

ORIGINAL

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

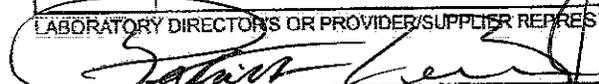
PRINTED: 02/03/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 01/23/2014
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NAME OF PROVIDER OR SUPPLIER  BETHESDA OF BERESFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 606 W CEDAR BERESFORD, SD 57004
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F 000	INITIAL COMMENTS  Surveyor: 26180 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/22/14 through 1/23/14. Areas surveyed included resident care issues, nursing services, neglect, social services, and administration. Bethesda of Beresford was found not in compliance with the following requirements: F226, F250, F281, F323, F490, F493, and F514.	F 000	Addendums noted with an asterisk per 2/24/14 telephone to facility administrator and DON.  CS/SDDOH/JJ	
F 226 SS=G	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, record review, interview, and policy review, the provider failed to investigate and report to the appropriate state agency South Dakota Department of Health [SD DOH] two of two sampled resident incidents (1 and 2) resulting in injuries. Findings include:  1. Observation of resident 2 on 1/23/14 at 2:10 p.m. revealed she had a bruised large raised bump (the size of a goose egg) on her forehead with bruises in various stages of discoloration over her face. Interview at that time with resident 2 revealed she was unable to recall how she had received the bruise on her forehead and her face.	F 226	F 226 - Develop/Implement Abuse Neglect, ETC Policies  A revision was made to the Abuse & Neglect Policy and Procedure.  The incident report document was revised to be inclusive for falls, skin and other adverse resident events.  Professional nursing staff was educated February 13th, 2014, on the importance of: <ul style="list-style-type: none"> <li>➤ Use of psychotropic medications prior to full assessment of needs i.e. pain and toileting;</li> <li>➤ Documentation of response to interventions;</li> <li>➤ Development of a behavior plan.</li> </ul> Investigative follow-up to be initiated by the charge nurse at time of an adverse event through: <ul style="list-style-type: none"> <li>➤ A revised fall follow-up form;</li> <li>➤ A revised skin follow-up form.</li> </ul>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 02/14/2014
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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 226	<p>Continued From page 1</p> <p>Review of resident 2's 1/10/14 nurses notes revealed:                  *She had received Ativan (an antianxiety medication) for agitation at 7:00 p.m.                  *There was no documentation if they had ruled out pain as the reason for the agitation before giving the Ativan.                  *She had been sleeping in her wheelchair at the nursing station prior to the fall.                  *She had fallen forward out of her wheelchair onto the floor at 2330 (11:30 p.m.) as she was being pushed in her wheelchair. The certified nursing assistant (CNA) was taking her to her room to put her to bed.                  -The CNA had not been identified in the notes.                  *She had hit her head when she fell.                  *She had received a 9 x 7 centimeter (cm) bruise/bump to her forehead.                  *She had a skin tear 2 cm x 1 cm on the bump on her forehead oozing a small amount of blood drainage and had bruising to her knees, elbow, and fingers.                  *She had a small amount of blood coming from her nostrils (nose).</p> <p>Interview on 1/23/14 at 4:00 p.m. with the DON confirmed the bruising on resident 2's face was a result of the fall on 1/10/14. A request for the investigation report was made at that time.</p> <p>Review of resident 2's 1/10/14 Falls-Resident Incident Report/Unusual report and interview on 1/24/14 at 10:30 a.m. with the resident care coordinator (RCC) revealed:                  *That was the investigative report they had completed after her above fall.                  *They had not assessed why the resident was still sitting in her wheelchair at 11:30 p.m. nor how</p>	F 226	<p>This was also covered at the February 13<sup>th</sup> nursing in-service.</p> <p>Incident investigation follow-up to be completed will include:</p> <ul style="list-style-type: none"> <li>➤ Resident/family interview;</li> <li>➤ Staff interview;</li> <li>➤ Determination for mandatory reporting as outlined in the regulations;</li> <li>➤ Appropriate corrective action as deemed necessary by the DON or designee.</li> </ul> <p>The revised Abuse &amp; Neglect Policy will be covered upon hire and annually thereafter. <i>* The entire nursing staff and Department Heads received education on this revision on 2/13 and 2/14/14.</i>                  Professional nursing staff was educated February 13<sup>th</sup>, 2014 on the following:</p> <ul style="list-style-type: none"> <li>➤ The importance of fully completing Incident report forms;</li> <li>➤ When to notify administrative staff of adverse events.</li> </ul> <p><i>*all CS/5000H/JT</i>                  Auditing of Incident Reporting and Investigation follow-up will be completed by the DON or designee monthly for at least 6-months and reported at the quarterly QA meeting by the DON or designee.</p>	03/14/2014
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F 226	<p>Continued From page 2 long she had been sleeping. *The report did not identify the CNA involved in the incident. *There was no indication the CNA had been asked any questions about the incident. *When it asked if pain medication had been ordered it was left unanswered. *The RCC agreed there were unanswered questions in the report, and the fall had not been investigated. *There was no evidence that fall had been reported to the required state agency.</p> <p>Review of the provider's 8/1/11 Abuse and Neglect policy revealed it had not addressed completing an investigation or reporting to the SD DOH of unusual events resulting in resident injury.</p> <p>Surveyor: 22452 2. Review of resident 1's 11/16/13 through 12/28/13 nurses' notes revealed: *11/16/13- "New bruise noted to left shin (lower leg) measuring 20 centimeters (cm) by 10 cm. No apparent pain." *11/21/13- "Alert but mostly non-verbal. Wants/needs anticipated by staff." *11/22/13- "Two assist [two staff assistance] with lift and all other cares." *12/10/13- "Noted 2 cm by 2 cm bruise to left knee. No pain." *12/28/13- "Two bruises on left breast. One area 3 cm by 3 cm and one area 7 cm by 4 cm."  Interview on 1/22/14 at 4:00 p.m. with the director</p>	F 226	<p>*Education was provided February 13 and 14, 2014 to all nursing staff and Department Heads on the updated abuse and neglect policy and procedure.</p> <p>*Investigative follow-up was completed on January 10, 2014 regarding resident #2's falls. This included interview of the CNA witness and coaching with the charge nurse.</p> <p>*Documentation of investigation of December 25, 2013, adverse event completed on Resident #1, to include CNA actions, nurse follow-up, family communication and administrative staff involvement with a note of time lapse and limited accuracy.</p> <p style="text-align: right;">CS/SDDOH/JJ</p>		

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F 226	Continued From page 3 of nursing (DON) regarding resident 1 revealed: *They thought the bruises on her legs had happened as a result of using the stand-aide for transfers, but no one had documented that. *There had been no preventative measures put in place to prevent the reoccurrence of bruising. *The bruise on her breast had also occurred as the result of a transfer with a lift. She had been transferred on 12/25/13 using the stand-aide instead of the sling lift that she should have been transferred with. *The resident did not verbalize and would not have been able to recall how she had received the bruises or if she was having pain from them. *They never really investigated bruises of unknown origin other than to document they were found.	F 226	*Care conference documentation on Resident #1 will not be corrected/updated due to a lapse in time and the inability to complete it accurately.  CS/SDDOH/JJ	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE  The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review and interview, the provider failed to ensure family concerns were resolved regarding resident care issues for one of two sampled residents (1). Findings include:  1. Review of resident 1's 3/15/13 through 11/27/13 social service progress notes revealed: *3/15/13- "Care conference with daughter and	F 250	<b>F 250 - Provision of Medically Related Social Services</b>  The Interdisciplinary Care Team was educated February 5 <sup>th</sup> , 2014, on the content of care conference notes to include:  ➤ Conversations of resident/family concerns and complaints along with a plan of action; ➤ Changes in resident level of care/status i.e. change in transfer device, ADL changes, referrals to outside agencies, etc; ➤ Review of medication regimen; ➤ All other pertinent information regarding resident care.  The Interdisciplinary Care Team and professional nursing staff were educated February 14 <sup>th</sup> , 2014, on the importance of documenting resident/family discussions regarding resident care and status.	

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F 250	<p>Continued From page 4</p> <p>son. Nursing reported that her health has been stable and no new concerns have arisen. Family agrees that she has been fortunate to have kept away from any major illnesses this winter. Staff report she continues to stand in the stand-aid in the mornings, but otherwise uses the total lift for transfers. No concerns were noted." *6/7/13-"Care conference with son and daughter in attendance. Staff provided a review of her status. Nursing staff noted that her functional status remains about the same. She continues to use the commode [portable toilet] for her bowels as needed." *11/27/13- "Enjoys being around others. Staff and family visits. Disposition is pleasant and smiles often. Has a need for nothing. No concerns and seems comfortable."</p> <p>Interview on 1/23/14 at 11:10 a.m. with the social worker regarding resident 1 revealed: *For the 11/27/13 care plan her family had not attended the care plan meeting, and they just sent them a letter. *She was aware of some family issues, but the family usually went to nursing directly. *She was aware the family wanted her to use the commode [portable toilet] instead of a bed pan. *Nursing had told her the family was very vocal regarding the EZ stand should have been used for transfers for toileting. Nursing had felt the use of the EZ stand was unsafe related to her becoming very anxious and SOB (short of breath) whenever the EZ stand was used. Nursing had told her the family were aware of those spells and still wanted the EZ stand used. *She thought she had offered to call the ombudsman (resident advocate from social services) to come talk to the family, but she had failed to document that.</p>	F 250	<p>The Administrator, DON and/or designee will attend care conferences involving resident/family and/or identified care concerns.</p> <p>A form has been developed to assist with accurate documentation of care conferences.</p> <p>Audits will be completed by the DON or designee comparing <sup>all</sup> care conference notes worksheets to medical record documentation weekly for at least 4 weeks and then monthly for at least 5 months. Results will be reported at the quarterly QA meeting by the DON or designee.</p>	CS/s200H/JJ  03/14/2014	

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F 250	Continued From page 5 *She thought she had spoken to the ombudsman regarding her but also had failed to document that. The ombudsman usually did not come to the facility unless the family would have requested them to. **I was asked to come into the meeting with the resident care coordinator on 1/26/13 when she was meeting with the family and they were crying. They were upset the use of the EZ lift on 12/25/13 had caused her increased shortness of breath, anxiety, and bruising and pain on her left breast." *She had not documented her interaction with the family on 12/26/13. Nursing had wanted her to help comfort the family. *She knew the physician had ordered hospice on 12/25/13, but she had been informed by nursing the family did not want to proceed with that. The family had thought she was having an isolated cardiac event until they found out her respiratory distress had been caused from nursing using the EZ stand instead of the EZ lift. *Hospice was offered on 1/10/14. The family wanted to wait and talk to another family member who was a social worker at a specific hospice facility. *Several hospice providers had been offered to the family on 1/16/14, but they chose the hospice where the family member was the social worker. *Hospice never evaluated her, because she died later that day. *She really had never met with the family regarding any of the concerns they had with the resident's care. She had thought nursing had resolved all their concerns.	F 250			
F 281	Refer to F323, finding 2. 483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281			

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F 281 SS=D	Continued From page 6 <b>PROFESSIONAL STANDARDS</b>  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, record review, interview, and policy review, the provider failed to ensure one of two sampled residents (2) had their physician notified in a timely manner following a fall with a head injury. Findings include:  1. Review of resident 2's 1/10/14 nurses notes revealed she: *She had fallen forward out of her wheelchair onto the floor at 2330 (11:30 p.m.) as she was being taken to her room to go to bed. *Had been sleeping in her wheelchair at the nursing station prior to that. *Had hit her head when she fell. *Received a 9 x 7 centimeter (cm) bruise/bump to her forehead. *Had a skin tear on the bump 2 cm x 1 cm oozing a small amount of bloody drainage. *Had a small amount of blood coming from her nostrils (nose). *Also had bruising to her knees, elbow, and fingers. *She was drowsy and unable to follow commands. *The Hospice nurse was called and informed of the fall. *The physician had not been informed at the time of the fall.  Review of a physician's fax form revealed	F 281	<b>F 281 - Professional Standards</b>  The Fall & Neurological Status Policy and Procedures were revised.  Professional nursing staff was educated February 13 <sup>th</sup> , 2014, on notifying the physician at the time of a change in status and/or adverse event.  An audit will be completed by the RCC or Designee regarding documentation of physician notification on change in resident status and/or adverse event, bi-weekly for at least 6 months. The DON or designee will report at the quarterly QA meeting the results of the audit.	03/14/2014 <i>5 records CS/SEARCHED</i>

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F 281	<p>Continued From page 7</p> <p>resident 2's physician was notified of the fall and head injury on 1/11/14 at 7:45 a.m. That was eight hours after the fall had occurred.</p> <p>Observation of resident 2 on 1/23/14 at 2:10 p.m. revealed she had a large bruised raised bump (the size of a goose egg) on her forehead. She had multiple bruises in various stages of discoloration all over her face.</p> <p>Interview on 1/23/14 at 4:00 p.m. with the director of nursing confirmed the bruising on resident 2's face was a result of the fall on 1/10/14.</p> <p>Review of the hospice provider's general outline of responsibilities stated "Hospice retains responsibility for all cares related to the terminal illness."</p> <p>Review of the provider's 5/23/06 fall prevention and investigation policy revealed: **Nursing will perform follow-up charting for a minimum of 3 days following an accident. *Any new findings will be communicated to the resident's primary physician. *It had not addressed how to determine whether the physician should have been notified at the time a fall occurred."</p> <p>Interview on 1/23/14 at 4:00 p.m. with the director of nursing regarding resident 2 revealed: *They would have notified the physician if there was a change in condition or a fall with an injury. *They would not have notified the physician with the above fall unless there had been a neurological (nervous system) change.</p> <p>Interview on 1/24/14 at 10:30 a.m. with the resident care coordinator regarding resident 2</p>	F 281			

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F 281	Continued From page 8 revealed: *The reason the resident was on hospice was dementia with behavioral disturbance. *They had not notified the physician at the time of the fall. *She could not confirm the above fall was related to the terminal illness and the justification for hospice being notified rather than the resident's physician. *The hospice nurse had been to see the resident since her fall, but she had not left any nursing documentation from those visits.  Review of Patricia A.Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., p. 358, St. Louis, MO, 2013 revealed: *"A registered nurse makes a telephone report when significant events or changes in a patient's [resident] condition have occurred." *An incident or occurrence was any event that was not consistent with the routine operation of a health care unit or routine care of a patient. *Examples of incidents include patient falls."	F 281			
F 323 SS=G	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: 22452	F 323	<b>F323 - Free of Accident Hazards/Supervision/Devices</b>  The injury prevention Policy and Procedure was reviewed and updated. <i>*All CS/5000H/JJ</i> Nursing staff and Department Heads were in-serviced February 14 <sup>th</sup> on resident safety including: ➤ Proper positioning; ➤ Lift/transfer safety; ➤ Wheelchair transportation; ➤ Evaluation of equipment function.		

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F 323	<p>Continued From page 9</p> <p>Based on record review, interview, and policy review, the provider failed to:</p> <p>*Properly use transfer equipment to prevent unnecessary distress for one of one sampled resident (1).</p> <p>*Prevent falls for one of one sampled resident (2) who had multiple falls.</p> <p>Findings include:</p> <p>1. Review of resident 1's 11/22/13 quarterly nursing assessment revealed:</p> <p>***She does not respond with any verbalization and has not for some time."</p> <p>***She is on oxygen continuous."</p> <p>***Observed bed to chair transfer and resident did not become very short of breath (SOB) with activity and when lying down in bed."</p> <p>***She tolerates transfers in the lift with big eyes and some facial grimacing. She does not deny or confirm pain. She does shake her head no when you ask her if she hurts anywhere."</p> <p>***On interview with other staff she has not been verbal other than a laugh."</p> <p>***She had acute bronchitis that has now progressed into pneumonia. Intravenous antibiotics have been given here."</p> <p>Review of resident 1's 9/26/12 care plan revealed she:</p> <p>*Was non-ambulatory and was to be transferred with the EZ lift only (a total mechanical lift that required no active participation by the resident). Two staff should have assisted with those transfers.</p> <p>***May use EZ stand (a mechanical lift that required the resident to actively participate by bearing weight on his/her legs) with assist of 2 [two staff assistance] for bowel movements only."</p> <p>*The following was handwritten on 12/27/13:</p>	F 323	<p>The CNA wing "side sheets" will be updated by the DON or designee weekly and as needed to reflect resident care needs/status including:</p> <ul style="list-style-type: none"> <li>➤ Toileting, transfer, safety devices, assistive devices, ADL needs, etc.</li> </ul> <p>The Adverse event investigation follow-up has been updated as defined in F226.</p> <p>The auditing of safe use of assistive devices and positioning completed by the SDC or designee will occur <sup>5 times</sup> <del>bi</del> weekly for at least 8 weeks and then monthly for at least 4 months. The results will be reported to the quarterly QA meeting by the DON or designee.</p> <p style="text-align: right;"><i>CS/SOOH/JJ</i></p>	03/14/2014

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F 323	<p>Continued From page 10</p> <ul style="list-style-type: none"> <li>- "Difficulty with transfers."</li> <li>- "Resident will transfer safely with EZ lift with minimal stress."</li> <li>- "Do not use standard (EZ stand)."</li> <li>- "EZ lift only."</li> <li>- "Transfer slowly and monitor status."</li> </ul> <p>Review of resident 1's 12/25/13, 9:50 p.m. nurse's notes revealed:</p> <ul style="list-style-type: none"> <li>*Medication nurse discovered resident with extreme SOB and facial grimacing.</li> <li>*Oxygen saturation 86 percent (%). (Normal is greater than 90%). Oxygen was increased to 5 liters per mask.</li> <li>*Nitroglycerin (medication for chest pain) was given three times with relief of SOB but not completely relieved.</li> <li>*Family requested resident be kept at facility and comfort measures to have been given.</li> <li>*On-call physician was called and new orders received and noted.</li> <li>*First doses of morphine (narcotic pain medication) and Ativan (anti-anxiety medication) administered with greater relief of SOB and anxiety.</li> </ul> <p>Review of resident 1's 1/9/14, 1:35 p.m. nurse's notes revealed:</p> <ul style="list-style-type: none"> <li>*The resident was found in her room leaning out of the Broda (multi-positional chair) to the left side. Her arm was hanging over the side of the chair.</li> <li>*The resident was very SOB and grimacing. Her face was flushed.</li> <li>*Her oxygen saturations were less than 80%. Duoneb (inhalation medication) was given, and her oxygen saturations increased to upper 80%. Her oxygen was increased to 5 liters per nasal cannula immediately on discovery of that incident.</li> </ul>	F 323		

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F 323	<p>Continued From page 11</p> <p>*As needed (PRN) Roxanol (narcotic pain medication) and Zofran (medication for nausea) was given per order. Oxygen saturations increased to low 90%.</p> <p>*Her SOB lessened but she still used her accessory muscles (muscles in her chest).</p> <p>*Second dose of Roxanol was administered at 1:50 p.m. Oxygen saturation was 93% on oxygen 5 liters.</p> <p>Interview on 1/22/14 at 5:40 p.m. with the DON regarding resident 1 revealed:</p> <p>*Two certified nursing assistants (CNA) A and C were transferring her on 12/25/13 at 10:00 p.m. from her recliner to the bed after they had gotten her ready for bed. They had not toileted her, so they should have not been using the EZ-stand (mechanical lift that required the resident to participate in the transfer by bearing weight on her legs).</p> <p>*CNAs A and C were counseled for not following the care plan by using the EZ lift to transfer her, but she had failed to document anything. The CNAs had said nothing to the nurses about using the incorrect lift to transfer the resident. The nurses had been informed by the resident's family.</p> <p>*The resident's family had met with the resident care coordinator (RCC) on 12/26/13 but had failed to document that.</p> <p>*CNAA had told the resident's family the resident had been transferred using the EZ stand instead of the EZ lift. The use of the EZ stand caused her to become anxious and SOB.</p> <p>*CNA A had stated she worked only weekends and was unsure how the resident should have been transferred.</p> <p>*She had been informed the resident was not SOB or anxious until she had been transferred by</p>	F 323		

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F 323	<p>Continued From page 12</p> <p>the use of the stand-aide (mechanical lift that required the resident to be an active participant and have the ability to bear some weight on her legs).</p> <p>*She had spoken to the CNA who had not put the arm down on the Broda chair on 1/9/14. If the arm of the Broda chair had been in a down position the resident would not have been hanging out of the chair.</p> <p>*Usually the resident was left by the nurse's station after the noon meal until the CNAs were ready to put her in her recliner. On 1/9/14 the staff had taken her to her room and left her in the Broda chair.</p> <p>*The resident's family had always wanted her to bear some weight and that was why they were even trying to use the EZ stand for toileting.</p> <p>*The family had been upset with her "That I had taken away her parallel bars and the EZ stand because of her poor tolerance."</p> <p>Interview on 1/22/14 at 6:25 p.m. with CNAs B and C regarding resident 1 revealed:</p> <p>*CNA B stated she was coming back from her supper break on 12/25/13 between 6:00 p.m. and 6:15 p.m. and was paged to the resident's room by CNA A to assist with transferring the resident into her recliner. The resident's family always wanted her transferred from the Broda chair into the recliner right after supper.</p> <p>*The resident was holding her breath which she always did when the staff transferred her. She tried to "chicken wing" (arms in a flexed position to her sides with elbows pointing upwards toward the head) when they raised her up in the EZ stand, and then became SOB.</p> <p>*CNA B stated she was unsure why CNA A was transferring the resident with the EZ stand instead of the EZ lift. CNA B stated she usually worked</p>	F 323		

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F 323	<p>Continued From page 13 down another hall and was not familiar on how the resident should have been transferred. *CNA C came in the room after they had gotten the resident into the recliner. She was red and SOB. CNA obtained the resident's vital signs (blood pressure, pulse, respirations), and then went out to get the nurse. *CNA C also stated the family also wanted them to use the EZ stand.</p> <p>Interview on 1/23/14 at 10:00 a.m. with the resident care coordinator (RCC) regarding resident 1 revealed: *The family always wanted them to use the EZ stand for transfers to keep her as weight bearing as much as possible. *The DON had said in September 2013 the EZ stand could no longer be used. The resident had three separate episodes of becoming SOB and had not tolerated being transferred with the EZ stand. The EZ lift should have been used for all transfers. The three incidents of poor tolerance of transfers with the EZ stand had not been documented nor had the change from the EZ stand to the EZ lift done by the DON. *Her care plan meeting was last held in September 2013 and should have reflected the change from the EZ stand to the EZ lift. When changes were made to the care plan the discontinued items should have been yellowed out. The nurse making the new changes should have put the date and their initials when it had been implemented. *CNA A should have known better than to use the EZ stand to transfer her on 12/25/13. *The Minimum Data Set (MDS) coordinator should have updated the care plan. *She had updated the care plan on 12/27/13 to use only the EZ lift for transfers after her incident</p>	F 323		

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F 323	<p>Continued From page 14</p> <p>on 12/25/13, so there would be no question on how she should have been transferred.</p> <p>**We tried to appease the family. They were very vocal and they grieved terribly and wanted her to stay as independent as possible."</p> <p>*After her incident on 12/25/13 they wanted only comfort measures. They had declined hospice the physician had ordered on 12/25/13. The family had made that decision prior to knowing the use of the EZ stand caused her SOB, and that it was not an isolated acute episode.</p> <p>*She had met with the family on 12/26/13. She knew they had just wanted to vent and had asked to speak with her. The family was very angry the EZ stand had been used for the 12/25/13 transfer. She had documented none of the conversation. She had not informed the DON or the administrator prior to her meeting with the family but had informed them after. "I think there was a little bit of an issue between the family and the DON."</p> <p>*The family was not angry at the CNAs for using the EZ stand, but they thought there was a communication problem in the facility. "The family seemed fine after I talked to them."</p> <p>Interview on 1/23/14 at 10:40 a.m. with licensed practical nurse (LPN) D regarding resident 1 revealed:</p> <p>*She was on duty 12/25/13 and on 1/9/14 when the resident had her acute episodes.</p> <p>*On 12/25/13 she had no idea her SOB had been caused by the use of the EZ stand for transferring the resident. The CNAs A, B, or C had not informed her of that. She had found out about the transfer after CNA A had informed the family.</p> <p>*She thought the resident was having an acute cardiac episode on 12/25/13 and just wanted to get her some morphine to keep her comfortable.</p>	F 323		

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F 323	<p>Continued From page 15</p> <p>She had called the RCC to help her get the morphine from the pharmacy after she had received the orders from the on-call physician.</p> <p>Interview on 1/23/14 at 11:45 a.m. with the registered nurse Minimum Data Set (MDS) coordinator regarding resident 1 revealed:            ***We have a working care plan. Any changes to the care plan should have been yellowed out when discontinued and dated with new changes."            *Every quarter when the MDS and care plan were reviewed she had observed the staff transfer her always with the EZ lift. She had never observed her to become anxious or SOB when the staff had transferred her with the use of the EZ lift. The resident's daughter had also observed the transfers.            *She was not familiar with any communication between the DON and the RCC. The use of the EZ stand should have been yellowed off the care plan in September 2013 when the change had been made to use the EZ lift only. The DON had made the decision and should have made the changes on the care plan.</p> <p>Interview on 1/23/14 at 12:30 p.m. with resident 1's son and daughter revealed they:            *Thought the staff had always been using the EZ lift to transfer her.            *At no time had they ever insisted the staff use the EZ stand for transfers. They had always relied on the nursing staff to make the best clinical decisions, and they would abide by them.            *Knew nothing about the three episodes of poor tolerance of the EZ stand she had in September 2013.            ***Our goal was always for her to be comfortable."            *Were not aware her SOB/anxiety were caused by the use of the EZ stand on 12/25/13 until CNA</p>	F 323		

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F 323	<p>Continued From page 16</p> <p>A had informed them. The nursing staff had not informed them.</p> <p>*Stated a CNA told them the resident had turned purple when they had transferred her on 12/25/13 from the Broda chair to her recliner. CNA B "had to blow on her face to get her to breathe."</p> <p>*Felt the whole problem was communication with the CNAs not being informed how they should have transferred the resident.</p> <p>*Felt the use of the EZ stand on 12/25/13 was the cause of her increased SOB, anxiety, and large bruise that was on her left breast.</p> <p>Phone interview on 1/24/14 at 2:30 p.m. with CNA A regarding resident 1 revealed:</p> <p>*She had not been informed she should have transferred resident 1 only with the use of the EZ lift.</p> <p>*She only worked very part time on the weekends and did not usually work down the hall where that resident lived.</p> <p>**"She was holding her breath real bad so we put her back down."</p> <p>*It took "myself" and CNAs B and C to get her positioned in the chair. Her color had started to return to normal after that.</p> <p>*CNA C stayed with the resident until LPN D came in the room to assess her.</p> <p>*She thought the bruise on her left breast came as a result of the use of the EZ stand.</p> <p>*She had informed LPN D and E she had transferred her with the use of the EZ stand instead of the EZ lift right after the incident. She had informed the nurses prior to informing the family.</p>	F 323			

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F 323	<p>Continued From page 17</p> <p>Surveyor: 26180 2. Review of resident 2's medical record revealed there was faxed communication with her physician and revealed: *On 1/8/14 she had fallen on the floor. -The TAB monitor (device that alarms when a resident moves) had been removed by the resident. -There were no apparent injuries. -She had been incontinent. -She had been trying to get out of bed unassisted. *She had fallen on 1/10/14 out of her wheelchair while being pushed to her room. She had multiple injuries including bruising, bleeding, skin tears, and bumps on her forehead. *She was found on the floor next to her bed on 1/17/14 at 11:45 p.m. -The TAB monitor had been disconnected by the resident. -She had been incontinent at the time of the incident. -She had been trying to get out of bed unassisted.</p> <p>Review of resident 2's fall care plan revealed: *The last review date was 9/5/13. *On 8/2/07 they had identified a problem related to needing assistance with daily care due to incontinence, limits in mobility, and cognitive (memory) loss. *The goal was to have no injury from falling over the next ninety days. *The approaches included keep environment free of clutter along with: -Fall precautions in place. -Observe for changes in mobility, assist as needed.</p>	F 323		

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F 323	<p>Continued From page 18</p> <p>*They had not altered the care plan to:</p> <ul style="list-style-type: none"> <li>-Enhance the toileting plan to prevent incontinence.</li> <li>-Ensure the resident could not easily remove the TAB monitor.</li> <li>-Ensure the Tab monitor was being checked more frequently or that it was in place.</li> <li>-Show they had used the Fall report findings to reduce the incidents of the resident falling.</li> </ul> <p>Interview on 1/24/14 at 3:00 p.m. with the director of nursing (DON) regarding resident 2 revealed:</p> <ul style="list-style-type: none"> <li>*They had recently identified the resident had a urinary tract infection.</li> <li>*That was the reason for her increased agitation and the increased falls.</li> <li>*They had not used a concave mattress (mattress with raised edges) with her, because she had an air mattress on her bed.</li> <li>*They had not put any other fall prevention measures in place.</li> </ul> <p>Review of the provider's 5/23/06 Fall prevention and Investigation policy revealed:</p> <ul style="list-style-type: none"> <li>**[Name of facility] will make all attempts to prevent accidents within the facility.</li> <li>*When accidents do occur, a thorough investigation will be completed to aide in the prevention of future occurrences.</li> <li>*Upon admission, residents are assessed in several areas including: wander risk, pain risk, fall risk, and risk for skin breakdown.</li> <li>*Upon these assessments the care team will make decisions regarding specific safety recommendations for all residents and interventions will be care planned accordingly.</li> <li>*In the event that an accident should occur, the charge nurse, or designee, will be in charge of the investigation of the accident.</li> </ul>	F 323		

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F 323	Continued From page 19	F 323	<p><b>F490 - Effective Administration / Resident Well-Being</b></p> <p>Investigation follow-up to occur as outlined in F226.</p> <p>The Progressive Discipline process has been updated to further document the corrective action completed on staff and included in the employee handbook.</p> <p>Disciplinary action of CNA A was completed with mandatory review of EZ lift/stand transfer video to be completed within 1 month of disciplinary action dated January 28<sup>th</sup>, 2014.</p> <p>* CS/SADOK/JJ</p>  <p>*The administrator or designee will review the frequency of the coaching opportunities afforded to all employees at the weekly Department Head meetings and sign off on all performance improvement, decision making, leave and terminations. (continued on Page 21).....</p>	03/14/2014
F 490 SS=E	<p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, record review, and interview, and policy review, the provider failed to ensure: *Two of two sampled residents (1 and 2) had incidents resulting in distress and injury were investigated. *One of one sampled resident's (1) received appropriate social services in relation to unresolved family concerns and concerns about care. *One of one sampled resident's (2) who had a fall with an injury was reported to the physician in a timely manner. *Certified nursing assistant's (A and C) received disciplinary action when one of one resident care plans (1) were not followed resulting in physical distress. *One of one sampled resident's (2) with multiple falls had appropriate interventions to prevent falls. *Two of two sampled residents' medical records (1 and 2) had thorough and complete documentation. Findings include:</p>	F 490		

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F 490	Continued From page 20  1. Review of residents 1 and 2's medical records revealed the provider neglected to investigate incidents that had resulted in injury and distress to those residents. Refer to F226, findings 1 and 2.  2. Review of resident 1's medical record revealed medically related social services had not been provided in relation to unresolved family concerns. Refer to F250, finding 1.  3. Review of resident 2's falls with a head injury was reported to the physician in a timely manner. Refer to F281, finding 1.  4. The failure for administration to follow-up or discipline staff when resident 1's care plan had not been followed and had resulted in physical distress to the resident. Refer to F226, finding 1.  5. Documentation of two sampled residents (1 and 2) was incomplete for physician's orders, investigations, hospice notes, and social service interventions. Refer to F226, F250, F323, and F281.	F 490	This information will be reported by the Administrator or designee at the quarterly QA meeting to help ensure appropriate utilization of the new Progressive Disciplinary process.  CS/SDDOH/JJ	
F 493 SS=E	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN  The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the	F 493	<b>F 493 - Governing Body - Facility Policies/ Appoint Adm</b>  The Administrator or designee will oversee the implementation of up-to-date and effective Policy and Procedures to help ensure a safe, secure environment for the residents.	

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F 493	Continued From page 21 facility  This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, interview, and policy review, the governing body failed to ensure the facility was administered in a manner that ensured: *Two of two sampled residents' (1 and 2) incidents with injuries were investigated and reported to the South Dakota Department of Health (SD DOH) according to the regulations.. *Family concerns were resolved regarding resident care issues for one of two sampled residents (1). *The physician was informed in a timely manner of one of one sampled resident (2) who had a fall with a head injury. *Preventative fall measures were initiated and followed for one of one sampled resident (2) who had multiple falls. *The proper mechanical transfer equipment was used for one of one sampled resident (1) to prevent injury. *Adequate documentation was in the medical record for two of two sampled residents (1 and 2) who had significant changes in condition. Findings include:  1. Interviews, observations, record reviews, and policy reviews throughout the course of the survey from 1/22/14 through 1/23/14 revealed the administrator had not ensured the safe management and overall well-being of the residents. Refer to F226, F250, F323, F281, and F514.	F 493	The Administrator or designee will collaborate with all departments on use of the revised Progressive Discipline process for consistent accountability of employees and safety of residents.  The Administrator or designee will report to the Board of Trustees any significant resident safety concerns and attend the quarterly QA and Safety meetings to ensure resident safety issues are being identified and resolved.	03/14/2014

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F 514 F 514 SS=D	Continued From page 22 483.75(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: 22452 Based on record review and interview, the provider failed to ensure adequate documentation in the medical record for two of two sampled residents (1 and 2) who had significant changes in condition. Findings include:  1. Review of resident 1's 11/16/13 through 12/28/13 nurses' notes revealed: *11/16/13- "New bruise noted to left shin (lower leg) measuring 20 centimeters (cm) by 10 cm. No apparent pain." *12/10/13- "Noted 2 cm by 2 cm bruise to left knee. No pain." *12/28/13- "Two bruises on left breast. One area 3 cm by 3 cm and one area 7 cm by 4 cm."  Interview on 1/22/14 at 4:00 p.m. with the director of nursing regarding resident 1 revealed they	F 514 F 514	<b>F 514 - Res Records-Complete/ Accurate / Accessible</b>  An in-service occurred on Friday, February 14 <sup>th</sup> , 2014, educating all nursing staff on how to accurately and completely document pertinent resident information which includes family notification, physician notification, status change, resident/family conferences, etc.  Investigation follow-up to occur as outlined in F226* for Residents #1 and #2. CS/soobHJJ  Audits will be completed by the DON or designee to monitor pertinent resident documentation bi-weekly for at least 6 months. The DON or designee will report the results to the quarterly QA meeting.	03/14/2014	

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F 514	<p>Continued From page 23</p> <p>thought the bruises on her legs had happened as a result of using the stand-aide for transfers, but no one had documented that.</p> <p>2. Review of resident 1's 12/25/13, 9:50 p.m. nurse's notes revealed:</p> <ul style="list-style-type: none"> <li>*Medication nurse discovered resident with extreme SOB and facial grimacing.</li> <li>*Oxygen saturation 86 percent (%) (normal is greater than 90%). Oxygen was increased to 5 liters per mask.</li> <li>*Nitroglycerin (medication for chest pain) was given three times with relief of SOB but not completely relieved.</li> <li>*Family requested resident be kept at facility and comfort measures to have been given.</li> <li>*On-call physician was called and new orders received and noted.</li> <li>*First doses of morphine (narcotic pain medication) and Ativan (anti-anxiety medication) administered with greater relief of SOB and anxiety.</li> </ul> <p>Interview on 1/22/14 at 5:40 p.m. with the director of nursing (DON) regarding resident 1 revealed:</p> <ul style="list-style-type: none"> <li>*Two certified nursing assistants (CNA) A and C were transferring her on 12/25/13 at 10:00 p.m. from her recliner to the bed after they had gotten her ready for bed. They had not toileted her, so they should have not been using the EZ-stand (mechanical lift that required the resident to participate in the transfer by bearing weight on her legs).</li> <li>*CNAs A and C were counseled for not following the care plan by using the EZ lift to transfer her, but she had failed to document anything. The CNAs had said nothing to the nurses about using the incorrect lift to transfer the resident. The nurses had been informed by the resident's</li> </ul>	F 514			

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F 514	<p>Continued From page 24</p> <p>family. There was no documentation in the medical record that the EZ stand had been used for the transfer instead of the EZ lift.</p> <p>*The resident's family had met with the family on 12/26/13 but had failed to document that.</p> <p>*CNA A had told the resident's family the resident had been transferred using the EZ stand instead of the EZ lift. The use of the EZ stand caused her to become anxious and SOB.</p> <p>Interview on 1/23/14 at 10:00 a.m. with the resident care coordinator (RCC) regarding resident 1 revealed:</p> <p>*The family always wanted them to use the EZ stand for transfers to keep her as weight bearing as much as possible. There was no documentation regarding that since 2012. The resident's physical and mental condition had changed significantly since then.</p> <p>*The DON had said in September 2013 that the EZ stand could no longer be used. The resident had three separate episodes of becoming SOB and had not tolerated being transferred with the EZ stand. The EZ lift should have been used for all transfers. The three incidents of poor tolerance of transfers with the EZ stand had not been documented nor had the change from the EZ stand to the EZ lift done by the DON.</p> <p>*She had met with the family on 12/26/13. She knew they had just wanted to vent and had asked to speak with her. The family was very mad the EZ stand had been used for the 12/25/13 transfer. She had documented none of the conversation.</p> <p>Surveyor: 26180</p> <p>3. Review of resident 2's 1/10/14 nurses notes revealed she:</p> <p>*Had received Ativan (an antianxiety medication) for agitation at 7:00 p.m.</p>	F 514		

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F 514	<p>Continued From page 25</p> <ul style="list-style-type: none"> <li>*There was no documentation if they had ruled out pain as the reason for the agitation before giving the Ativan.</li> <li>*Had fallen forward out of her wheelchair onto the floor at 2330 (11:30 p.m.) as she was being pushed in her wheelchair by a certified nursing assistant (CNA).</li> <li>-The CNA had not been identified.</li> <li>*Had hit her head when she fell.</li> <li>*Received a 9 x 7 centimeter (cm) bruise/bump to her forehead.</li> <li>*Had a skin tear 2 cm x 1 cm on the bump on her forehead oozing a small amount of blood drainage.</li> <li>*Had a small amount of blood coming from her nostrils (nose).</li> <li>*Also had bruising to her knees, elbow and fingers.</li> <li>*Hospice had been notified of the fall.</li> <li>*There were no Hospice nurses notes since the fall.</li> </ul> <p>Interview on 1/22/14 at 4:00 p.m. with the director of nursing revealed:</p> <ul style="list-style-type: none"> <li>*The bruising on resident 2's face was a result of the fall on 1/10/14.</li> <li>*A request for the investigation report was made at that time.</li> </ul> <p>Review of resident 2's physician orders revealed there was not a current order for Hospice.</p> <p>Review of resident 2's 1/10/14 Falls-Resident Incident Report/Unusual report and interview on 1/34/14 at 10:30 a.m. with the resident care coordinator (RCC) revealed:</p> <ul style="list-style-type: none"> <li>*That was the investigative report they had completed after her above fall.</li> <li>*The report did not assessed why the resident</li> </ul>	F 514			

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F 514	Continued From page 26 was still sitting in her wheelchair at 11:30 p.m. or how long she had been sleeping. *It had not identified who the staff person that was involved. -There was no indication the CNA had been asked any questions about the incident. *When it asked if pain medication had been ordered it was left unanswered. *The RCC agreed there were unanswered questions in the report, and the fall had not been thoroughly investigated.	F 514			