloth needed to have been placed back in the bucket with the suds. *The sanitizer needed to have been allowed to air dry on the food preparation counter. *The sanitizer cloth should not have been left next to the can opener. *The cart and the food preparation counter had not been sanitized properly.</p> <p>2. Observation and interview with cook A on 4/19/16 in the dining room at 9:30 a.m. revealed: *An uncovered electric countertop warmer with water in the water well. -That water was opaque (not able to see through) colored with bits of what looked like food crumbs floating on the water. *The above warmer's water was changed every other day.</p> <p>Interview on 4/21/16 at 8:30 a.m. with the dietary manager confirmed and revealed she agreed the electric countertop warmer needed to have had the water drained out daily and cleaned once per day according to the provider's policy.</p> <p>3. Observation on 4/20/16 at 8:55 a.m. in the 100 wing's kitchenette area revealed:</p>	F 371			

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F 371	<p>Continued From page 39</p> <p>*A Frigidaire stove top with all four stove burner pans with a moderate amount of black, tan, and brown spots along with a greasy-type film on them.</p> <p>-Inside was a moderate amount of burnt black spots on the interior bottom of the stove.</p> <p>*A GE refrigerator's freezer had five ice packs sitting directly on the shelf.</p> <p>-One of those ice packs was marked with resident 12's name.</p> <p>-The rest of those ice packs were unmarked with any residents' names.</p> <p>*The freezer also contained a pint of ice cream, four freeze pops, and an opened package of ice chips.</p> <p>Surveyor: 35625</p> <p>4. Observation on 4/19/16 at 8:45 a.m. in the SCU refrigerator's freezer revealed:</p> <p>*Two small ice packs sitting directly on the shelf.</p> <p>*The freezer also contained an opened gallon container of ice cream and several unopened single-serving frozen dinners.</p> <p>Surveyor: 32331</p> <p>Interview on 4/21/16 at 8:30 a.m. with the dietary manager revealed she agreed:</p> <p>*The oven located in the 100 hall kitchenette was the responsibility of housekeeping to have kept it clean.</p> <p>*The refrigerators' freezers in the 100 hall kitchenette and the SCU were for storage of foods used for residents.</p> <p>-Those above freezers were not to have been used for storage of resident care items including ice packs.</p> <p>Interview on 4/20/16 at 9:00 a.m. with certified nursing assistant G regarding the stove and the</p>	F 371		

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F 371	<p>Continued From page 40</p> <p>ice packs at the above location revealed: *The kitchenette was a resident use area. *The refrigerator and stove were used for residents. *He thought the ice packs were used by nursing.</p> <p>Interview on 4/20/16 at 9:05 a.m. with the director of nursing regarding the stove and the ice packs at the above location revealed: *The ice packs were used for resident care by nursing and therapy. *Those resident care items should not have been stored with food. *She agreed the stove's burner pans and the interior bottom of the stove had not been cleaned. *Housekeeping was responsible for cleaning the stove. *Nursing was responsible for the ice pack storage.</p> <p>Interview on 4/20/16 at 9:55 a.m. with housekeeping assistant F regarding the stove at the above location revealed: *Housekeeping was responsible for cleaning the stove burners and the interior of the stove. *The stove top was to have been cleaned daily and the interior of the stove cleaned on a weekly basis. *She agreed those above areas needed to have been cleaned.</p> <p>Record review of the provider's cleaning schedule for the oven revealed it had last been cleaned on 4/18/16 by housekeeping.</p> <p>5. Observation on 4/19/16 at 5:50 p.m. during the evening meal service regarding resident 8's room tray revealed: *At 5:50 p.m. her meal was taken to her room by</p>	F 371		

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F 371	<p>Continued From page 41</p> <p>a family member with the silverware partially covered.</p> <p>-That above tray went through a service area and down a resident hallway prior to being delivered to the resident.</p> <p>*The silverware had not been covered.</p> <p>Interview on 4/21/16 at 8:30 a.m. with the dietary manager revealed she agreed the silverware needed to have been covered for resident 8 who had received a room tray.</p> <p>Interview on 4/21/16 at 10:05 a.m. with the dietary manager revealed she did not have a policy regarding covering items that included the silverware on the room tray.</p> <p>6. Review of the provider's 2001 Sanitization policy revealed:</p> <p>*The kitchen was to have been maintained in a clean and sanitary manner.</p> <p>*All food contact surfaces were to have been washed to loosen and remove soil by using manual means necessary and sanitized using a chemical sanitizing solution.</p> <p>*Sanitizing of environmental surfaces were to have been completed that included a 150-200 parts per million (ppm) quaternary (quat) ammonium compound (kills germs).</p> <p>*Between use cloths used to wiped kitchen surfaces were to have been soaked in containers filled with approved sanitizing solution.</p> <p>*That sanitizing solution was to have been changed at least once per shift or if the solution became cloudy or visibly dirty.</p> <p>Review of the provider's 2010 manufacturer's instructions for Redi San RTU Hard Surface Sanitizer revealed:</p>	F 371		

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F 371	<p>Continued From page 42</p> <ul style="list-style-type: none"> *It was an effective sanitizer for use on food contact as well as non-food contact surfaces. *It contained 200 ppm active quat. *It could be used on washable hard nonporous surfaces that included countertops. *It was an effective sanitizer for use on a pre-cleaned food contact surface in sixty seconds. *Directions for sanitizing food contact surfaces had included: <ul style="list-style-type: none"> -Prior to application remove food particles and soil by a pre-wash. -Thoroughly wash area with a detergent. -Follow with a water rinse before applying sanitizer. -Treated surface should have remained wet for sixty seconds. -Allow to air dry. <p>Review of the provider's 2001 Food Preparation and Service policy revealed:</p> <ul style="list-style-type: none"> *Dietary employees were to have prepared and served food in a manner that complied with safe food handling practices. *Potentially hazardous foods included meats, poultry, and eggs. *All food stored in the refrigerator were to have been labeled, dated, and served by the "use by date." <p>Review of the provider's undated Food Receiving and Storage policy revealed food was to have been stored in a manner that complied with safe food handling practices.</p> <p>Review of the provider's undated Food Preparation and Service policy revealed:</p> <ul style="list-style-type: none"> *Leftovers were to have been labeled with contents and date of storage. 	F 371			

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F 371	<p>Continued From page 43</p> <p>*Leftovers were not to have been held longer than three days. -Exceptions to the above leftovers had included foods containing high sugar or acid content such as vegetables, fruits, and juices. *The dietary manager was responsible for food preparation and service.</p> <p>Review of the provider's undated Cleaning Hot Food Tables revealed: *Hot food tables (such as the electric countertop warmer) were to have been maintained in a clean and sanitary condition. *Units heated by steam needed to have had the water drained out and the tank cleaned at least once a day.</p> <p>Review of the provider's undated Cleaning Ovens policy revealed ovens were to have been clean and free of build-up of grease or spills.</p> <p>Review of the provider's August 2014 Use of a Disposable Cold/Ice Pack revealed: *Ice packs were to have been used with physician's orders to have provided relief to reduce swelling. *To comply with infection control practices only disposable cold/ice packs were to have been used. *Those packs were designed for single-use only. *The policy did not include any information regarding not to have been stored with food.</p>	F 371		
F 372 SS=E	<p>483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY</p> <p>The facility must dispose of garbage and refuse properly.</p>	F 372	<p>F372</p> <p>1. The dumpsters were emptied on 4/20/16. The refuse company has been contacted regarding repair or replacement of dumpster lids *to be completed</p> <p>by 5/19/16. JVE/SDDOHEL</p>	5-19-16

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F 372	<p>Continued From page 44</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation and interview, the provider failed to maintain two of two dumpsters in a sanitary manner. Findings include:</p> <p>1. Observation on 4/19/16 at 9:26 a.m. revealed: *Two dumpsters located behind the outside of the building with the following: -Overflowing black trash bags on the top of one of the dumpsters. -Cardboard boxes overflowing on top of the second dumpster.</p> <p>Observation on 4/20/16 at 10:05 a.m. regarding the above dumpsters revealed: *One dumpster with the following: -Four out of the six lids were missing. -Those two lids remaining had not been closed. *The second dumpster with the following: -Two out of the six lids were missing. -Two lids had not been closed. -The two lids closed had a bag of trash located on the top of one of those lids.</p> <p>Interview on 4/20/16 at 3:10 p.m. with the maintenance supervisor regarding the above dumpsters revealed: *The trash was picked up once per week by _____ (the waste management company). *The dumpsters were owned by the service provider. *He had been aware they had been overflowing and had needed repair. *He had not followed-up with the service provider regarding the missing lids. *The maintenance department was responsible</p>	F 372	<p>2. All residents are at risk.</p> <p>3. The Administrator will educate all staff on ensuring dumpster lids are closed and to report when dumpster full no later than 5-14-16. Those not in attendance at education session will be educated prior to their first shift worked.</p> <p>4. The Administrator or designee will audit refuse area four times a week to ensure dumpsters are not over flowing and lids are closed. Audits will continue for four weeks and then monthly for three months. Audits will be discussed by the Administrator at monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit.</p>	

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F 372	Continued From page 45 for monitoring those dumpsters. *He was not aware of any policy regarding the dumpsters. *He agreed those dumpsters needed to have been kept closed for sanitation and pest control. Interview on 4/21/16 at 8:15 a.m. with the administrator regarding the above dumpsters revealed: *There was no policy regarding those dumpsters. *She agreed those dumpsters needed to have been kept closed.	F 372		
F 441 SS=D	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	F 441	<p>F441</p> <p>1. No correction can be made to Resident 2's dressing change. RN N and RN C were educated on proper procedure at the time of survey. Resident 2 in now deceased. The hydrocollator has been cleaned.</p> <p>2. All residents are at risk.</p> <p>3. The DON will educate all nurses on the dressing change procedure no later than 5-14-16. The Restorative Aide has been educated on the Hydrocollator policy that is to have the temperature checked weekly and the cleaned monthly. Those not in attendance at education session will be educated prior to their first shift worked. *The DON provided education to the restorative aide on 5/14/16.</p> <p>4. The DON or designee will audit four dressing changes each week to ensure procedure is performed per policy. The hydrocollator will be checked to ensure</p>	5-19-16

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F 441	<p>Continued From page 46</p> <p>from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, record review, policy review, and procedure review, the provider failed to ensure infection control practices were followed for: *One of one sampled resident (2) during one of one observed dressing change for a stage four pressure ulcer (full thickness loss of skin exposing bone, tendon, or muscle due to an injury caused by unrelieved pressure) on her coccyx. *Cleaning, disinfection, and temperature monitoring for one of one Hydrocollator (a device that is a thermostatically controlled water bath for maintaining moist heat therapy pacs). Findings include:</p> <p>1. Observation on 4/20/16 at 10:00 a.m. of resident 2's dressing change to her pressure ulcer with registered nurses (RN) C and N revealed: *RN N performed the dressing change while RN C assisted with the positioning of the resident. RN</p>	F 441	<p>temperatures are obtained weekly and it is cleaned monthly. Audits will continue for four weeks and then monthly for three months. Audits will be discussed by the DON at monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit.</p> <p><i>*The DON or designee will do audits on the hydrocollator. JVE/SDDO/H/EL</i></p>	

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F 441	<p>Continued From page 47</p> <p>N then:</p> <ul style="list-style-type: none"> -Placed a clean pad on the resident's bed and placed the unopened dressings containing gauze soaked in silver alginate (substance that prevents infections) and a foam pad on it. -Placed several 4x4 gauze dressings in a pile on top of each other and a large Q-tip that had been taken out of the package on top of some paper notes that had been placed on the resident's bedside table. That would not have been considered a clean surface. -She used the 4x4s to clean the pressure ulcer after removing the old dressings. -She used the Q-tip to try to remove the old dressings, and then used the same Q-tip later to pack in the new silver alginate gauze into the ulcer. *She took off her gloves and without sanitizing her hands took the foam dressing out of its package and placed it on top of the outside of the package. *She then placed the silver alginate gauze into the pressure ulcer and put the foam dressing on top of it. <p>Interview immediately following the dressing change with RN N revealed:</p> <ul style="list-style-type: none"> *She had taken the opened 4x4s out of a stock supply. *Stated "I didn't use the bottom one [4x4]" when asked if she had placed them on a clean barrier before use. *"I only used the Q-tip to take out the old packing [dressing]." -She was unaware she had also used it to pack in the new gauze dressing and that she should have taken a clean one. -She was unaware the Q-tip should have been on a clean barrier. 	F 441			

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F 441	<p>Continued From page 48</p> <p>Review of resident 2's current 4/19/16 care plan revealed there was no documentation regarding her dressing changes.</p> <p>Interview on 4/21/16 at 1:40 p.m. with the director of nursing (DON) and the administrator regarding resident 2's dressing change revealed they:</p> <ul style="list-style-type: none"> *Thought the placement of the open 4x4's on an unclean surface was alright, because the bottom one had not been used. *Agreed the Q-tip should not have been placed on an unclean surface then used on the resident. *Agreed the new foam dressing should not have been handled in the way it had been. <p>Review of the provider's April 2014 Dressings Clean/Aseptic policy revealed:</p> <ul style="list-style-type: none"> *Provide a clean barrier to place the supplies on. **"Open dry, clean dressing(s) by pulling corners of the exterior wrapping outward, touching only the exterior surface. Pour prescribed cleansing solution over the dry, clean gauze, if used." **"Cleanse the wound with prescribed solution, use a clean gauze forceps, q-tip, or swab for each cleansing stroke." <p>Surveyor: 29354</p> <p>2. Observation, record review, and interview from 4/20/16 at 9:00 a.m. through 9:15 a.m. in the therapy/restorative room revealed a Hydrocollator (liquid heating device) located in a seperate room. The Hydrocollator had hot water inside of it.</p> <p>Record review and interview at the above time with restorative aide H regarding the Hydrocollator revealed:</p> <ul style="list-style-type: none"> *The Hydrocollator temps (temperature) flow 	F 441			

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F 441	<p>Continued From page 49 sheet from 4/1/15 through 4/15/16 confirmed from:</p> <ul style="list-style-type: none"> -April 2015: Had the temperature checked once and had not been cleaned. -May 2015: Had the temperature checked once and had not been cleaned. -June 2015: Had not had the temperature checked and had not been cleaned. -July 2015: Had not had the temperature checked and had not been cleaned. -August 2015 through March 2016: Had not had the temperature checked and had not been cleaned. <p>Interview at the above time with restorative aide H revealed she had:</p> <ul style="list-style-type: none"> *Been responsible to clean the Hydrocollator. *Tried to record the temperatures weekly. *Not checked the temperatures weekly. *Not cleaned the Hydrocollator as often as she should have. <p>Interview on 4/20/16 at 9:15 a.m. with physical therapist aide I regarding the Hydrocollator revealed:</p> <ul style="list-style-type: none"> *She had been responsible for the use of the Hydrocollator. *Residents who had received therapy used the Hydrocollator. *The Hydrocollator had been used on outpatients. *The last resident to have used the hydrocollator was two to three months ago. <p>Interview on 4/21/16 at 9:00 a.m. with the infection control nurse regarding the cleaning and checking the temperature of the Hydrocollator revealed her expectations would have been for the staff to follow the Hydrocollator policy.</p>	F 441			

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F 441	Continued From page 50 Interview on 4/21/16 at 10:00 a.m. with the DON regarding the Hydrocollator revealed her expectations would have been for the staff to follow the hydrocollator policy. Review of the provider's 12/14/11 Hydrocollators procedure revealed: **"Water temperature on the machine will be recorded weekly by an assigned staff member. *Cleaning of machine to be done monthly by an assigned staff member."	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on record review, interview, and checklist review, the provider failed to ensure there was a complete physician's order for one of two sampled residents (1) receiving an antipsychotic (a medication to clear thinking) medication. Findings include:	F 514	F514 1. Resident 1's Haldol has been discontinued. 2. All residents are at risk. 3. The DON will educate nurses no later than 5-14-16 on order transcription for medications that must include indication for medication use and date and time of order. Those not in attendance at education session will be educated prior to their first shift worked. 4. The DON or designee will audit four medication orders each week to ensure orders obtain indication for use and date and time of order. Audits will continue for four weeks and then monthly for three months. Audits will be discussed by the DON at monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit.	5-19-16

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F 514	<p>Continued From page 51</p> <p>1. Review of resident 1's medical record revealed: *She was admitted to the special care unit on 9/21/15. *She had diagnoses of: -Alzheimer's disease with behavioral disturbance. -Elevated cholesterol. -Underactive thyroid. -High blood pressure. -Overactive bladder. -Impaired glucose tolerance (higher than normal blood sugar). -Attention or concentration deficit. -Major depressive disorder, recurrent and severe without psychotic features.</p> <p>Review of resident 1's physician's orders revealed: *On 3/21/16 at 5:00 p.m. a prn (as needed) order for Haldol (a medication to reduce agitation and clear thoughts) 2 milligrams (mg) was obtained by telephone order. *On 4/6/16 the physician signed an order sheet with the Haldol medication handwritten on the form. -It had not contained a date and time the medication was ordered. -No indication for use was written with the medication.</p> <p>Interview on 4/21/16 at 10:30 a.m. with the director of nursing regarding resident 1's 4/6/16 physician's order revealed: *The medication was handwritten on the order sheet since the printed copy was already in process when the initial order was given. *She acknowledged any physician's order should have been completed with a date and time.</p>	F 514			

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F 514	Continued From page 52 *She did not provide any input regarding the indication for use of the Haldol. Review of the provider's undated Physician's Order Checklist revealed: *A new medication was to include an indication for use or diagnosis. *An order was to have contained a date and time. *The checklist served as a policy in regard to physician's orders.	F 514			

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K 000	<p><i>*Addendums noted with an asterisk per 5/18/16 per telephone with facility administrator. LF/SDOH/EL</i></p> <p>INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 4/19/16. Prairie View Healthcare Community was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K025, K051 and K056 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	<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>	
K 025 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure smoke barrier walls were properly sealed to prevent the spread of smoke in one randomly observed location (sprinkler pipe wall penetration above the smoke barrier doors between building 1 and building 2). Findings include:</p> <p>1. Observation at 11:25 a.m. on 4/19/16 revealed a smoke barrier separating building 01 (original building) and building 02 (2012 addition). Further</p>	K 025	<p>K025</p> <ol style="list-style-type: none"> The wall penetration was sealed with a fire rated caulking. All residents are at risk. The Maintenance Supervisor will inspect the attic area for any additional penetrations and ensure such are sealed. 	5-9-16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE **Kayla Evans** TITLE **Admin, eph** (X6) DATE **5/10/16**

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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(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
K 025	Continued From page 1 observation above the double-cross corridor smoke barrier doors revealed a sprinkler pipe penetrating through that smoke barrier wall. The space around the sprinkler piping was not properly sealed with any fire rated caulking material. That void space around the sprinkler piping had the ability to transfer smoke between smoke compartments. Interview with the maintenance supervisor at the time of the above observation confirmed that condition. He indicated he had not noticed that sprinkler pipe penetration was unsealed. He indicated that sprinkler piping was installed with the addition 2012. This deficiency has the potential to affect two of six smoke compartments.	K 025	4. Going forward, the Maintenance Supervisor will inspect the attic after any contract work is performed in the attic area to ensure any penetrations made by pipes, wires, or other means is appropriately sealed. <i>*The findings of the attic inspections will be discussed by the maintenance supervisor at monthly QAPI meetings for review and recommendations on continuation or discontinuation of audits. LF/SDOTTJEL</i>	
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the	K 051	K051 1. The Bankoe Company, the software company for the alarm system, has been contacted and will come facility to re-code doors at their earliest convenience. 2. All residents are at risk. 3. The Maintenance Supervisor learned of the deficient practice and was educated on the requirements at the time of survey. 4. The doors will be checked at each fire drill to ensure magnetic doors to not reset while alarm is in silent mode. A new fire drill checklist will be devised to include this check off at each monthly fire drill. Any abnormality will be reported to the Bankoe Company for repairs.	5-11-16

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K 051	Continued From page 2 alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure the fire alarm system was installed and maintained in accordance with NFPA 72, National Fire Alarm Code (fire alarm system not functioning correctly). Findings include: 1. Observation at 1:30 p.m. on 4/19/16 during a fire drill revealed the fire alarm system was not functioning correctly. Upon completion of the fire drill the fire alarm system was put into silent operating mode. That mode should have kept the fire alarm system in alarm status and just muted the horns and strobes from operating. While in silent mode the magnetic door hold-opens for the smoke barrier doors in building 01 were able to be reset. Those magnetic devices should remain inactive during silent operating mode. The smoke barrier doors separating building 01 and building 02 did not reset and remained unable to be held open. Interview with the maintenance supervisor at the time of the above observation confirmed that condition. He indicated he was unaware of that condition. He was unsure why just the doors in building 01 were resetting in silent mode. This deficiency has the potential to affect five of six smoke compartments.	K 051	* The findings of the magnetic doors when the fire alarm is in silent mode will be discussed by the maintenance supervisor at monthly QAPI meetings for review and recommendation on the continuation or discontinuation of audits. LF/SPD/HJL	
K 056	NFPA 101 LIFE SAFETY CODE STANDARD	K 056		

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K 056 SS=D	Continued From page 3 Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on record review and interview, the provider failed to ensure the automatic sprinkler system was maintained in accordance with National Fire Protection Association (NFPA) 25. Quarterly sprinkler dry system testing was not being performed on the sprinkler system. Findings include: 1. Document review of the fire sprinkler inspection reports prepared by the maintenance supervisor and Building Sprinkler Inc. revealed missing required periodic testing requirements. In accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems the quarterly testing of the low air alarm shall be required for the dry pipe fire sprinkler system installed at the facility. Interview with the maintenance supervisor at 10:15 a.m. on 4/19/16 revealed he was not aware of the above testing requirement. He indicated he believed Building Sprinkler was conducting all required dry system testing requirements when	K 056	K056 1. The sprinkler inspection company, Building Sprinkler, Inc has conducted an inspection on 4/27/16. 2. All residents are at risk. 3. The Maintenance Supervisor was educated on the testing requirements at the time of survey and has NFPA 25 available to review. 4. Going forward, Building Sprinkler, Inc will be contracted to inspect the system quarterly to ensure testing requirements are maintained. <i>*The maintenance supervisor will update the QAPI committee of the completed and upcoming scheduled sprinkler inspections during monthly QAPI meetings for review and recommendations on continuation or discontinuation of reports. LF/SDDOHT/EL</i>	4-27-16

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K 056	Continued From page 4 they came annually. He indicated he had a copy of NFPA 25 available for review of the required inspection, testing, and maintenance. This deficiency has the potential to affect six of six smoke compartments.	K 056			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435118	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 2 B. WING _____	(X3) DATE SURVEY COMPLETED 04/19/2016
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K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 new health care occupancy) was conducted on 4/19/16. Prairie View Healthcare Community was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for new health care occupancies upon correction of deficiencies identified at K018, K025, K038, and K056 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	* Addendums noted with an asterisk per 5/18/16 per telephone with facility administrator. LF/SDDOH/L	
K 018 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. 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 positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation, testing, and interview, the provider failed to ensure doors protecting corridor openings were properly maintained to resist the passage of smoke in one randomly observed location. The door to resident room 305 was not latching into the door frame. Findings include: 1. Observation at 1:30 p.m. on 4/19/16 during a	K 018	K018 1. Room 305 door was repaired and now correctly latches. 2. All residents are at risk. 3. The Administrator will educate staff on ensuring doors latch and to report any doors that fail to latch. Education will be provided no later than 5-14-16 and those not in attendance at the education session will be educated prior to their first shift worked. 4. The Maintenance Supervisor will audit eight doors a week to ensure proper latching. Audits will be weekly for four weeks and then monthly for three months. Results of the audits will be discussed by the Maintenance Supervisor at monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit.	S-14-16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Kayla Evans	TITLE Admin, rph	(X6) DATE 5/10/16
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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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K 018	Continued From page 1 fire drill revealed the door to resident room 305 was closed to resist smoke from entering the room. That door would not stay closed. Testing of that door revealed the door hardware would not latch into the door frame and allowed the door to creep open. Interview with the maintenance supervisor at the time of the above observation confirmed that condition. He indicated he was not aware that door was not latching into its frame. He did not indicate when that door was last checked to ensure it was latching properly.	K 018			
K 025 SS=B	This deficiency has the potential to affect one of six smoke compartments. NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure smoke barrier walls were properly sealed to prevent the spread of smoke in one randomly observed location (sprinkler pipe wall penetration above the smoke barrier doors between building 1 and building 2). Findings include: 1. Observation at 11:25 a.m. on 4/19/16 revealed a smoke barrier separating building 01 (original building) and building 02 (2012 addition). Further	K 025	K025 1. The wall penetration was sealed with a fire rated caulking. 2. All residents are at risk. 3. The Maintenance Supervisor will inspect the attic area for any additional penetrations and ensure such are sealed. 4. Going forward, the Maintenance Supervisor will inspect the attic after any contract work is performed in the attic area to ensure any penetrations made by pipes, wires, or other means is appropriately sealed.	5.9.16	

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K 025	Continued From page 2 observation above the double-cross corridor smoke barrier doors revealed a sprinkler pipe penetrating through that smoke barrier wall. The space around the sprinkler piping was not properly sealed with any fire rated caulking material. That void space around the sprinkler piping had the ability to transfer smoke between smoke compartments. Interview with the maintenance supervisor at the time of the above observation confirmed that condition. He indicated he had not noticed that sprinkler pipe penetration was unsealed. He indicated that sprinkler piping was installed with the addition 2012.	K 025	*The findings of the attic inspections will be discussed by the maintenance supervisor at monthly QAPI meetings for review and recommendations on construction or discontinuation of audits. LF/SPDOH/EL		
K 038 SS=D	This deficiency has the potential to affect two of six smoke compartments. NFPA 101 LIFE SAFETY CODE STANDARD Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1.18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation, testing, and interview, the provider failed to ensure exits were readily available at all times. A delayed egress panic bar on the main entrance vestibule door did not disengage with activation of the fire alarm. Findings include: 1. Observation at 1:45 p.m. on 4/19/16 revealed the east vestibule exit door at the main entrance to building 02 was provided with a delayed egress panic bar. Testing of that delayed egress door during a fire drill scenario revealed the locking mechanism on that door did not deactivate. The	K 038	K038 1. The Bankoe Company, the software company for the alarm system, has been contacted and will come facility to re-code doors at their earliest convenience. 2. All residents are at risk. 3. The Maintenance Supervisor learned of the deficient practice and was educated on the requirements at the time of survey. 4. The exit egress doors will be checked doors will be checked at each fire drill to ensure the delayed egress panic bar disengages with activation of the fire alarm. A new fire drill checklist will be devised to include this check off at each monthly fire drill. Any abnormality will be reported to the Bankoe Company for repairs.	S-11-16	

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K 056	<p>Continued From page 4</p> <p>inspection reports prepared by the maintenance supervisor and Building Sprinkler Inc. revealed missing required periodic testing requirements. In accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems the quarterly testing of the low air alarm shall be required for the dry pipe fire sprinkler system installed at the facility.</p> <p>Interview with the maintenance supervisor at 10:15 a.m. on 4/19/16 revealed he was not aware of the above testing requirement. He indicated he believed Building Sprinkler was conducting all required dry system testing requirements when they came annually. He indicated he had a copy of NFPA 25 available for review of the required inspection, testing, and maintenance.</p> <p>This deficiency has the potential to affect six of six smoke compartments.</p>	K 056	<p>*The maintenance supervisor will update the QAPI committee of the completed and upcoming scheduled sprinkler inspections during monthly QAPI meetings for review and recommendations on continuation or discontinuation of reports.</p> <p>LF/SPD/H/EL</p>	
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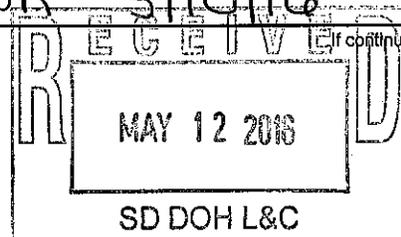
South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10714	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/21/2016
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NAME OF PROVIDER OR SUPPLIER PRAIRIE VIEW HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 401 S 1ST AVE POST OFFICE BOX 68 WOONSOCKET, SD 57385
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S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 29354 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, requirements for nursing facilities was conducted from 4/19/16 through 4/21/16. Prairie View Healthcare Community was found not in compliance with the following requirement: S173.</p>	S 000	<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>S173</p> <p>1. A light cover was installed in the family dining room and the cracked covers in the main dining room have been replaced. The lint in the dryer vents has been cleaned</p> <p>2. All residents are at risk.</p>	5-19-16
S 173	<p>44:73:02:18(8-10) Occupant Protection</p> <p>The facility shall take at least the following precautions: (8) Any light fixture located over a resident bed, in any bathing or treatment area, in a clean supply storage room, in any laundry clean linen storage area, or in any medication set-up area shall be equipped with a lens cover or a shatterproof lamp; (9) Any clothes dryer shall have a galvanized metal vent pipe for exhaust; and (10) The storage and transfilling of oxygen cylinders or containers shall meet the requirements of the NFPA 99 Standard for Health Care Occupancies, 2012 Edition.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 29354 Based on observation, interview, and policy review, the provider failed to maintain: *Light covers for 1 of 9 light fixtures in the resident/family dining room and for 2 of 13 cracked light covers in the main dining room. *Two of three dryer vents free from lint.</p>	S 173		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Kayla Evans	TITLE Admin, eph	(X6) DATE 5/11/16
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S 173	<p>Continued From page 1</p> <p>Findings include:</p> <p>1. Observation from 4/19/16 through 4/21/16 revealed: *In the resident/family dining room: -One overhead light fixtures did not have a cover. -The light bulbs were exposed in the overhead light fixture. *In the main dining room two overhead light fixtures were cracked with pieces missing.</p> <p>Interview on 4/20/16 at 4:57 p.m. with the director of nursing regarding the above light fixture covers revealed: *The door to the resident/family dining room was left open. *Resident's had access to the resident/family dining room. *Agreed the light fixture covers could be a safety concern if the lights had shattered.</p> <p>Observation and interview on 4/20/16 at 5:05 p.m. with the maintenance supervisor revealed he: *Had been aware there was not a cover over the light fixture in the resident/family dining room. *Had come to work a while back on a Monday morning and the light cover had been leaned up against the wall. *Confirmed the lights in the resident/family dining room were not shatteproof. *Had not been aware of the two light covers in the main dining room being cracked with pieces missing.</p> <p>Review of the provider's revised January 2014 Safety and Supervision of Residents policy revealed: *The facility strived to "Make the enviornment as free from accident hazards as possible."</p>	S 173	<p>3. The Administrator will educate all staff on the requirements for light covers and daily cleaning of the dryer lint. Education will occur no later than 5-14-16. Those not in attendance at education session will be educated prior to their first shift worked.</p> <p>4. The Maintenance Director or designee will audit four light fixtures each week to ensure they have covers are not broken or missing pieces and will audit the dryer vents four times each week to ensure they have been cleaned and a lint cleaning log is maintained. Audits will continue for four weeks and then monthly for three months. Audits will be discussed by the Maintenance Director at monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit.</p>

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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 173	<p>Continued From page 2</p> <p>*Resident risk factors and environmental hazards included electrical safety.</p> <p>2. Observation and interview on 4/19/16 at 4:50 p.m. with the maintenance supervisor in the laundry room revealed: *There was a large amount of lint build-up in two of the dryer vents. *The laundry staff were to vacumm the dryer vents at the end of their shifts.</p> <p>Interview and flow sheet review on 4/20/16 at 8:25 a.m. with laundry aide M regarding the dryer vents revealed: *The lint traps were to be cleaned and vacummed out at the end of each shift. *She confirmed there was no documentation the lint trap had been cleaned or vacummed out on 4/19/16.</p> <p>Interview on 4/21/16 at 10:35 a.m. with the administrator and the nurse consultant regarding the lint in the two dryer vents confirmed their expectations would have been for them to have been cleaned at the end of the laundry staff shift.</p> <p>Review of the provider's 10/4/15 Laundry Cleaning Schedule revealed: *"Objective: To rid equipment of dirt, lint, and germs. -Equipment: Broom and dustpan. -Procedure: Dryers - Sweep lint out from under the dryers. Daily."</p>	S 173		
S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 29354 A licensure survey for compliance with the Administrative Rules of South Dakota, Article</p>	S 000		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10714	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/21/2016
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NAME OF PROVIDER OR SUPPLIER PRAIRIE VIEW HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 401 S 1ST AVE POST OFFICE BOX 68 WOONSOCKET, SD 57385
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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 000	Continued From page 3 44:74, Nurse Aide, requirements for nurse aide training programs was conducted from 4/19/16 through 4/21/16. Prairie View Healthcare Community was found in compliance.	S 000		