

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

ORIGINAL

PRINTED: 03/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/20/2014
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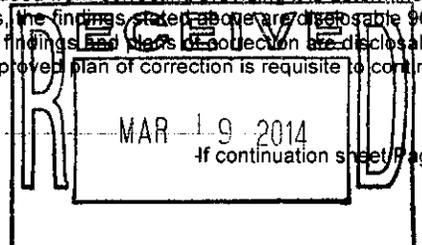
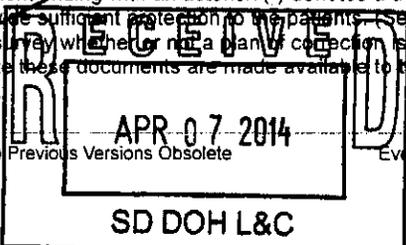
NAME OF PROVIDER OR SUPPLIER THE NEIGHBORHOODS AT BROOKVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 2421 YORKSHIRE DR BROOKINGS, SD 57006
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F 000	INITIAL COMMENTS Surveyor: 30170 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/18/14 through 2/20/14. Areas surveyed included resident neglect and quality of life. The Neighborhoods at Brookview were found not in compliance with the following requirement: F224.483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN 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: 30170 Based on interview, record review, and policy review, the provider failed to ensure an appropriate and safe mechanical lift transfer had occurred for one of one sampled resident (4) during morning personal care. Findings include: 1. Interview on 2/18/14 at 2:30 p.m. with resident 4 revealed she: *Was very hard of hearing and was deaf in the right ear. *Was alert and orientated to person and place, and was not sure of the exact time of day. *Had just returned on 2/17/14 from a hospital stay.	F 000		
F 224 SS=D		F-224	<ol style="list-style-type: none"> All staff were re-educated on the abuse and neglect policy. Resident 4 was removed from the unsafe situation immediately. Employee involved was terminated prior to the survey as per policy. All residents requiring mechanical lift transfers are at risk. All staff will be re-educated on the new procedure "Safe Lifting and Movement of Residents" during an in-service on March 18. All staff will also be educated by a Volaro lift representative annually on the mechanical lifts. The Nursing Director or her designee will audit 3 mechanical lift transfers weekly x 4 and monthly x 3 to ensure compliance and safety. Results of audits will be provided by Nursing Director to the QAA monthly committee with follow as recommended by the committee. 	4-11-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 3-18-14
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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 state procedures are disclosed 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 224	<p>Continued From page 1</p> <p>*Had fallen out of her personal mechanical lift recliner and had fractured her nose and received a large gash on her forehead on 2/12/14.</p> <p>*Required total assistance from the nursing staff using a mechanical stand aide for all transfers from her bed, her chair, and for toileting.</p> <p>*Remembered having been left in the mechanical stand aide unattended. She stated she was "scared."</p> <p>2. Observation and interview on 2/19/14 at 7:47 a.m. with resident 4 and certified nursing assistant (CNA) A revealed:</p> <p>*The resident was dressed and had been sitting on the toilet in her bathroom.</p> <p>*CNA A was finishing the resident's morning care.</p> <p>*CNA A had called for assistance with the transfer with the mechanical lift for the resident. She waited until 8:05 a.m. until CNA B entered the room which was after CNA A had called several times for assistance.</p> <p>*CNA A and B confirmed residents who needed to have been transferred with a mechanical lift should never have been left unattended.</p> <p>*CNA A had stayed with the resident during the time she had waited for CNA B to assist with the transfer of the resident from the toilet to her wheelchair.</p> <p>Review of resident 4's 12/19/13 Minimum Data Set (MDS) revealed:</p> <p>*She was alert and orientated.</p> <p>*Her lower legs were weak.</p> <p>*She had used a stand aide mechanical lift with two person assistance for all transfers.</p> <p>Review of resident 4's 9/11/13 plan of care revealed she was a two- person assist with all transfers using a stand aide mechanical lift.</p>	F 224		

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F 224	<p>Continued From page 2</p> <p>Review of the 2/10/14 reportable events form for resident 4 revealed: *The resident had been left unattended in the Volaro stand mechanical lift by CNA D. *There was a report of yelling from resident 4's room. *When household coordinator F entered the room she had found the resident approximately three feet from her bed suspended from the mechanical stand aide lift. *The resident was connected to the stand aide and her buttocks were down by her ankles. *The resident had stated she was "scared." *CNA D had called for assistance that morning. Another staff member asked CNA D for her assistance in another room. She left resident 4 in her room alone attached to the mechanical stand aide lift sitting on the bed.</p> <p>Review of CNA D's employee file revealed: *She was hired on 1/9/13 as a CNA. *There was no documentation regarding the appropriate training for the mechanical lifts used for residents. *There was no indication competencies were performed to ensure mechanical lifts were used appropriately and safely by the staff. *She was terminated after the investigation for gross misconduct of leaving a resident unattended in a mechanical stand aide lift.</p> <p>Interview on 2/19/14 at 4:00 p.m. with registered nurse I who was the staff education coordinator regarding mechanical lift transfers revealed: *The newly hired CNAs were given a video to watch from the manufacturer of the mechanical lifts. *There was never any hands on demonstration</p>	F 224		

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F 224	<p>Continued From page 3</p> <p>from the CNAs to have shown they were competent in operating the mechanical lifts safely.</p> <p>*She agreed there should have been further education provided to staff for the appropriate operation of mechanical lifts.</p> <p>Interview on 2/20/14 at 9:45 a.m. with resident 4's daughter regarding the incident on 2/7/14 at approximately 8:05 a.m. revealed:</p> <p>*She had come to the facility at approximately 8:00 a.m. to visit her mother.</p> <p>*Her mother's door was shut, and she heard yelling from the room.</p> <p>*She entered the room and had saw her mother suspended from the mechanical stand aide lift about three feet from her bed with her buttocks down by her ankles.</p> <p>*She went to put the call light on, because there were no staff in the room.</p> <p>*She then stepped out in the hallway and yelled for assistance.</p> <p>*CNA D and household coordinator F had come running into the room.</p> <p>*Both CNA D and household coordinator F yelled "Oh, my God."</p> <p>*They both assisted resident 4 back to her bed.</p> <p>*She had spoken to both the administrator and the director of nursing (DON) about the incident.</p> <p>Interview on 2/20/14 at 1:55 p.m. with the DON regarding the above incident revealed:</p> <p>*On 2/7/14 at approximately 8:05 a.m. the resident's daughter found her mother hanging from the mechanical stand aide.</p> <p>*She estimated the resident was left unattended for approximately five up to ten minutes.</p> <p>*The resident was hooked to the mechanical stand aide lift by the sling and left sitting on the</p>	F 224		

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F 224	<p>Continued From page 4</p> <p>edge of her bed.</p> <p>*The household coordinator F and another staff member had transferred the resident back to the bed safely.</p> <p>*There was no documentation in CNA D's employee file that she had the appropriate training to perform the mechanical stand aide lift safely.</p> <p>Review of the undated Volaro Stands Series 4 manufacturer's operational manual revealed it was recommended to have two persons in attendance when performing transfers from bed to the chair.</p> <p>Review of the provider's February 2013 Abuse and Neglect policy revealed: **Each resident shall be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion. Mistreatment, neglect of abuse of residents and misappropriation of resident property is prohibited by any individuals. *Neglect: Failure to provide goods, materials, an services necessary to avoid physical harm, mental anguish, or mental illness. Examples include: failure to provide food, pain medications, social interaction, repositioning, and failure to assist with personal cares."</p> <p>Upon request there was no policy provided for the proper and safe use of mechanical lifts.</p>	F 224			