

South Dakota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>10601</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>10/29/2014</b> |
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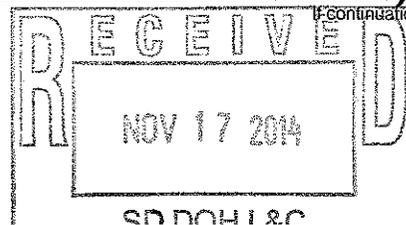
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>UNITED RETIREMENT CENTER</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>405 1ST AVE<br/>BROOKINGS, SD 57006</b> |
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| S 000 | Initial Comments<br><br>Surveyor: 32355<br>A complaint health survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 10/27/14 through 10/29/14. United Retirement Center was found not in compliance with the following requirements: S166.  | S 000 |   |            |
| S 166 | 44:04:02:17(1-10) OCCUPANT PROTECTION<br><br>The facility must take at least the following precautions:<br>(1) Develop and implement a written and scheduled preventive maintenance program;<br>(2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents;<br>(3) Provide a call system for each...resident bed and in all toilet rooms and bathing facilities routinely used by...residents. The call system must be capable of being easily activated by the...resident and must register at a station serving the unit;<br>(4) Provide handrails firmly attached to the walls on both sides of all resident corridors in nursing facilities;<br>(5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks;<br>(6) Install an electrically activated audible alarm on all unattended exit doors in nursing facilities. Other exterior doors must be locked or alarmed. The alarm must be audible at a designated nurses' station and may not automatically silence when the door is closed; | S 166 | On November 4, 2014 United Technologies • 737 W. 10th Street, Sioux Falls, SD 57104 programed door #1 (main entrance) to remain locked at all times. The door requires a public pass code for all people exiting the building at all times. The door continues to be locked during the hours of 11 PM and 6 AM however there is an additional safety feature the only code that will open the door is the STAFF ONLY Code. Any person who leaves the building between the hours of 11 PM and 6 AM MUST BE ESCORTED BY A STAFF MEMBER. The front door now requires a code every time someone exits. It does have a sensor outside, so guests are able to come in without the code, but they MUST enter a code to exit. Wander guards will set off the alarm any time someone is in close proximity, and/or the door is open, the audible alarm will continue | 11/04/2014 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

STATE FORM 6899 V9DJ11 11/17/2014



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| S 166 | <p>Continued From page 1</p> <p>(7) Portable space heaters and portable halogen lamps may not be used in a facility;<br/>             (8) Household-type electric blankets or heating pads may not be used in a facility;<br/>             (9) Any light fixture located over a...resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof lamp; and<br/>             (10) Any clothes dryer must have a galvanized metal vent pipe for exhaust.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by:<br/>             Surveyor: 32355<br/>             Based observation, interview, and policy review, the provider failed to ensure 1 of 11 door alarms (main entrance) was activated when unattended. Findings include:</p> <p>1. Random observations from 10/27/14 through 10/29/14 of the main entrance door revealed while the surveyors:<br/>             *Exited on 10/27/14 at 6:15 p.m. the door was unlocked, unattended, and unalarmed.<br/>             *Entered on 10/28/14 at 7:30 a.m. the door was unlocked, unattended, and unalarmed.</p> <p>Interview on 10/28/14 at 8:15 a.m. with the administrator regarding the above observation revealed the main entrance door:<br/>             *Had been set on a timer to automatically lock and unlock.<br/>             *Should have been locked from 5:30 p.m. until 6:00 a.m.<br/>             *Should have been monitored by the receptionist</p> | S 166 | <p>and/or the door will remain locked until the person has exited the area. The only way to override this is to enter the new STAFF CODE. A staff person must escort and/or reset the alarm when safety has been established.</p> <p>The Director of Environmental Services or maintenance designee will continue to check all door alarms for audible alarm, transferring to the call pagers and locking mechanisms for proper operation. The Director of Environmental Services is responsible for preventive maintenance pursuant to policy on a weekly basis for four (4) weeks then quarterly through the QAPI process. QAPI results will be reported to the Administrator weekly for four (4) weeks, then quarterly for one year</p> |  |
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| S 166              | <p>Continued From page 2</p> <p>or staff when unlocked.<br/>*The receptionist worked Monday through Friday 8:30 a.m. to 5:00 p.m.<br/>*Would have automatically locked when any resident wearing a Wanderguard (signaling device worn by cognitively impaired (confused) residents who wandered or were exit seeking) approached the door.<br/>*When unlocked allowed for easy exiting by residents who did not wear a Wanderguard device.</p> <p>Interview on 10/28/14 at 9:00 a.m. with administrative assistant A regarding the main entrance door revealed:<br/>*She had worked Monday through Friday from 8:30 a.m. to 5:00 p.m.<br/>*The door would have automatically locked at 10:00 p.m. and unlocked at 6:00 a.m.<br/>*She would not have always been at her desk. She was expected to deliver mail, take a break, and do any other personal requests from staff.<br/>*No staff had been designated to replace her when she was gone or during the weekend.<br/>*The charge nurses were to have been monitoring the door when she was not working.<br/>*The alert residents were to have signed a sheet upon leaving the building. She could not guarantee that all the residents had done that. That had been the only monitoring process the provider had in place to monitor residents without Wanderguards.</p> <p>Interview on 10/28/14 at 10:00 a.m. with registered nurse C confirmed the above interview with the administrative assistant.</p> <p>Interview on 10/28/14 at 11:15 a.m. with resident 2 revealed she:<br/>*Was alert and oriented to person, place, and</p> | S 166         |   |                    |

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| S 166              | <p>Continued From page 3</p> <p>time.</p> <p>*Used an electric wheelchair for mobility and was able to go outside as desired.</p> <p>*Was expected to sign a sheet or inform a staff member when going outside. She had never signed a sheet stating "I don't, I don't go far anyway."</p> <p>Observation on 10/28/14 at 5:45 p.m. and on 10/29/14 at 8:00 a.m. of the main entrance door revealed the door was unlocked, unalarmed, and unattended.</p> <p>Review of the provider's July 2012 Alarms and Outside Doors policy revealed:</p> <p>*Purpose "To ensure the safety of the [facility name] residents.</p> <p>*No procedure in place on how to monitor:</p> <ul style="list-style-type: none"> <li>-The main entrance door when unlocked or unalarmed.</li> <li>-The safety of the residents who did not require the use of a Wanderguard system.</li> </ul> | S 166         |   |                    |

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| F 000         | <p><i>Addendums noted with an asterisk per 11/27/14 telephone to facility DON. JK/SDOH/IME</i></p> <p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 22452<br/>An extended/complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 10/27/14 through 10/29/14. Areas surveyed included resident care issues and an unexpected resident death. United Retirement Center was found not in compliance with the following requirements: F309, F354, F356, and F490.</p>   | F 000 | <p>1. Orientation is completed for nurses K, L, and N). Nurse D is no longer with the facility. Nurse M's orientation was completed on Oct. 31, 2014 October 28th and 29th, 2014: training was held with RN-Director of Nursing, with 13 out of the 18 licensed nurses on staff. At this time we educated on the proper procedure of suctioning. The remaining (5) licensed nurses were instructed in the proper use of the suctioning machine and skill validation demonstration before they are allowed to work the floor as the charge nurse. All training was completed by October 31, 2014, Director of Nursing will be responsible for ensuring the complete skills orientation check list form is complete and accurate before the licensed nurse is placed on the floor as charge nurse. Human Resources with the Director of Nursing will monitor findings of accuracy and completeness for quality assurance; will report to the Administrator monthly for the next three months and quarterly reports for the next year to be filed with QAPI committee.</p> <p>2. October 28th and 29th, 2014: training was held with RN-Director of Nursing, with all licensed nurses (except one) on staff. The remaining license nurse to be trained will not be allowed to work until training is completed. At this time we have</p> |                   |
| F 309<br>SS=J | <p><b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b></p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Surveyor: 32355<br/>Based on record review, interview, policy review, and job description review, the provider failed to ensure:<br/>*Five of five sampled nurses (D, K, L, M, and N) had initial orientation provided and documented that included emergency services.<br/>*One of one sampled resident (1) who had an acute change in condition was transported to the emergency room (ER) as directed by the physician.<br/>*Ten of eighteen licensed nurses (C, D, J, K, L, M, N, O, P, and Q) were currently trained in</p> | F 309 |   | <i>11/27/2014</i> |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br><i>Sallyanna</i> | TITLE<br><i>Administrator</i> | (X6) DATE<br><i>11/14/2014</i> |
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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 309   | Continued From page 1<br>cardiopulmonary resuscitation (CPR).<br><br>NOTICE:<br>Notice of immediate jeopardy was given verbally to the administrator and the director of nursing (DON) on 10/28/14 at 4:35 p.m. They were asked for a plan of correction to be given to the surveyors on 10/29/14 at 9:00 a.m. They were asked that the plan of correction include:<br>*The completion of the initial orientation including emergency services for the above five nurses prior to their next shift assignment.<br>*The action plan to ensure the newly hired staff completed their initial orientation prior to actively working in the facility.<br>*The training and updating of all nursing staff on the procedure of cardiopulmonary resuscitation (CPR) (a life-saving technique used to help restore a stopped heartbeat or breathing).<br>*The action plan to ensure all the nursing staff had CPR certifications that were current.<br><br>PLAN:<br>A plan of correction for the initial orientation of newly hired staff that included emergency services, suctioning, and training for all the nursing staff on CPR was accepted on 10/29/14 at 1:30 p.m. The plan of correction included the training for both hardline and portable phone use. It also included a system set in place to ensure all staff had pagers, a check-in/out process, and a maintenance program to ensure proper functioning of that system. A policy and procedure was created for Emergency Ambulance Transfers. The plan implemented to achieve the above compliance was as follows:<br>*The certification of CPR for all licensed nurses would be completed by 10/31/14. All other nursing staff would be certified in CPR no later | F 309   | educated licensed nurses on the proper procedure of Admission/Discharge/Transfer/Death, with emphasis on: Emergency Ambulance Transfer and Emergency Ambulance Transfer Policy and Procedure. This training was completed by November 10, 2014 for all nurses. Director of Nursing will be responsible for reviewing all emergency transfers for accuracy and that proper procedures were followed. The written report of review will be presented to the Administrator monthly for one year. Quarterly reports will be included in the QAPI quarterly meeting for one year.<br><br>3. The facility has assured that Staff C, J, K, L, M, N, O, P, Q are now certified in CPR by the American Heart Association. Staff member D is no longer with the facility.<br><br>October 31, Nov. 1, 2, 3, 4, 10, 12, 17 2014: there were CPR classes held. The trainers were certified in the American Heart Association BLS Instructor Essentials. The 5 licensed nurses that needed certification were trained on Oct 31, 2014 to ensure the nurses scheduled were certified before working the floor. The Human Resource Department has included the names and dates for recertification of all nursing |                      |   |

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| F 309   | <p>Continued From page 2</p> <p>than November 10, 2014. Human resource director I would be responsible to ensure all CPR certifications were kept current and newly hired staff would be trained prior to actively working for the provider.</p> <p>*On October 28 and 29, 2014, the DON held a training for thirteen of the eighteen licenses nurses. That training and education was on the procedures for:</p> <ul style="list-style-type: none"> <li>-Suctioning.</li> <li>-Admissions, discharges, transfers, and death.</li> <li>-The new policy and procedure for Emergency Ambulance Transfer.</li> <li>-Those trainings would all be completed by 11/10/14.</li> </ul> <p>*The DON would be responsible to ensure all licensed nurses had completed the orientation process and check-list prior to actively working for the provider.</p> <p>*A count on all the pagers would be done by 10/29/14. The provider would ensure all staff had access to a pager with two extra purchased by 10/31/14. A policy and procedure for the use and maintenance of those pagers would be implemented no later than 11/10/14. The DON and human resource director would be responsible for the training on this policy for any newly hired staff.</p> <p>*The vendor for the hardline and cordless phones would be contacted on 10/29/14 to set a date for training on the use of those phones. A policy and procedure for the use and maintenance of those phones would be implemented by 11/10/14. The DON and human resource director would be responsible for the proper use of the phones. The director of maintenance would be responsible for compliance and quality assurance.</p> <p>Additional findings include:<br/>Surveyor: 22452</p> | F 309   | <p>staff on the Smart Links personnel records software program, for automatic notification. Human Resource Director will be responsible for monthly checks for quality assurance; the report will be given to the Administrator weekly for 3 months, monthly for 3 months and quarterly reports for one year. Job descriptions for the charge nurse, operations nurse, MDS nurse and CNAs were updated to require current certification in CPR. Licensed Nurse Skill orientations Check List were updated to reflect a higher standard of accountability and clear expectations.</p> |                      |   |

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| F 309   | Continued From page 3<br>1a. Review of licensed practical nurse (LPN) D's personnel file revealed:<br>*A 8/19/14 hired date.<br>*Review of her registered nurse (RN)/LPN skill orientation checklist revealed portions had been documented as completed on 9/9/14 and 10/15/14.<br>*There was no documentation admission/discharge/transfer/death orientation had been completed that included:<br>-Transfer forms if transported to the ER.<br>-Transportation using ambulance or private vehicle.<br>-Needing orders from the physician prior to transferring to the emergency room.<br><br>b. Review of RN J's personnel record revealed:<br>*A 8/14/14 hired date.<br>*Review of her RN/LPN skill orientation checklist revealed portions had documentation "self" and no date.<br>*There was no documentation admission/discharge/transfer/death orientation had been completed.<br><br>c. Review of RN K's personnel file revealed:<br>*A 7/7/14 hired date.<br>*There was not an orientation checklist in her file that any orientation training had been completed.<br><br>d. Review of RN L's personnel file revealed:<br>*A 7/8/14 hired date.<br>*There was not an orientation checklist in her file that any orientation training had been completed.<br><br>e. Review of RN M's personnel file revealed:<br>*A 6/10/14 hired date.<br>*There was not an orientation checklist in her file that any orientation training had been completed. | F 309   | 3. There was a count of pagers in house completed by October 29, 2014 by 5pm. There was an order for the number of pagers needed with two additional back up pagers ordered through United Technologies, United Living Community supplier, on October 30, 2014 and were in house by October 31, 2014. A policy and procedure of checking in and out the pagers was developed, Phones, Pagers and Gait Belt sign-in-out Procedure. Training on the new policy for present staff will be completed by November 27, 2014, or prior to the employees next scheduled shift and implemented to ensure each CNA on duty has a pager. Human Resources and Director of Nursing will include training the new staff on the proper use of the pagers, transfer of pagers to the replacement staff at the initial orientation and nursing skills training. Charge nurses will ensure each C.N.A. has a working pager. Maintenance Director will place on their weekly preventative maintenance checklist to ensure proper functioning. Director of Maintenance for quality assurance; will report to the Administrator weekly for 3 months, monthly for 3 months and quarterly reports for one year that an accurate completed signed check list has been completed and quarterly reports for one year and be included in the quarterly QAPI committee. |                      |   |

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| F 309   | <p>Continued From page 4</p> <p>f. Interview on 10/28/14 at 10:30 a.m. with the administrator regarding the above revealed:<br/>*It was the responsibility of the director of nursing (DON) to start the orientation checklist.<br/>*The checklist was dated and initialed by the nurse on the floor who went over each orientation area with the new employee.<br/>*It was the responsibility of the new employee to make sure the completed orientation checklists were returned to the DON or human resources.<br/>*She confirmed LPN D and RN J had no orientation training documented regarding emergency services and they should have had that prior to working on the nursing floor.<br/>*She confirmed RNs K, L, and M had no documentation of orientation training, and they should have had that prior to working on the nursing floor.</p> <p>Interview on 10/28/14 at 10:45 a.m. with the DON regarding the above staff revealed she:<br/>*Had only been the DON since August 2014.<br/>*Was unaware the above licensed nurses orientation training was incomplete or not done at all.<br/>*Confirmed orientation training should have been completed prior to the nurses having been scheduled on their own on the nursing floors.<br/>*Stated they were in the process of redoing their orientation program and had just hired two nurses in a new position.</p> <p>2. Review of resident 1's medical record revealed:<br/>*A 7/7/08 admission date.<br/>*Diagnoses included:<br/>-Anoxic (no oxygen) brain injury on 6/11/06.<br/>-Spastic quadriplegia (paralysis arms and legs).</p> | F 309   | <p>4. There was training of hard-line and portable phone use for staff on November 6, 2014. The vendor, Swiftel Communication, provided training. Those select staff will be responsible to train their respective staff, no later than November 22, 2014 or before their next scheduled shift. Documentation of training shall be provided to the Administrator and then reported at the QAPI quarterly meeting. Swiftel was here October 15, 2014 and completed a maintenance check on all 6 cordless phones. All cordless phones by 5 pm on October 15, 2015 were in working condition. Prior to November 22, 2014 a policy and procedure of checking in and checking out the cordless phones will be written and implemented to ensure the charge nurse for each shift has a cordless phone. Human Resources and the Director of Nursing will include training the staff on the proper use of the phones, transfer of phones.</p> <p>1a. Staff member D is no longer employed by the facility.</p> <p>1b. Staff member J completed orientation on October 28, 2014, regarding the admission/discharge/transfer/death orientation. The remainder of the checklist will be completed by November 17, 2014 by the Director of Nursing.</p> <p>1c. Staff member K completed orientation on October 28, 2014, regarding the admission/discharge/transfer/death orientation. The remainder of the checklist will be completed by November 17, 2014 by the Director of Nursing.</p> |   |

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| F 309   | <p>Continued From page 5<br/>-Depression.</p> <p>Review of resident 1's 9/5/13 care plan revealed:<br/>**"I have seizures."<br/>**"I have impaired memory related to my brain injury."<br/>**"My wheelchair is my independence. I have a new power chair."<br/>**"I require two assistance with bed mobility."<br/>**"I will require two staff with transfers and gait belt for transferring, unless I am being toileted or bathing I require two assist with the PAL lift (mechanical lift)."<br/>**"I sometimes just yell for assistance instead of using my call light if I drop items."<br/>**"I have been taught that I should let my frustration out by hitting things such as my pillow or mattress instead of yelling. I am going to get frustrated as it is part of my brain injury."</p> <p>Review of resident 1's CPR policy and declaration signed by his physician on 5/13/14 revealed:<br/>**"I do want to have CPR administered."<br/>**"I understand the difference in policy between a witnessed event and an unwitnessed event."</p> <p>Review of resident 1's 10/18/14 progress notes by LPN D revealed:<br/>*8:10 a.m.- "Resident had emesis (vomiting) this morning at breakfast. Was given as needed (PRN) Zofran (medication for vomiting) around 7:30 a.m. Resident wanted to go back to his room and be layed down. Waited about a half hour before he was helped to bed. Resident had put on his call light many times this morning. Resident has also been calling out for many different things. A few times for TV adjustment and a drink of water. Temperature was taken and was elevated at 104.6 (normal 98.6). Called ER</p> | F 309   | <p>1d. Staff member L completed orientation on October 29, 2014, regarding the admission/discharge/transfer/death orientation. The remainder of the checklist will be completed by November 17, 2014 by the Director of Nursing.</p> <p>1e. Staff member M completed orientation on October 31, 2014, regarding the admission/discharge/transfer/death orientation. The remainder of the checklist will be completed before the start of M's next shift.</p> <p>1f. The Skill Orientation Checklist for RN/LPN was revised by Friday, November 7, 2014. All RNs and LPNs, will complete the skills orientation check list for all except staff member M by November 17, 2014. Staff member M will complete the checklist prior to M's next scheduled shift. No staff member will mark "self" on the checklist. No staff member will be allowed to complete their own checklist.</p> |                      |   |

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| F 309   | Continued From page 6<br>and received telephone order to be transferred to the ER."<br>*9:30 a.m.- "After receiving order to be transferred to the hospital, went in to check on the resident. Resident was in his room in bed at that time 8:50 a.m. Resident had foam around his mouth and was not breathing. Checked heart rate, no heart rate noted. Checked heart rate again with stethoscope [external device used to listen to the heart or lungs] and again no heart rate noted. Resident was cold to the touch. Called another nurse down to resident's room to confirm. Time of death is 8:50 a.m. Resident was dead upon nurse entering room. CPR not initiated due to no heart rate."<br>*9:35 a.m.- "From the time nurse received order to transfer to the ER to the time of death nurse had gotten called away to another neighborhood and was taking care of another resident that needed a catheter [tube in the bladder to drain urine] change. Nurse was also looking for some guidance from LPN E as to how to transfer resident from facility to ER. Was not sure if ambulance needed to be called or if beta bus [non-emergency bus used by hospital] could be used. Did not get a chance to talk with LPN E as she was busy. When nurse returned to sunshine neighborhood certified nursing assistant (CNA) F had told nurse the resident was sleeping. Went in to check on resident as he had been calling out for different things during the morning and was not sure he would be sleeping. Went into resident's room and found not breathing. Necessary steps then taken per facility policy."<br><br>Review of resident 1's 10/18/14 progress notes by LPN E revealed:<br>*11:22 a.m.- "Upon arrival to resident room at about 8:55 a.m., resident was cold to touch and | F 309   | 3d. Staff received training on the indications about when not to do CPR as stated the CMS Survey and Certification Letter (14-01-NH) dated October 13, 2013. The policy was changed to delete any reference about whether the patient's condition was witnessed in order to clarify when CPR should be initiated. The following statement from the old policy was deleted in the updated policy: "In the event the resident is found without a pulse and is not breathing, CPR will not be initiated, 911 will not be called and hospital field emergency care providers will not arrive to provide continued medical care."<br><br>The Welcome to United Living Community brochure will be updated to reflect the new directives regarding CPR as described above.<br><br><i>*Resident 1 had passed away by the time of this survey.<br/>JK/SDDH/MF</i> |                      |   |

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| F 309   | <p>Continued From page 7</p> <p>no heart rate or respirations. ER called for time of death at 8:50 a.m. Sister called right after and informed of resident death. While she was upset, she did ask details of his death and events of the morning were explained to her as outlined in charting. Administration called. DON called. Doctor faxed. Pastor was called and notified of death. Family to arrive for viewing and will give funeral home direction at that time."</p> <p>*11:28 a.m.-"Resident mother called to inquire about hotel rooms and condolences were given. She went on and asked about events surrounding resident's death. These were explained to her as outlined in charting."</p> <p>*2:58 p.m.- "Sister arrived and was greeted at the door. After seeing her brother, she had questions about funeral home and cleaning room. She also wondered about CPR being performed and was surprised to know that resident was full code (CPR should be started if no heart beat) as documented in the paper chart. Witnessed event and unwitnessed event was explained to her. She had no further questions at this time. She went on to say that she does not want information shared with resident's ex-wife."</p> <p>Review of resident 1's 10/18/14 physician's verbal telephone orders revealed:<br/>*8:10 a.m.- "Okay to transfer to ER for temperature 104.6" written by LPN D.<br/>*9:00 a.m.- "Time of death 8:50 a.m. Okay to release body to funeral home" written by LPN E.</p> <p>Review of resident 1's 10/18/14 medication and PRN record revealed documentation he received the following medications:<br/>*At breakfast (no time documented)-<br/>-Aspirin.<br/>-Citalopram (antidepressant medication).</p> | F 309   |   |                      |   |

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| F 309   | <p>Continued From page 8</p> <ul style="list-style-type: none"> <li>-Divalproex (seizure medication).</li> <li>-Docusate sodium (stool softner).</li> <li>-Furosemide (medication for edema [retaining fluid]).</li> <li>-Loratadine (medication for rash).</li> <li>-Miralax (stool softner).</li> <li>-Tamsulosin (prostate medication).</li> <li>-Zanaflex (medication for muscle spasms).</li> <li>-Vitamin C.</li> </ul> <p>*Acetaminophen at 8:10 a.m. for temperature of 104.6.</p> <p>*Zofran at 8:10 a.m. for nausea (upset stomach).</p> <p>Review of the 10/18/14 event report (monitoring of when a resident's call light was activated and the time elapsed before it was answered) provided by the administrator revealed the following for resident 1:</p> <ul style="list-style-type: none"> <li>*12:45 a.m. was activated and time elapsed before staff response was 8 minutes and 47 seconds.</li> <li>*3:10 a.m. was activated and time elapsed before staff response was 3 minutes and 26 seconds.</li> <li>*4:49 a.m. was activated and time elapsed before staff response was 1 minute.</li> <li>*6:14 a.m. was activated and time elapsed before staff response was 14 minutes and 54 seconds.</li> <li>*7:22 a.m. was activated and time elapsed before staff response was 11 minutes and 22 seconds.</li> <li>*7:47 a.m. was activated and time elapsed before staff response was 1 minute.</li> <li>*7:55 a.m. was activated and time elapsed before staff response was 1 minute.</li> <li>*8:02 a.m. was activated and time elapsed before staff response was 2 minutes and 27 seconds.</li> <li>*8:45 a.m. was activated and time elapsed before staff response was 7 minutes and 48 seconds.</li> <li>*8:53 a.m. was activated and time elapsed before staff response was 18 minutes and 3 seconds.</li> </ul> | F 309   |   |                      |   |

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| F 309   | <p>Continued From page 9<br/>(There was handwriting by the elapsed time "Bumped.")</p> <p>Review of the typed interview notes for the morning of 10/18/14 provided by the DON revealed:<br/>*CNA F who worked 6:00 a.m. to 9:00 a.m.: "Resident 1 was acting like resident 1. He does not like working with new people. I do not think he was acting unusual. He was dressed and put in his chair. At breakfast he ate a little bit. His arms and legs were flailing (moving rapidly), which caused him to spill his glass. His legs kept coming off the foot rests. He kept asking to have his feet put back on the foot pedals. He had an emesis in the dining room, went to his room, and threw up again. He has his shirt changed by CNA B and CNA F who then left the room. He kept calling CNA B back and wanted to drink water. He asked to lie down and LPN D and unlicensed assistive personnel (UAP) G laid him down. CNA B and F went into the dining room. LPN D stated he wanted up again and to get another temperature since his temperature was high. A cold cloth was placed on his forehead. CNA F assisted another resident in getting dressed and toileted, and when finished, she saw his call light was on. CNA F went into his room, turned his call light off at that time. She asked him a question if he was okay with no response. CNA F said the head of the bed was flat, and she did not see any vomit around his mouth. He was a natural color and had color in his face. CNA F then left the floor. CNA F told CNA B and UAP G, who later told LPN D that he was sleeping."<br/>*CNA B who worked 6:00 a.m. to 2:30 p.m.: "At 6:30 a.m. his call light was on. He was angry and frustrated due to new staff getting him ready for the day. He was coughing and gagging and he</p> | F 309   |   |                      |   |

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| F 309   | Continued From page 10<br>threw up. The dietary aide said he was feeding himself an egg sandwich and told CNA B he was not acting right. His arms were jerking and flailing more than usual and he knocked over his cup at breakfast. LPN D was around and saw that he was throwing up. He was taken to his room, they changed his shirt and cleaned his face. He was not hot at this time. He said he wanted to stay in his wheelchair in his room. He called out for me many times for small things, to move his phone charger and to move his call light. He continued yelling out but not asking for help. He said he was fine and was no longer nauseated. He put on his call light again asking to go back to bed. LPN D and UAP G put him in bed. They took his temperature, and he was really hot. LPN D said at that time he wanted to get up. At 8:40 a.m. he was still hollering. Around 9:00 a.m. he stopped yelling. I saw LPN D and told her that he was sleeping, and that they would wait to get him up. LPN D rushed into his room. LPN D told me he was dead. His face was bright purple, he had foam around his mouth, and there was yellow liquid coming out of his nose running down his neck, and yellow and chunks of emesis spilled out of his mouth when he was turned. He was still warm at this time."<br>*UAP G who worked 6:00 a.m. to 2:30 p.m.: "He was hollering loudly and his yells were heard by staff members out in the hallway. His typically easily agitated, but his yells were worse than usual. Staff members thought he was more easily irritable this day because there were different staff members working than usual. He was louder than normal. He ate some breakfast and threw up. His pills were given between 7:30 a.m. and 8:00 a.m. in his room. At 8:10 a.m. Zofran and Tylenol were given. He was driving his wheelchair into the trash can, door, and walls which was | F 309   |   |                      |   |

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| F 309   | <p>Continued From page 11</p> <p>unusual. He cornered himself in his room. He sat in his wheelchair for 30 minutes waiting to go to bed. He laid down flat in bed with brief on and no sheet. He had a red face and you could feel the heat coming off his body. He was sweaty. A cold washcloth was placed on his forehead. His fan was on. He continued to yell and LPN D helped him. I remember LPN D going in the room quite often after he was lying down. CNA F was leaving around 9:10 a.m. She checked on him prior to leaving and said he was sleeping. When found his mouth was foamy and he turned purple."</p> <p>*LPN E who worked 6:00 a.m. to 6:30 p.m.:<br/>"There was nothing in report about him being ill. Five minutes to 9:00 a.m. LPN D called my phone and asked if I could come to the Sunshine wing right now. LPN D said the resident was dead. We went into his room and took his apical (chest) pulse with no pulse. He was cool, discolored, and had no respirations (breathing). His face had some dried substance on his beard. He had grey foam around his mouth. The sheet by his head was wet she thought maybe was from sweating. The sheet was wet right behind his neck and shoulder. He was lying flat. When LPN D was asked if he had a pulse or respirations when she had found him LPN D said no. I told her to document that. I explained the policy of witness/unwitnessed events for starting CPR. I started the resident death checklist. I told the CNAs to clean up the resident. CNAs said there was a large amount of foam coming out of his mouth. I reviewed the call light times for him. At 8:45 a.m. his call light was on. At 8:53 a.m. his call light was turned off."</p> <p>*LPN D who worked 6:00 a.m. to 6:30 p.m.:<br/>"There was nothing said in report about any abnormalities with him on the night shift. 6:30 a.m. I was on the floor. First thing he was calling</p> | F 309   |   |   |

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| F 309   | Continued From page 12<br>to get him up. He was more needy than typical. He was the first one at breakfast. He was the first one they took care of, and he took a bit longer to get up. Maybe around 7:00 a.m. he was out to breakfast. He threw up at breakfast. He was gagging and threw up in a bag. He was taken back to his room right away. He was saying he was very hot. It was a half hour before LPN D and UAP G put him back in bed. I took his temperature and immediately gave Tylenol and baclofen (medication for muscle spasms). He was insisting on drinking and I gave him one and one-half cup full of water. He was asked if he wanted to go to the hospital to which he responded that he did not want to go to the hospital (a CNA heard this in the hallway). I called the ER anyway and received a verbal order to transfer him to the ER. I did not write down the order immediately. I wrote it later in the morning. The actual time of the order is unknown. The ER staff member on the phone said that the Bata bus sometimes transfers residents to the ER. I went back into his room and said that he needed to be changed. I told CNA B to change him. I was not sure if I should call the ambulance or use the Bata bus so I needed to ask the other nurse LPN E. I did not know how to use the overhead paging system in the Sunshine wing and I chose not to use the one in the Riverview wing. I then went to look for LPN E in the Southridge wing. When I was in the Southridge wing, another resident was in the tub and her Foley (catheter) tubing came unconnected. I went to find tubing and a leg bag. I helped transfer this resident into the tub chair. This took about a half hour. I could not find LPN E, but I got LPN E's portable phone number when I went through Morningview wing. When back in the Sunshine wing, I asked if he had been changed, it was quiet, and they said he was | F 309   |   |                      |   |

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| F 309   | <p>Continued From page 13</p> <p>sleeping. I rushed into his room. He was cool when found. I checked his wrist and used a stethoscope. He did not anything after emesis at breakfast. After I got order, I went back into his room and he was still hollering. I went in there and he was drinking water and watching TV. He was very thirsty. He was cool when found, cyanotic (without color), and foam on his mouth. I should have called the ambulance right away."</p> <p>Interview on 10/28/14 at 9:45 a.m. with LPN E regarding resident 1 revealed:</p> <ul style="list-style-type: none"> <li>*She had been there about fifteen years.</li> <li>*She was working on another nursing unit on 10/18/14. During the course of a day there was little interaction between nurses the way the building was designed and each area having its own dining room.</li> <li>*She thought LPN D had been employed by the facility about a year.</li> <li>*The first time she had been made aware the resident was sick was after he had died.</li> <li>*They had a policy in place for do not resuscitate or full code. If an event was witnessed for a resident with a full code CPR was then initiated. If an event was not witnessed for a no code resident then no CPR was initiated.</li> <li>*She had reviewed his call light log as "It was bothering me later in the day."</li> <li>*The last time his call light was on was at 8:45 a.m. and had been turned off at 8:53 a.m. He was already likely dead.</li> <li>*CNA had told CNA B and UAP G he was sleeping when she had answered his call light.</li> <li>*LPN D did not have a portable phone on her, and she was unsure why.</li> <li>*The Bata bus was used to transport non-emergent resident situations, and the ambulance was called if they needed the ER.</li> </ul> | F 309   |   |                      |   |

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| F 309   | Continued From page 14<br><br>Interview on 10/28/14 at 10:00 a.m. with CNA F regarding resident 1 revealed:<br>*She had been employed at the facility about a year.<br>*She had come in extra to help with staffing on 10/18/14 from 6:00 a.m. to 9:00 a.m.<br>*She very seldom ever worked on the Sunshine wing where he resided.<br>*She had been working primarily in the restorative area.<br>*CNA B who was working with her that day also rarely ever worked on the Sunshine wing.<br>*CNA B and I got him up out of bed about 6:45 a.m. when he turned his call light on.<br>*He was very upset that staff he was not familiar with were caring for him.<br>*He was not happy with CNA B and myself, and he hollered loudly the whole time we were getting him up. We were giving him the care he should have received but not to his satisfaction.<br>*He used his motorized wheelchair to go independently to breakfast about 7:00 a.m.<br>*The dietary aide (not sure of her name) asked us what we had done to make him so upset as he was so crabby when he came to the dining room.<br>*The dietary aide told us she thought he was going to get sick, and I got him some bags.<br>*We took him to his room, and he had another emesis.<br>*CNA B and I changed his shirt. We thought the emesis was breakfast.<br>*I never talked to LPN D. She talked to CNA B more.<br>*I do not believe I ever informed LPN D he was sick.<br>*I was supposed to be done at 9:00 a.m., and his call light was on.<br>*She had been told LPN D had given him Tylenol | F 309   |   |                      |   |

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| F 309   | <p>Continued From page 15</p> <p>and put a washcloth on his forehead which he had taken off right away.</p> <p>*CNA B had told her LPN D wanted them to take his temperature again prior to her answering his light. She thought the Tylenol had relaxed him, and he had fallen asleep.</p> <p>*The room was dark when I answered his call light. His eyes were closed, and I could not see his mouth.</p> <p>*I told CNA B and UAP G that he had fallen asleep before I left the floor after answering his light. I then went down to the restorative room.</p> <p>*I was surprised when I heard a little after 10:00 a.m. he had passed away.</p> <p>Interview on 10/28/14 at 10:15 a.m. with CNA B regarding resident 1 revealed:</p> <p>*She had been employed by the facility since March 2014.</p> <p>*There were issues in report that morning about what CNAs should work on the Sunshine unit.</p> <p>*The other CNAs decided where they were going to work, and it was left up to CNA F and herself to work on the Sunshine wing.</p> <p>*She usually never worked on the Sunshine wing and neither did CNA F.</p> <p>*LPN D was not in the dining room when he vomited, but she was in the hallway and had seen me grab the emesis pan.</p> <p>*The UAP usually focused on passing the medications in the morning, and the nurse worked on treatments.</p> <p>*UAP G and LPN D put him to bed about 8:00 a.m.</p> <p>*At about 8:40 a.m. LPN D told me to get him back up and take his temperature. CNA F and I were just going to get another resident up and did that first which took us until about 9:00 a.m.</p> <p>*Between about 8:40 a.m. and 9:00 a.m. we did</p> | F 309   |   |                      |   |

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| F 309   | <p>Continued From page 16</p> <p>not hear him hollering anymore when we were getting the other resident up for the day.</p> <p>*The whole morning he had been constantly hollering which could be heard in the hallway and when in other residents' rooms.</p> <p>*CNA F peeked in on him before she left at 9:00 a.m. and told myself and UAP G he was sleeping.</p> <p>*I told LPN D he was sleeping. When I told her he was sleeping LPN D rushed into his room. I guess she felt something was not right.</p> <p>*There was a shortage of pagers that weekend to alert staff when call lights were on. There was only one pager down the Sunshine wing, and I did not have one.</p> <p>Interview on 10/28/14 at 11:00 a.m. with UAP G regarding resident 1 revealed:</p> <p>*The morning started out unusual with the CNAs not communicating who was going to work where.</p> <p>*Since she was more familiar with the Sunshine wing than CNAs B and F, she had asked CNA B if she wanted to pass the medications. She did not.</p> <p>*He had thrown up before his pills. She had asked LPN D if she should go ahead and give him his pills, and LPN D had told her to go ahead.</p> <p>*She went back later and gave him Zofran.</p> <p>*She knew he had vomited shortly after he had gotten up between 6:45 a.m. and 7:00 a.m.</p> <p>*She heard about 8:00 a.m. his temperature was 104.7.</p> <p>*LPN D gave him Tylenol for his temperature.</p> <p>*He wanted to go to bed between 7:30 a.m. and 8:00 a.m. after she had given him his medications.</p> <p>*He was laid down in bed after she had given him the Zofran but was unsure of the time.</p> <p>*He had started initially to holler when CNA B and CNA F went to get him up for the day.</p> <p>*She thought he had been hollering "Bed" a lot.</p> | F 309   |   |   |

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| F 309   | <p>Continued From page 17</p> <p>*He usually had a lot of tantrums, but "they were beyond different" on that day.</p> <p>*LPN was the one that found him dead.</p> <p>Interview on 10/28/14 at 1:20 p.m. with LPN D regarding resident 1 revealed:</p> <p>*She had worked at the facility about one month "maybe a little more."</p> <p>*She thought she had been hired in September 2014.</p> <p>*She had "shadowed" a couple nurses on the day and night shift once or twice. She thought about four shifts before she was on her own.</p> <p>*When you shadow another nurse you follow that nurse and ask a lot of questions.</p> <p>*She was unsure how many times she had worked with resident 1 prior to 10/18/14.</p> <p>*She knew he was pretty vocal but felt comfortable working with him.</p> <p>*She knew CNA B and CNA F usually never worked with him, and UAP G was more familiar with him.</p> <p>*It was the nurse who decided where the CNAs worked, and it had been decided UAP G would administer medications that day.</p> <p>*The nurse was usually busy doing treatments and did not have a lot of time to help the CNAs on the floor.</p> <p>*There was nothing in report about any abnormalities with him during the night shift.</p> <p>*His hollering was not alarming to her as "he could be like that."</p> <p>Interview on 10/28/14 at 2:00 p.m. with the DON and administrator regarding resident 1 revealed:</p> <p>*They were in the process of rebuilding their orientation program.</p> <p>*The assistant DON and education director had left before the DON started three months ago.</p> | F 309   |   |                      |   |

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| F 309   | <p>Continued From page 18</p> <ul style="list-style-type: none"> <li>*They were starting a new position. An operations nurse that would bridge the gap in direct care staff education.</li> <li>*They had made some cuts due to financial reasons in all departments but nursing the past year.</li> <li>*Nursing had only been restructured, but the nursing staff were having difficulty adjusting to the changes.</li> <li>*LPN D had received orientation when she had started on 8/19/14 how to use the phone and paging system.</li> <li>*They confirmed there was no documentation on her orientation checklist she had received emergency service training.</li> <li>*Their expectation would have been basic emergency care would have been taught in nursing school.</li> <li>*LPN D should have transported him to the ER when she had received the verbal order from the physician at 8:10 a.m.</li> <li>*They had offered to LPN D more education on their policies and procedures prior to 10/18/14, but she had declined.</li> <li>*Since 10/18/14 LPN D had been reassigned to CNA duties.</li> </ul> <p>Review of the provider's undated Charge Nurse job description revealed:</p> <ul style="list-style-type: none"> <li>*A charge nurse's duties included accessing residents' records, monitoring residents, and informing physicians of changes to residents' conditions.</li> <li>*Additional duties included communicating with supervising nurses about residents' conditions when needed.</li> <li>*Provided appropriate interventions or recommended interventions based on interpretations of changes in residents'</li> </ul> | F 309   |   |                      |

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| F 309   | <p>Continued From page 19 conditions.</p> <p>3a. Review of RN C and M's personnel files revealed their CPR certifications had both expired.</p> <p>b. Review of LPN D and O's personnel files revealed no documentation of any CPR certifications.</p> <p>c. Review of RN J, K, L, N, P, and Q's personnel files revealed no documentation of any CPR certifications.</p> <p>d. Review of the provider's undated CPR Status policy and declaration revealed:<br/>**If you choose to CPR administered, the following will occur:<br/>-CPR will be initiated by the staff in the event the resident stops breathing and has no pulse in the presence of staff. In other words, if this event is witnessed CPR will be initiated.<br/>-911 will be called.<br/>-Hospital field emergency care providers will continue with the resuscitation process and transport the resident to the hospital.<br/>-In the event the resident is found without a pulse and is not breathing, CPR will not be initiated, 911 will not be called, and hospital field emergency care providers will not arrive to provide continued medical care. The family and physician will be notified of the death."<br/>**If you choose you do not want CPR administered, the following will occur:<br/>-CPR will not be initiated in the event you become pulseless and not breathing.<br/>-The resident will be maintained as comfortable as possible including the administering of pain medication as ordered by the doctor."</p> | F 309   |   |   |

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| F 309   | Continued From page 20  | F 309   |  |   |
| F 354<br>SS=D   | <p>483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON</p> <p>Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.</p> <p>Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.</p> <p>The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Surveyor: 22452<br/>Based on record review and interview, the provider failed to ensure registered nurse (RN) coverage for eight consecutive hours, seven days a week for four of fifty-six days. Findings include:</p> <p>1. Review of the 9/1/14 through 10/26/14 daily twenty four hour staffing sheets revealed the following days there was only six hours of RN coverage:<br/>*10/4/14.</p> | F 354   | <p><b>F 354</b><br/>Beginning on 10-30-2014 United Living Community staff scheduler is confirming there is a licensed R.N. in house 8 consecutive hours in a 24 hour period seven days a week. The staff scheduler will check the daily nursing schedule and posting and report to the Director of Nursing the 8 hours of RN coverage. [redacted] will report each payroll to the</p> <p>Administrator for 3 months, monthly for the next 3 months and quarterly reports for one year. The report will be filed with the QAPI committee quarterly meeting for compliance <del>for</del> <i>for</i> one year. JK/SDDH/MF</p> <p><i>* The Director of Nursing or designee will be responsible for resolving RN shift coverage problems. The Director of Nursing JK/SDDH/MF</i></p> | <p><i>11/27/2014</i></p>  |

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| F 354   | Continued From page 21<br>*10/18/14.<br>*10/19/14.<br>*10/26/14.<br><br>Interview on 10/28/14 at 4:00 p.m. with the director of nursing and administrator regarding the above revealed they:<br>*Confirmed the above dates there was not eight hours of consecutive RN coverage.<br>*Had not realized there was not eight hours of consecutive RN coverage on those dates.<br>*Did not have a policy regarding the need for RN coverage for eight consecutive hours, seven days a week.   | F 354   |   |
| F 356<br>SS=B   | 483.30(e) POSTED NURSE STAFFING INFORMATION<br><br>The facility must post the following information on a daily basis:<br>o Facility name.<br>o The current date.<br>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>- Registered nurses.<br>- Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>- Certified nurse aides.<br>o Resident census.<br><br>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:<br>o Clear and readable format.<br>o In a prominent place readily accessible to residents and visitors. | F 356   | F 356<br>Our facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. using the United Living Community – Daily Nursing Staff form Posting Direct care Daily staffing numbers policy the charge nurse at the beginning of each shift, the number of Licensed Nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. The form will be removed <del>at</del> at midnight, forwarded to the staff scheduler and filed as a permanent record for 18 months. The forms will be reviewed by the<br><br>X [redacted] see page 73 JK/SDDH/MF<br><br>11/27/2014<br>JK/SDDH/MF |

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| F 356   | <p>Continued From page 22</p> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Surveyor: 32355<br/>Based on record review, policy review, and interview, the provider failed to ensure the twenty-four hour nursing staff posting reflected the actual staffing that was on duty to provide the basic care needs to all seventy-one residents. Findings include:</p> <p>1. Random review of the twenty-four hour nursing staff postings from 10/21/14 through 10/27/14 revealed:<br/>*10/21/14, The nursing schedule reflected one registered nurse (RN) was on duty from 12:00 midnight to 2:00 a.m. That was not documented on the twenty-four hour nursing staff posting. The twenty-four hour nursing staff posting indicated that two RNs had worked from 12:00 midnight to 6:00 a.m. The nursing schedule reflected two certified nursing assistants (CNA) worked from 6:00 a.m. to 4:30 p.m. The twenty-four hour nursing staff posting indicated that three CNAs worked from 6:00 a.m. to 4:30 p.m.<br/>*10/22/14, The nursing schedule reflected one licensed practical nurse (LPN) was on duty from 7:30 a.m. to 6:00 p.m. That was not documented on the twenty-four hour nursing staff posting. The twenty-four hour nursing staff posting indicated</p> | F 356   | <p>* (continued from page 22)<br/>administrator each payroll period for 3 months, monthly for the next 3 months and quarterly reports for one year. The report will be filed with the QAPI committee quarterly meeting for compliance for one year. JK/SDDCHJMF</p> |                      |   |

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| F 356   | <p>Continued From page 23</p> <p>one LPN worked from 6:00 a.m. to 6:00 p.m.<br/>*10/25/14, The nursing schedule reflected one charge nurse on duty from 6:00 p.m. to 12:00 midnight to care for all seventy-one residents. The twenty-four hour nursing staff posting reflected two charge nurses had been on duty from 6:00 p.m. to 6:00 a.m.<br/>*10/27/14, The nursing schedule reflected two CNAs worked from 8:30 p.m. to 12:00 midnight and two from 8:30 p.m. to 10:30 p.m. The twenty-four hour nursing staff posting indicated that three CNAs worked from 8:30 p.m. to 7:00 a.m.</p> <p>Interview on 10/28/14 at 9:15 a.m. with staff scheduler H revealed:<br/>*She had been responsible for the daily internal twenty-four hour staffing worksheet.<br/>*That worksheet was an internal tool for the staff and her to use throughout the day when any staffing changes had occurred.<br/>*The night nurse would have documented on the twenty-four hour nursing staff posting according to what was written on the internal staffing worksheet.<br/>*The night nurse posted the twenty-four hour nursing staff posting for residents and visitors to view at 12:00 midnight each day.<br/>*She had not been aware the twenty-four hour nursing staff posting:<br/>-Was not updated as nursing staff changes occurred.<br/>-Should have been updated as staffing changes occurred throughout the day.<br/>*She could not recall if the twenty-four nursing staff posting had ever been updated throughout the day.</p> <p>Interview on 10/28/14 at 9:25 a.m. with the</p> | F 356   |   |                      |   |

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| F 356   | Continued From page 24<br>administrator confirmed the twenty-four nursing staff posting should have been updated as staff changes occurred throughout the day. She would have expected that posting to reflect the current staff working for that day.<br><br>Review of the provider's March 2013 Daily Nursing Staff policy and procedure revealed:<br>*Purpose "Center for Medicare and Medicaid requirement, staffing quality assurance tool."<br>*Procedure:<br>-"This form will be completed by the director of nursing to the start of the day."<br>-"The night shift charge nurse will perform the physical head count of residents and document total on the Daily Nursing Staff form."<br>*No process in place for updating or changing the daily nursing staff posting as staffing changes occurred. | F 356   | 490<br>The administrator of the facility will ensure by November 27, 2014 the following will be completed.<br>1. Orientation is completed for nurses K, L, and N). Nurse D is no longer with the facility. Nurse M's orientation was completed on Oct. 31, 2014 October 28th and 29th, 2014: training was held with RN-Director of Nursing, with 13 out of the 18 licensed nurses on staff. At this time we educated on the proper procedure of suctioning. The remaining (5) licensed nurses were instructed in the proper use of the suctioning machine and skill validation demonstration before they are allowed to work the floor as the charge nurse. All training was completed by October 31, 2014; Director of Nursing will be responsible for ensuring the complete skills orientation check list form is complete and accurate before the licensed nurse is placed on the floor as charge nurse. Human Resources with the Director of Nursing will monitor findings of accuracy and completeness for quality assurance; will report to the Administrator monthly for the next three months and quarterly reports for the next year to be filed with QAPI committee. |                      |   |
| F 490<br>SS=F   | 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 32355<br><br>Surveyor: 22452<br>Based on record review, interview, policy review, and job description reviews, the provider failed to ensure the facility was operated and administered   | F 490   |  | 11/27/2014           |   |

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| F 490   | <p>Continued From page 25</p> <p>in a manner that ensured the safety and overall well-being for all its seventy-one residents by ensuring:</p> <p>*All newly hired licensed nurses (D, K, L, M, and N) had initial orientation provided and documented that included emergency services.</p> <p>*An acutely ill resident (1) was transported to the hospital in a timely manner according to the physician's orders.</p> <p>*All licensed nurses (C, D, J, K, L, M, N, O, P, and Q) were currently certified in cardiopulmonary resuscitation (CPR).</p> <p>*Registered nurse (RN) coverage was provided for eight consecutive hours, seven days a week on a consistent basis.</p> <p>*The twenty-four hour nursing staff postings reflected the actual staffing that was on duty to provide the basic care needs to all residents.</p> <p>Findings include:</p> <p>1. Interview on 10/28/14 at 2:00 p.m. with the administrator and director of nursing (DON) regarding the above issues revealed:</p> <p>*They were in the process of rebuilding their orientation program.</p> <p>*The assistant DON and education director had left before the current DON started three months ago.</p> <p>*They were starting a new position that an operations nurse would bridge the gap in direct care staff education.</p> <p>*They had made some cuts due to financial reasons in all departments but nursing the past year.</p> <p>*Nursing had only been restructured, but the nursing staff were having difficulty adjusting to the changes.</p> <p>*No staff wages or benefits had been changed related to the cuts.</p> | F 490   | <p>procedures were followed. The written report of review will be presented to the Administrator monthly for one year. Quarterly reports will be included in the QAPI quarterly meeting for one year.</p> <p>3. The facility has assured that Staff C, J, K, L, M, N, O, P, Q are now certified in CPR by the American Heart Association. Staff member D is no longer with the facility.</p> <p>October 31, Nov. 1,2,3,4,10,12,17 2014: there were CPR classes held. The trainers were certified in the American Heart Association BLS Instructor Essentials. The 5 licensed nurses that needed certification were trained on Oct 31, 2014 to ensure the nurses scheduled were certified before working the floor. The Human Resource Department has included the names and dates for recertification of all nursing staff on the Smart Links personnel records software program, for automatic notification. Human Resource Director will be responsible for monthly checks for quality assurance; the report will be given to the Administrator weekly for 3 months, monthly for 3 months and quarterly reports for one year. Job descriptions for the charge nurse, operations nurse, MDS nurse and CNAs were updated to require current certification in CPR.</p> |                      |   |

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| F 490   | <p>Continued From page 26</p> <p>*All licensed nurses should have had their initial orientation completed and documented.</p> <p>*All licensed nurses should have current CPR certification. A copy of their CPR certification should have been placed in their employee files upon having been hired and updated when necessary.</p> <p>*All nurses should have been taught in nursing school how to utilize critical thinking and their nursing skills in resident emergency situations.</p> <p>Review of the provider's 1/24/14 DON job description revealed functions and tasks associated with his/her role that included:<br/>**Responsible to the owner/governing body/licensed administrator for:</p> <ul style="list-style-type: none"> <li>-The overall coordination and execution of nursing services.</li> <li>-Monitoring and evaluating the outcomes of nursing care.</li> </ul> <p>*Providing nursing oversight. The DON should:</p> <ul style="list-style-type: none"> <li>-Oversee all staff who provided nursing care to the facility's residents.</li> <li>-Ensure there was a procedure to collect and review nursing staff licensure/certification/credentials.</li> <li>-Ensure all nursing staff were held accountable for the care they delivered to residents in the nursing facility.</li> </ul> <p>*Ensuring nursing accountability. The DON should implement and enforce policies and procedures that covered essential nursing responsibilities to the residents and the facility including:</p> <ul style="list-style-type: none"> <li>-Supporting resident discharges and transfers.</li> <li>-Providing adequate ongoing nursing coverage.</li> <li>-Providing appropriate, timely, and pertinent documentation.</li> </ul> <p>*The DON ensured that nursing practice in the</p> | F 490   | <p>Licensed Nurse Skill orientations Check List were updated to reflect a higher standard of accountability and clear expectations.</p> <p>3. There was a count of pagers in house completed by October 29, 2014 by 5pm. There was an order for the number of pagers needed with two additional back up pagers ordered through United Technologies, United Living Community supplier, on October 30, 2014 and were in house by October 31, 2014. A policy and procedure of checking in and out the pagers was developed, Phones, Pagers and Gait Belt sign-in-out Procedure. Training on the new policy for present staff will be completed by November 27, 2014, or prior to the employees next scheduled shift and implemented to ensure each CNA on duty has a pager. Human Resources and Director of Nursing will include training the new staff on the proper use of the pagers, transfer of pagers to the replacement staff at the initial orientation and nursing skills training. Charge nurses will ensure each C.N.A. has a working pager. Maintenance Director will place on their weekly preventative maintenance checklist to ensure proper functioning. Director of Maintenance for quality assurance; will report to the</p> |                      |   |

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| F 490   | Continued From page 27<br>facility reflects skill in resident assessment, critical thinking, and nursing interventions."<br><br>Review of the provider's 4/9/97 Administrator's job description revealed the administrator performed a wide range of difficult to complex administrative activities related to:<br>*Staffing.<br>*Personnel operations.<br>*Promotion of services.<br><br>Interviews, record reviews, job description review, and policy reviews, throughout the course of the survey from 10/27/14 to 10/29/14 revealed the administrator had not ensured the safe management and overall well-being of the residents.<br><br>Refer to F309, F354, and F356. | F 490   | Administrator weekly for 3 months, monthly for 3 months and quarterly reports for one year that an accurate completed signed check list has been completed and quarterly reports for one year and be included in the quarterly QAPI committee.<br><br>4..There was training of hard-line and portable phone use for staff on November 6, 2014 The vendor, Swiftel Communication, provided training. Those select staff will be responsible to train their respective staff, no later than November 22, 2014 or before their next scheduled shift. Documentation of training shall be provided to the Administrator and then reported at the QAPI quarterly meeting. Swiftel was here October 15, 2014 and completed a maintenance check on all 6 cordless phones. All cordless phones by 5 pm on October 15, 2015 were in working condition. Prior to November 22, 2014 a policy and procedure of checking in and checking out the cordless phones will be written and implemented to ensure the charge nurse for each shift has a cordless phone. Human Resources and the Director of Nursing will include training the staff on the proper |                      |   |

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| F 490   | Continued From page 27<br>facility reflects skill in resident assessment, critical thinking, and nursing interventions."<br><br>Review of the provider's 4/9/97 Administrator's job description revealed the administrator performed a wide range of difficult to complex administrative activities related to:<br>*Staffing.<br>*Personnel operations.<br>*Promotion of services.<br><br>Interviews, record reviews, job description review, and policy reviews, throughout the course of the survey from 10/27/14 to 10/29/14 revealed the administrator had not ensured the safe management and overall well-being of the residents.<br><br>Refer to F309, F354, and F356. | F 490   | use of the phones, transfer of phones.<br><br>1a. Staff member D is no longer employed by the facility.<br><br>1b. Staff member J completed orientation on October 28, 2014, regarding the admission/discharge/transfer/death orientation. The remainder of the checklist will be completed by November 17, 2014 by the Director of Nursing.<br><br>1c. Staff member K completed orientation on October 28, 2014, regarding the admission/discharge/transfer/death orientation. The remainder of the checklist will be completed by November 17, 2014 by the Director of Nursing.<br><br>1d. Staff member L completed orientation on October 29, 2014, regarding the admission/discharge/transfer/death orientation. The remainder of the checklist will be completed by November 17, 2014 by the Director of Nursing.<br><br>1e. Staff member M completed orientation on October 31, 2014, regarding the admission/discharge/transfer/death orientation. The remainder of the checklist will be completed before the start of M's next shift. |                      |   |

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| F 490   | Continued From page 27<br>facility reflects skill in resident assessment, critical thinking, and nursing interventions."<br><br>Review of the provider's 4/9/97 Administrator's job description revealed the administrator performed a wide range of difficult to complex administrative activities related to:<br>*Staffing.<br>*Personnel operations.<br>*Promotion of services.<br><br>Interviews, record reviews, job description review, and policy reviews, throughout the course of the survey from 10/27/14 to 10/29/14 revealed the administrator had not ensured the safe management and overall well-being of the residents.<br><br>Refer to F309, F354, and F356. | F 490   | 1f. The Skill Orientation Checklist for RN/LPN was revised by Friday, November 7, 2014. All RNs and LPNs, will complete the skills orientation check list for all except staff member M by November 17, 2014. Staff member M will complete the checklist prior to M's next scheduled shift. No staff member will mark "self" on the checklist. No staff member will be allowed to complete their own checklist.<br><br>3d. Staff received training on the indications about when not to do CPR as stated the CMS Survey and Certification Letter (14-01-NH) dated October 13, 2013.<br><br>The policy was changed to delete any reference about whether the patient's condition was witnessed in order to clarify when CPR should be initiated. The following statement from the old policy was deleted in the updated policy: "In the event the resident is found without a pulse and is not breathing, CPR will not be initiated, 911 will not be called and hospital field emergency care providers will not arrive to provide continued medical care." |                      |   |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>UNITED RETIREMENT CENTER</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>405 FIRST AVE</b><br><b>BROOKINGS, SD 57006</b>  |                      |   |
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| F 490   | Continued From page 27<br>facility reflects skill in resident assessment, critical thinking, and nursing interventions."<br><br>Review of the provider's 4/9/97 Administrator's job description revealed the administrator performed a wide range of difficult to complex administrative activities related to:<br>*Staffing.<br>*Personnel operations.<br>*Promotion of services.<br><br>Interviews, record reviews, job description review, and policy reviews, throughout the course of the survey from 10/27/14 to 10/29/14 revealed the administrator had not ensured the safe management and overall well-being of the residents.<br><br>Refer to F309, F354, and F356. | F 490   | The Welcome to United Living Community brochure will be updated to reflect the new directives regarding CPR as described above. The Administrator will monitor and report progress of the restructuring of the nursing department, staff orientation, and training program, and provide reports of QAPI quarterly meetings to the Board of Directors at the monthly board meetings for one year. |                      |   |

*ADU*