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

ORIGINAL

PRINTED: 10/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435041		C 10/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN HEALTH AND REHAB	1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 29162 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted on 10/16/13. Areas surveyed included resident neglect, resident assessment, and quality of care. Aberdeen Health and Rehab was found not in compliance with the following requirements: F281, F309, and F387.	F 000	Addendums noted with an asterisk per 11/15/13 telephone to facility administrator. MP/SDDOH/MF	
F 281 SS=G	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: 29162 Based on record review, interview, and policy review, the provider failed to ensure: *Two of seven sampled residents (1 and 4) received laboratory (lab) tests as ordered by the physician. *One of seven sampled residents (5) had physician orders for lab tests per standing orders. *Three of seven sampled residents (1, 3, and 5) had physicians' orders accurately transcribed to their medication administration records (MAR). *One of seven sampled resident's (3) physician was notified of the unavailability of an ordered medication. Findings include: 1. a. Review of resident 1's medical record revealed:	F 281	See next page	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Megan Kleinsasser
TITLE: Exe Director
(X6) DATE: 11-8-13

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 281	Continued From page 1 A report dated 9/9/13 from an appointment at _____ (specialty clinic) with the following: *Resident 1's lab tests had been stable. *Labs were to have been done twice weekly until her next appointment scheduled for 10/9/13. *Those lab test were to have been done on Mondays and Thursdays. *That order had been signed by a certified nurse practitioner (CNP) from the clinic. *Those orders had not been noted by the provider. A Clinic Referral Form from the provider revealed: *That form had been sent to the clinic for resident 1's appointment on 9/9/13. *There had been physician's orders written on it. -Those orders stated "twice a week labs Monday/Thursday." *The orders had been signed by a CNP. *Those orders had been noted by registered nurse (RN) B. A fax from the provider that had been sent to resident 1's primary physician on 10/3/13 stated: *The resident had not had any lab work done for one month. *Her last lab tests had been completed while ahe had been hospitalized on 9/7/13. *The resident had voiced a concern to RN A and wondered if her physician wanted any lab tests completed. *A physician's order on the fax that ordered the provider to inquire with Dr. _____(specialty physician) who takes care of the resident's _____(specific illness). -That faxed ordered had been received on 10/4/13. *That order had been noted by RN A on 10/4/13	F 281	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states with respect to: 1. Resident #1 has been discharged from the facility. Resident #4's physician was contacted regarding necessary lab work. Labs were ordered and completed per the physician order. Resident #5's physician was contacted regarding necessary lab work. Labs were completed per physician order. Resident #3's Melatonin has been discontinued. Resident #5's Bactroban has been discontinued. 2. Physician orders will be reviewed for accuracy and that orders are being executed as ordered. 3. Licensed nursing staff will be re-educated by 11-12-13 by the DNS regarding receipt, transcription, ordering and completion of physician orders and physician notification if orders are not executed as ordered. Findings identified will be reviewed with licensed staff. Standing orders have been updated and will be reviewed by the Medical Director by 12-02-13.	

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F 281	Continued From page 2 at 6:00 p.m. *There had been no documentation identified in the resident's medical record that would have indicated RN A had contacted the resident's specialty physician for clarification of lab test orders. Review of the resident 1's nurses notes revealed: *On 10/5/13 she had been more lethargic than usual. *On 10/6/13 she had been very lethargic. *On 10/7/13 at 10:13 a.m. she had been very lethargic and unable to walk by herself. She had a small emesis of white phlegm. *On 10/7/13 at 11:59 a.m. her speciality physician had been contacted, and she had been sent to the emergency room for evaluation. *The resident had then been admitted to the hospital intensive care unit. -Her potassium level had been critically low at 2.4 (normal range 3.7 to 5.0 mmol/L) (mmol/l is millimoles/liter, a measurement for lab tests). Interview with RN B on 10/16/13 at 4:20 p.m. revealed she had not contacted resident 1's specialty physician as ordered by her primary physician. She stated she had not done that, because the resident had an appointment with her specialty physician later in the week. That appointment had been scheduled for five days after 10/4/13. That time frame included a weekend. Interview on 10/16/13 from 4:15 p.m. to 4:45 p.m. with the interim director of nurses revealed: *She would have expected RN A to have followed through with the noting of the physician orders on 9/9/13. *She would have expected RN B to have clarified	F 281	4. The DNS and/or her designee will audit 8 resident's medical records per week for accuracy of physician order transcription and execution for one month. Following QA meeting audits will continue at 4/week unless directed differently by the QA committee. In addition, 4 nurses /week for one month will be observed/monitored for understanding and adherence to the physician orders including receipt, transcription, ordering, completion of physician orders and notification of physician if an error occurs. Weekly the performance improvement team will study the data and review the system processes and act on any needed changes for system. On a monthly bases this will be reviewed and monitored by the DNS and at least quarterly by the Quality Assurance Committee. 5. The DNS is responsible for this area of compliance.	12-5-13

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F 281	Continued From page 3 the primary physician's order on 10/4/13 with resident 1's specialty physician. *She agreed not completing the ordered lab tests may have contributed to resident 1's need for hospitalization. Surveyor: 12218 1b. Review of resident 4's physician's orders for sixty days that started with September 2013 revealed the following laboratory tests had been ordered: *Clozaril level every 3 months (February, May, August, and November). therapeutic drug monitoring. *Fasting blood glucose every three months (February, May, August, and November for abnormal glucose (blood sugar). *Fasting lipid panel annually (November). *Liver function tests every three months (February, May, August, and November). *WBC (white blood count) with differential (w/diff) every four weeks (or 28 days), for therapeutic drug monitoring. Review of the laboratory test results in resident 4's medical record revealed: *The WBC w/diff every four weeks had been completed monthly from November 2012 through September 2013. October had been highlighted on the Medication Administration Record (MAR) as planned for October 17, 2013. *The July 2013 laboratory tests showed the glucose results, the lipid (fat) profile test results, the liver function, and the WBC with diff test results. *The findings related to fasting blood glucose or liver function test results revealed:	F 281		

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F 281	Continued From page 4 -None had been done prior to July 2013. -Those lab tests were done in July 2013 instead of in August 2013 as outlined by the physician's order. -Those lab tests were not highlighted on the November calendar. *There were no findings of any lab tests completed for the Clozaril levels. Interview with the director of nursing (DON) and the provider's regional nurse consultant at 4:10 p.m. on 10/16/13 revealed: *The provider's nurse had sent a Laboratory Requistion sheet on 9/19/13 for the WBC test for resident 4. *She had written Clozapine in the ICD -signs and symptoms box. *The DON stated their nurse should have written it down on the bottom of the sheet in the Additional Tests box and circled it. *They had received the 9/19/13 test results and only the WBC test had been done. Interview with the DON at 4:50 p.m. on 10/16/13 revealed: *She had called the clinic and had talked with the physician's nurse who did not know anything about the physician's laboratory tests for resident 4 that included Clozaril levels, fasting blood glucose, fasting lipid panel, and liver function tests. *The physician's nurse asked the DON to fax a copy of the those physician's orders for the laboratory tests. *She stated they had not done those tests. *The DON stated she did not think the provider was responsible for requesting those laboratory tests as the physician usually ordered them when	F 281		

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F 281	Continued From page 5 he made rounds. Interview with the provider's regional nurse consultant at 5:15 p.m. on 10/16/13 revealed: *She confirmed it was the responsibility of the provider to get the laboratory tests appointments completed when the monthly physician orders outlined which tests were to be done routinely. Surveyor: 32572 2. Review of the providers 10/31/12 Standing Order Protocols revealed when a resident had been on digoxin (medication to strengthen the heart beat) and a diuretic (water pill) the provider was to have drawn a digoxin level every six months. Resident 5 had been admitted on 1/26/13. The physician had ordered digoxin and Bumex (water pill) medications. He had been hospitalized in March 2013 with the following noted: *During that hospitalization it had been noted he had a digoxin level that had been higher than the normal limits. *His digoxin level had been monitored closely during that hospital stay. He had returned to the provider on 3/19/13. The following was noted: *There had not been clarification sought from the physician as to when the next digoxin level should have been drawn. Review of resident 5's medical record revealed there had not been a digoxin level completed during the month of September 2013 as directed by the standing orders that were in his medical record.	F 281		

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F 281	Continued From page 6 Interview on 10/16/13 at 4:00 p.m. with the administrator confirmed there had not been clarification as to when the next digoxin level was to have been drawn. She confirmed the digoxin level had not been completed in September 2013 as directed by the standing orders. Surveyor: 29162 3.a. Review of resident 1's medical record revealed: *Her August 2013 consolidated physician's orders stated the dosage for her Albuterol (for breathing) had been handwritten for the dosage of 90 micrograms (mcg). *Her September 2013 consolidated physician's orders revealed the dosage for her Albuterol had been recorded as Albuterol 90 mgb (not mcg). *Her October 2013 MAR had her Albuterol dosage as 90 mgb (not mcg). Interview on 10/16/13 with the DON revealed she agreed the dosage for resident 1's Albuterol had been incorrect on the resident's September 2013 consolidated physician's orders and on her October 2013 MAR. Surveyor: 32572 b. Review of the January through March 2013 consolidated physician's orders revealed an order for Cipro (antibiotic) 250 mg BID (twice a day) for five days for resident 3. Review of the medical record revealed: *The resident had been admitted on 1/26/13. *The January through March 2013 consolidated physician's order indicated the Cipro physician order had been written on 1/26/13, and it had been started on 1/28/13. *The January 2013 MAR indicated the medication	F 281		

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F 281	Continued From page 7 had been given for five days starting on the 27th. *The February 2013 MAR revealed the Cipro physician's order had been handwritten on the MAR. The MAR had been marked with a yellow marker to indicate the medication was not to be given. The medication had not been given. *The March 2013 MAR revealed the Cipro physician's order had been typed as all other orders. The MAR had "DC" (stop) hand written on it. The medication had not been given. Interview on 10/16/13 at 4:00 p.m. with the administrator confirmed the order should not have been on the February and March consolidated physician's orders. c. Review of resident 5's medical record revealed: *He had been admitted on 1/26/13. *The consolidated sixty day physician's order for July 2013 and September 2013 indicated an order for Bactroban (antibiotic) ointment 2% to be applied to affected area TID (three times a day) PRN (as needed). *Review of the MARs and treatment administration records (TAR) for July through September 2013 revealed the order had not been included. *Review of the nurses notes had not indicated the order had not been discontinued. The record also had not indicated why the order had not been included on the MARs or TARs. Interview on 10/16/13 at 4:00 p.m. with the administrator confirmed the order had not been included on the MARs or TARs 4. Review of the October 2013 medication administration record (MAR) for resident 3 revealed the physician's order Melatonin (sleep	F 281		

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F 281	Continued From page 8 medication) 1 milligram (mg) every HS (hour of sleep) for fourteen days then DC (stop). *The MAR indicated the medication was to have begun on the 9th. *The MAR indicated the medication had been given on the 9th and 10th. *The recording of the administration then had been initialed and circled (indicated not given) for the 11th through the 15th. *Under the circled initials on the 11th it stated "none in cart." *The 12th and 13th under the circled initials it stated "not here." Review of the medical record did not indicate the medication had not been there or had been not given on the dates indicated. The record did not reveal the physician had been notified or the medication had not been given or available. Interview on 10/16/13 at 4:00 p.m. with the administrator confirmed the medications had not been given on the 11th through the 15th. She confirmed the physician had not been notified of the situation. Surveyor: 29162 Review of the provider's undated registed nurse job description revealed the RN was to have had: *The ability to priortize tasks. *The ability to focus efforts toward quality resident care. *Excellent oral and written communication skills. *Sound mature judgement. *Completed daily assignments as assigned. *Verified the completion of all required documentation at the end of the assigned shift. *Prepared, administered, assessed effectiveness of, and documented medications, and treatments	F 281		

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F 281	Continued From page 9 for each resident is accordance with physician's orders. *Ordered lab as indicated. *Obtained specimens for lab tests as needed. *Received, transcribed, and carried out physician's orders. *Demonstrated knowledge of and enforced state and federal regulations. Review of the provider's June 2009 Transciption of Orders policy and procedure did not reveal instructions for transcribling or receiving physician orders from a fax or physician clinic visit. From: http://legis.state.sd.us/statutes/DisplayStatute.aspx Type=Statute&Statute=36-9-3. 36-9-3. Scope of registered nursing practice. As used in this chapter, the practice of nursing by a registered nurse means the: (1) Nursing diagnosis of human responses to actual or potential health problems of individuals or groups, providing preventative, restorative and supportive care, health teaching and counseling, case finding and referral; and (2) Administration, supervision, delegation, evaluation and teaching of health and nursing practice; which require substantial specialized knowledge, judgment and skill based upon the principles of the biological, physiological, behavioral and sociological sciences, and for which the registered nurse bears responsibility and accountabiliy. The registered nurse may perform in addition to the foregoing, those acts which require additional education which shall be authorized by the board through its rules.	F 281	F309 MK The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. 1. Resident #1 has been discharged from the facility. Resident #4's physician was contacted regarding necessary lab work. Labs were ordered and completed per the physician order.* [redacted] MP/SDDOH/MF 2. Physician orders will be reviewed for accuracy and that orders are being executed as ordered. 3. Licensed nursing staff will be re-educated by 11-12-13 by the DNS regarding receipt, transcription, ordering and completion of physician orders and physician notification if orders are not executed as ordered. Findings identified will be reviewed with licensed staff. Standing orders have been updated and will be reviewed by the Medical Director by 12-02-13.	
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

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F 309 SS=G	Continued From page 10 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: 29162 Based on record review, interview, and policy review, the provider failed to ensure laboratory tests had been completed as ordered by the physician for two of seven sampled residents (1 and 4). Findings include: 1. Review of resident 1's medical record revealed she had not received laboratory tests as ordered by her physician. Refer to F281, finding 1a. 2. Review of resident 4's physician's orders revealed laboratory tests had not been completed as ordered. Refer to F281, finding 1b.	F 309	4. The DNS and/or her designee will audit 8 resident's medical records per week for accuracy of physician order transcription and execution for one month. Following QA meeting audits will continue at 4/week unless directed differently by the QA committee. In addition, 4 nurses /week for one month will be observed/monitored for understanding and adherence to the physician orders including receipt, transcription, ordering, completion of physician orders and notification of physician if an error occurs. Weekly the performance improvement team will study the data and review the system processes and act on any needed changes for system. On a monthly bases this will be reviewed and monitored by the DNS and at least quarterly by the Quality Assurance Committee. 5. The DNS is responsible for this area of compliance.	12/05/2013
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs	F 387	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law.	

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F 387	Continued From page 11 not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on record review, interview, and policy review, the provider failed to ensure a sixty day physician visit had been completed for one of six sampled residents (3). Findings include: 1. Review of resident 3's medical record revealed she had been admitted on 1/26/13. *She had been seen by the physician on admission day with a progress note. *The thirty day physician visit had occurred on 2/27/13. The provider's Clinic Referral Form included a progress note from that visit. *The sixty day physician visit had not occurred. *The ninety day physician's visits had occurred on 4/29/13 with a progress note from that visit. Interview on 10/16/13 at 4:00 p.m. with the administrator confirmed the physician's visit had been missed. The provider was unable to provide a policy on the frequency of physician visits.	F 387	Without waiving the foregoing statement, the facility states with respect to: 1. Resident #3's physician visits are current. 2. All residents have been audited for any missed physician visits and all visits are current. 3. The facility has developed a tracking tool for all resident required physician visits. Licensed staff will be educated to this tool and then implementation. 4. The DNS and/or her designee will audit compliance with tracking tool and 3 resident medical records per month verifying physician visits remain in compliance with Federal and State requirements according to CMS and South Dakota Administrative Rule. At least one of these charts will be a new admission within the previous 90 days. 5. Monthly the performance improvement team will study the data and review the system processes and act on any needed changes for system. On a monthly bases this will be reviewed and monitored by the DNS and at least quarterly by the Quality Assurance Committee. 6. The DNS is responsible for this area of compliance.	12/05/13