

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

ORIGINAL

PRINTED: 10/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435077</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>10/08/2014</b>
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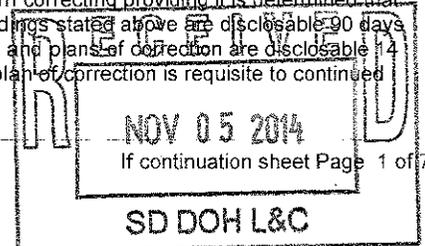
NAME OF PROVIDER OR SUPPLIER  <b>BRYANT PARKVIEW CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>303 W 6TH AVE POST OFFICE BOX 247 BRYANT, SD 57221</b>
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F 000	INITIAL COMMENTS  Surveyor: 22452 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 10/7/14 through 10/8/14. Area surveyed was resident abuse by an employee. Bryant Parkview Care Center was found not in compliance with the following requirements: F226 and F281.	F 000	Addendums noted with an asterisk per 11/19/14 telephone to facility administrator. TN/8000H/ME	
F 226 SS=D	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: 22452 Based on record review, interview, and policy review, the provider failed to thoroughly investigate bruises of unknown origin for one of one sampled resident (5). Findings include:  1. Review of resident 5's medical record revealed: *A 7/21/14 admission date. *Diagnosis of dementia (memory loss) with behavioral disturbances.  Review of resident 5's "somewhere between 9/11/14 and 9/14/14" incident report completed by certified nursing assistant (CNA) A and signed by the director of nursing (DON) revealed: *CNA A had signed the incident report.	F 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Lynelle Rust</i>	TITLE <i>Administrator</i>	(X6) DATE <i>11-4-14</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 226	<p>Continued From page 1</p> <p>*In the space for date of the incident was in parenthesis "(somewhere between the 11th and 14th)." The DON had signed under that.</p> <p>**"I was walking down the hall and heard a crash on the resident's wall. I went and she had her hand on the door handle. She was sitting on the foot of the bed on her left hip with her left shoulder and left side of her head on the wall."</p> <p>**"Resident was closing door and lost balance."</p> <p>**"I helped her sit up and put her in a chair and then called for the nurse."</p> <p>Review of resident 5's 9/14/14 investigation report completed by the social service designee (SSD) revealed:</p> <p>**"Type of incident was fall."</p> <p>**"Reported by registered nurse (RN) B."</p> <p>**"Witness CNA A."</p> <p>**"Staff was walking down the hall and heard a crash against a wall. Staff went into room and found this resident sitting on the foot of her bed on her left hip with her left shoulder and the left side of her head of the wall. Resident was trying to close the door when she lost her balance."</p> <p>**"Investigation reviews: Resident was trying to close the door and she lost her balance falling against the wall."</p> <p>**"Contributing factors to incident: Resident hit her shoulder and arm. Possible on light switch. Resident had also bumped into the door frame on the right arm the day before while I was in the unit."</p> <p>**"Was there injury to the resident: Bruising."</p> <p>**"Staff that was present during incident: CNA A and RN B."</p> <p>**"Recommendations and comments: Monitor for further bruising."</p> <p>**"These results were not reported to state agency (s) Department of Health and state ombudsman</p>	F 226	<p><b>1. The event reporting policy and procedure with accurate and thorough assessment and investigation was reviewed with SSD and DON by the Administrator .</b></p> <p><b>2. All staff was in-serviced on 10-30-14 on accurate and thorough assessments and investigation of resident events or incidents . Also, event reporting including the 24 hour notification and 5 day investigation. Documentation will be reviewed by DON/SSD and Administrator for completion.</b></p> <p><i>*All TN/SSD/CNA</i></p> <p><b>3. Resident events/incidents audits will be reviewed for trends and potential for abuse/neglect by DON/designee for need of investigation and reporting weekly X 4, monthly X 2 by the DON/designee and [REDACTED] the Administrator.</b></p> <p><i>TN/SSD/CNA</i> <b>Results will be reported to QA Committee Quarterly by the Administrator until advised to discontinue by the QA Committee.</b></p>	11-27-14

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F 226	<p>Continued From page 2 or medical director." *"No sign of abuse or neglect are founded at this time."</p> <p>Review of resident 5's 9/11/14 through 9/22/14 interdisciplinary notes revealed: *There was no documentation from 9/11/14 through 9/13/14 regarding the above incident. *9/14/14 at 11:30 a.m. "Resident has scattered purple bruising of various sizes to right arm extending from shoulder to wrist. Larger bruises are 7.0 centimeter (cm) by 7.0 cm, 5.0 by 3.0 cm, and 2.0 by 3.0 cm. All other bruises are smaller. Resident unable to explain how bruises occurred. No history of falling." *9/19/14: "Noted bruise to right side of face to cheek line."</p> <p>Review of resident 5's 9/22/14 interdisciplinary notes and Skin Issue Checklist form revealed "7.0 cm by 5.0 cm bruise dark purple bruise (indicative of a new bruise) noted to left hip of unknown origin. Found with toileting."</p> <p>Interview on 10/8/14 at 2:44 p.m. with the DON and SSD regarding resident 5 revealed: *They did not know why the dates "somewhere between the 11th and 14th" were documented on the incident report by CNA. It was not known whether that was when the incident occurred or when CNA had filled out the incident report. *They thought the bruises to her right arm had occurred during the incident on 9/14/14, but that did not make sense if CNA had found the resident on her left side. *They had not visited with CNA to see if the bruising could have occurred when she had transferred the resident to a chair. *The CNA reported the injury to nursing, and the</p>	F 226	<p>* Resident 5's record and care plan were reviewed from the previous event. The care plan has been updated and her room has been rearranged to promote a safer environment. TN/SSDH/MF</p>	

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F 226	Continued From page 3 nurse assessed the resident. The nurse then turned it over to the SSD to investigate injuries and determine if they were abuse and neglect issues. The SSD would report and investigate any injuries of unknown origin she felt were abuse and neglect issues. *The SSD had not reported to nursing on 9/14/14 when she had seen the resident run into the door frame on the right arm. *They thought the bruise found on the resident's left hip on 9/22/14 was a result of the 9/14/14 incident. They had not realized that had not made sense since the bruise on the left hip looked like it was new on 9/22/14, and the incident had occurred on 9/14/14. *They had not done any further investigation as felt it was not an abuse situation. The resident bruised easily and was in the memory care unit. *The resident often sat on the foot of her bed. *They had not done any preventative measures to pad the foot of her bed to prevent further injury.  Review of the provider's undated Accidents and Incidents Investigating and Reporting policy revealed: *"All accidents or incidents involving residents, employees, and visitors shall be investigated and reported to the administrator." *"The nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident."	F 226			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.	F 281			

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F 281	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452</p> <p>Based on record review, interview, and policy review, the provider failed to ensure suicidal comments were thoroughly assessed for one of one sampled resident (6). Findings include:</p> <p>1. Review of resident 6's medical record revealed: *A 7/2/13 admission date. *Diagnosis of memory loss.</p> <p>Review of resident 6's 11/21/13 psychologist's progress notes revealed: *"Is in treatment for anxiety, depression, agitation, and dementia." *"Has not made any suicidal comments." *"Has not tried to leave the facility." *"Should be continued to be monitored closely at the care center." *"Return one to two weeks, or earlier if needed."</p> <p>Review of resident 6's medical record revealed she never saw the psychologist after 11/21/13.</p> <p>Review of resident 6's 5/18/14 through 10/7/14 interdisciplinary progress notes revealed: *5/19/14: "Was exit seeking multiple times this shift and eloped once out of unit doors. Was very hard to redirect. Stated she just wanted to die may times. Wanted poison so she could just end her life." *5/20/14: "Resident was visibly upset. States that she does not want to be here, she has a house. Resident states she would drink poison before she stayed here. Redirected resident by going to</p>	F 281	<p>1. Resident #6 suicidal comments were reviewed with POA, physician ( Medical Director), psychologist for further direction . Any future residents with suicidal comments will adhere to the facility suicide threat policy.</p> <p>2. All staff was in-serviced on 10-30-14 on the facility Suicide Threat policy. Professional standards for services will be provided with notification of required physician( Medical Director), psychologist, and family representative. An internal checklist was developed to assist staff in completion of all requirements of suicide threat policy. Documentation will be reviewed by DON/designee and reported to Administrator for completion.</p> <p>3. Resident suicidal threat audits will be reviewed for compliance of Professional standards on the above policy and procedure weekly X 4, monthly X 2 by the DON/designee and the Administrator. Results will be reported To QA Committee Quarterly by the Administrator until advised to discontinue by the QA Committee.</p>	11-27-14

*\* All TN/SDDH/ME*

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F 281	<p>Continued From page 5 devotions."</p> <p>*5/23/14: "Night nurse reported that resident having increased exit seeking behavior with anger present. Night nurse stated hard to redirect."</p> <p>*7/9/14: "Certified nursing assistant reports suicidal comments and redirected with conversation."</p> <p>*7/11/14: "Resident eloped through unit doors. Resident visibly upset and states she is leaving. Assist of two to assist resident back into unit. Diversional activities provided."</p> <p>*7/25/14: "Exit seeking by resident. Making suicidal comments. Asking for a bottle of poison. Reassurance and diversional activities provided to resident."</p> <p>*9/8/14: "Resident exit seeking. Difficult to redirect with diversional activity."</p> <p>*9/19/14: "Resident eloped from unit."</p> <p>*9/26/14: "Resident exit seeking requiring redirection."</p> <p>Interview on 10/8/14 at 3:00 p.m. with the social service designee regarding resident 6 revealed: *They had not made a return appointment with the psychologist, because she thought he had stopped the visits. She was unable to locate any documentation regarding that. *They did not feel her suicidal comments were harmful as she did not have a plan. *She was unsure if they had followed their suicide policy, but likely they had not.</p> <p>Review of the provider's undated Suicide Threat policy revealed: *"Resident suicide threats shall be taken seriously and addressed appropriately." *"After assessing the resident, the nurse supervisor/charge nurse shall notify the resident's</p>	F 281		

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F 281	Continued From page 6 attending physician and responsible party, and shall seek further direction from the physician."	F 281		