

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

**ORIGINAL**

PRINTED: 12/17/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435126</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/08/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>VIOLET TSCHETTER MEMORIAL HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 22452 An extended/complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 12/2/14 through 12/4/14 and 12/8/14. Areas surveyed included resident transfer and discharge rights and resident care issues during an acute change in resident condition. Violet Tschetter Memorial Home was found not in compliance with the following requirements: F224, F250, F280, F309, F368, F428, and F490.</p>	F 000		
F 224 SS=J	<p><b>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN</b></p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, interview, and policy review, the provider failed to ensure: *One of one sampled resident (1) who was on a therapeutic diet was completely assessed and evaluated for the appropriate diet consistency. *One of one sampled resident (4) who was on a pureed diet was served the appropriate food. *One of one sampled resident (10) who was on a mechanical soft diet was served the appropriate food.</p>	F 224		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Jessie Spamer</i>	TITLE  <i>Executive Director</i>	(X6) DATE  <i>12-24-14</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 224	<p>Continued From page 1</p> <p>*Six of sixteen sampled nurses (C, F, G, H, M, and R) were certified in cardiopulmonary resuscitation (CPR).</p> <p>*Emergency equipment was available and readily accessible on all three floors (dining room, 2nd floor, and 3rd floor).</p> <p>*Four of sixteen sampled nurses (C, F, G, and H) had received a thorough nursing orientation to the provider's policies and procedures.</p> <p>*Four of four sampled residents (10, 11, 12, and 13) on mechanical soft diets were thoroughly assessed for the appropriate foods on their diet.</p> <p><b>NOTICE:</b></p> <p>Notice of immediate jeopardy was given to the executive director and the director of nursing (DON) on 12/3/14 at 12:30 p.m. They were asked for a plan of correction to be given to the surveyors on 12/4/14 by 8:00 a.m. They were asked that the plan of correction include:</p> <p>*The education of all the dietary and nursing staff regarding the appropriate foods allowed on a mechanical soft and pureed diet. There were four residents on mechanical soft diets and nine residents on pureed diets.</p> <p>*Emergency preparedness equipment was available in the dining room area.</p> <p>*All nurses would be current with their CPR training. Until all the nurses were current in CPR one nurse with current CPR would be on duty at all times.</p> <p>*The plan to monitor that all residents on mechanical soft and pureed diets received the appropriate foods on their meal trays and with snack pass on the nursing floors.</p> <p>*Pocket care plans (staff assignment sheets) would be updated for all certified nursing assistant (CNA), and the plan to keep them</p>	F 224	<p><b>F224</b></p> <p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusion set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:</p> <ol style="list-style-type: none"> <li>1. Resident #1 has been discharged. Identified Cook was re-educated regarding diet consistencies on 12/4/14. Licensed nurses C, F, G, H and R had their CPR renewed by 12/16/14. Employee M is not a licensed nurse. Emergency equipment was placed on each floor 12/3/14. Nurses C, F, G, and H reviewed the licensed staff competency evaluation checklist by 12/23/14. Residents #4, #10,</li> </ol>		

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F 224	<p>Continued From page 2 current and used by the CNAs. *A plan for communication between speech therapy (ST), nursing, and dietary regarding mechanically altered diets.</p> <p><b>PLAN:</b></p> <p>A plan of correction was accepted on 12/4/14 at 3:10 p.m. regarding: *The education of all dietary and nursing staff regarding serving the appropriate foods for residents with mechanical soft and pureed diets. -Training began on 12/3/14 at 2:00 p.m. for all employees working and would continue until all dietary and nursing employees had been trained. -Employees not able to attend the meetings would be educated prior to working their next shift by one of the following; the dietitian, certified dietary manager (CDM) or designee, DON or designee, or the executive director. -Pocket care plans were updated to include "diet with negotiated risk" for all residents that it applied to. The DON would have the overall responsibility to ensure the pocket care plans were kept current and the CNAs were using them. -Dietitian and CDM in conjunction with nursing reviewed on 12/3/14 the four residents on mechanical soft diets and the nine residents on pureed diets. The ST will review the four residents on mechanical soft and the nine residents on pureed diets on 12/4/14. -If a resident desires a food not allowed on their diets a negotiated risk form would be completed indicating the risks had been discussed. -The dietary supervisor and/or designee or the DON and/or designee would monitor the tray line to ensure the correct diet was served. A second check would be completed by the tray passer to</p>	F 224	<p>11, 12 and 13 were reassessed for diet consistency on 12/4/14. 2. All employees were re-educated on mechanical soft and puree diets and snack cart requirements by 12/9/14. All residents were reviewed for appropriate diet consistency and for need of negotiated risk agreements in place. Meal monitors were put into place for all meals. All licensed staff has been reviewed for CPR certification and were current by 12/16/14. All staff have been re-educated on the Heimlich Maneuver by 12/23/14 but all staff will not become CPR certified as written in the abatement plan. Emergency equipment was placed on each floor 12/3/14. Assignment sheets were reviewed and revised as necessary 12/4/14. A revised process for communication between ST, Dietary and Nursing was developed on 12/4/14. A supplement snack tracking system was implemented 12/4/14.</p>	

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F 224	Continued From page 3 ensure the diet card matched the meal served. -The cook who served resident 10 who was on a mechanical soft diet with pineapple chunks on 12/3/14 at 6:00 p.m. was re-educated. She stated it had been a resident preference in the past. -The CDM or designee would create a list of residents on specialized diets to be kept on the snack carts. Each resident would have a list of acceptable food items. -Training of mechanical soft and pureed diets would be included in orientation. -A tracking form would be created to ensure residents have been offered snacks and are receiving acceptable items. -ST would begin to use a three part communication form to ensure dietary, nursing, and the DON were aware of all changes to residents' current dietary plans. *Emergency preparedness had been reviewed with all nursing staff: -Emergency carts are available on each floor of the building and equipped with a blood pressure cuff, suctioning machine, back board for CPR, CPR mask, and other items as needed. -First floor emergency cart (dining room area) would be located in the chapel area. The other carts on 2nd and 3rd floor would be located in the unlocked CNA closet. Until a third suction machine arrives the suctioning machine from 2nd floor was moved to the dining room on 1st floor. The third suction machine was ordered on 12/3/14. The purchase order for the third suction machine was given to the surveyors on 12/4/14. -All licensed nursing staff would have a review regarding the use of the suction machines. Use of the suction machines would be included in nurse orientation. *CPR training has been set-up for 12/9/14 and 12/16/14. The schedule has been reviewed and	F 224	3. System changes include adding to new staff orientation – tray passing responsibilities, diet consistency training and supplement and snack passing expectations to all new staff who provide food to residents and updating of assignment sheets. A CPR tracking system has been implemented in which the Office Manager inputs the information upon hire and monthly will review the log and send a copy to the DNS. A communication system between Speech Therapy, Dietary, and Nursing was created and includes use of a 4 part duplicated form. Emergency care carts are in place with a monitoring system and nursing staff will be educated during new staff orientation and annually during emergency preparedness. 4. The DNS or designee will audit new staff orientation for completion including diet consistency training, supplement and snack delivery as well as charting		

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F 224	<p>Continued From page 4</p> <p>at least one nurse with current CPR training will be on duty at all times.</p> <p>*Eighty-eight percent of the nursing and dietary staff had been provided the above training and education at the time of the acceptance and removal of the immediate jeopardy on 12/4/14 at 3:10 p.m.</p> <p>Findings include:</p> <p>1. Review of resident 1's 1/6/14 care plan revealed "soft textures" per resident request.</p> <p>Review of resident 1's 9/9/14 Brief Interview for Mental Status (BIMS) assessment revealed a score of 4 out of 15 indicative of severe mental impairment.</p> <p>Review of resident 1's 10/8/14 at 3:15 p.m. nurse's notes by registered nurse (RN) B revealed:</p> <p>**Called to dining room at 1:10 p.m. Resident choking on food. Resident unable to cough." **Assisted resident by 2 to stand and this nurse performed the Heimlich maneuver [abdominal thrusts to dislodge food from the airway] several times. Unable to dislodge the food." **Was assisted to the floor. Finger sweep done. Unable to find any obstruction." **Ambulance called. By the time they had arrived respirations had ceased and no pulse was noted." **Returned resident to her room by ambulance stretcher."</p> <p>Review of speech therapist I 9/4/14 through 9/24/14 daily treatment notes revealed: *9/3/14- "Continue to trial regular cups with mechanical soft solids." *9/8/14- "Continue trial of ground meat. Trial nectar thick liquids to eliminate any signs and</p>	F 224	<p>for each new employee. The DNS/designee will audit CPR certification for current status of licensed staff monthly for the upcoming month including new hires. DNS/designee will audit Speech Therapy communication, C.N.A. assignment sheets for accuracy, and emergency carts location and for fully stocked two times per week for one month and then one time per week for 2 months. The data collected will be presented to the Quarterly Quality Assurance committee by the DNS. It will be reviewed/discussed and at this time the QA committee will make the decision/recommendation regarding follow-up or changes.</p>	1-1-15	

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F 224	<p>Continued From page 5</p> <p>symptoms of aspiration (swallowing into lungs)." *9/9/14- "Continue trial of mechanical soft with ground meat." *9/10/14- "Continue to trial mechanical soft with ground meat." *9/16/14- "Continue to trial mechanical soft with pureed (blended) meat." *9/17/14- "Continue diet change to mechanical soft due to increased intake." *9/24/14- "Trial nectar thick liquids. Current status has been documented based on patient tolerance of mechanical soft diet with ground meat."</p> <p>Interview on 12/2/14 at 2:50 p.m. with ST I regarding resident 1 revealed: *Nursing had reported to her in September 2014 the resident was having trouble swallowing and choking. She was pocketing food. *The resident wanted to continue on a mechanical soft diet with ground meat. She would have preferred the resident be on a pureed meat diet consistency with the other foods mechanical soft, but the resident did not like that type of food texture. *Her recommendation for the pureed meat consistency was related to the resident's fatigue. She did tolerate the mechanical soft diet okay, and her meal intake had improved. *Maybe she should have over-ruled the resident's decision with her diet consistency, but she was honoring the resident's rights. *She had asked occupational and physical therapy to evaluate utensils that would be easier for her to get to her mouth. *She should have documented in her notes the resident declined the pureed diet consistency, but she had not. *She knew the resident had memory issues, but she was adamant in her diet texture consistency</p>	F 224		

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F 224	<p>Continued From page 6</p> <p>and refusal to be at a dining room table where staff sat and assisted the residents. She had failed to document any of the that and should have.</p> <p>*She had not spoken to the resident's family regarding her recommendations, because she thought nursing had. She should have clarified with nursing if they had spoken to the resident's family.</p> <p>*She had also encouraged the resident to sit at a table in the dining room that was assisted, and she had also declined to do that.</p> <p>*The staff would check with her frequently during the meal how she was tolerating her meal and if she needed any assistance.</p> <p>*Grapes were considered "a grey area" on mechanical soft diets.</p> <p>*The nursing staff had told her the resident wanted grapes and had tolerated them in the past without choking. There was no documentation regarding that in her medical record.</p> <p>*Her time was limited for education of the nursing and dietary staff regarding residents' diets.</p> <p>Interview on 12/2/14 at 3:30 p.m. with the DON regarding resident 1 revealed:</p> <p>*Her investigation showed the resident was served the correct foods on her diet order and preferences.</p> <p>*The appropriate level of supervision was in place based on her individual assessment and plan of care.</p> <p>*On 10/8/14 she was the last resident in the dining room eating, because she was a slow eater. A staff member was sitting beside her giving her cues and supervision. The nurse had completed her medication pass in the dining room and was no longer in the dining room.</p> <p>*The resident had eaten grapes previously</p>	F 224			

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F 224	<p>Continued From page 7</p> <p>without problems and desired them even though they were not on her diet. She agreed there was no documentation to support that.</p> <p>*She and RN B had attempted the Heimlich maneuver on the resident with no food coughed out.</p> <p>*The resident lost consciousness and was not resuscitated related to her no code status (no CPR to be initiated).</p> <p>Interview on 12/3/14 at 9:30 a.m. with the dietitian and the CDM regarding resident 1 revealed:</p> <p>*They had not considered grapes being an issue with residents on mechanical soft diets. They based it on foods being able to "be squished in your fingers."</p> <p>*The dietitian had recommended eliminating grapes after the resident's choking incident. The executive director did not want to go that far.</p> <p>*Grapes were not to be served to any resident on a mechanical soft diet. They knew the resident had requested them, but there was no documentation of that in her medical record.</p> <p>*Grapes continued to be sent out to the nursing floors on the snack carts in baggies. The CNAs were responsible to give out snacks and were unsure if the CNAs were aware who should not have grapes.</p> <p>*The diets were to be on the CNAs pocket care plans (assignment sheets), but they were unsure who kept them updated with the residents' current diets.</p> <p>*The CNAs did not document on what snack a resident had been given unless they were on a specific supplement for weight loss.</p> <p>*There was no tracking method to determine if residents that should not receive grapes or any other type of food not allowed on a mechanical soft diet was being given to residents who should</p>	F 224			

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F 224	<p>Continued From page 8 not have them. *They followed the 2008 Becky Dorner and Associates diet manual for the mechanical soft diet. They confirmed fruits to avoid listed were pineapple, difficult to chew fresh fruits (grapes, apples, etc.), dried fruits, fruit leather, caramels or other chewy candies.</p> <p>Interview on 12/3/14 at 10:15 a.m. with RN B regarding resident 1 revealed she: *Was unsure of what the resident had been eating prior to getting called to the table. *Removed a half grape from the resident's cheek. There was no food in the back of her throat. *Was unsure if the resident had swallowed the rest of the grape or had aspirated [food went into lungs] the grape.</p> <p>2. Review of resident 4's 12/3/14 speech therapy notes revealed "Trial of puree (all food blended) and nectar thick liquids.</p> <p>Interview on 12/4/14 at 10:00 a.m. with the certified dietary manager (CDM) and the dietitian regarding resident 4 revealed: *The cook had served her a fruit cup (contained chunks of fruit) on 12/3/14 at supper. *They had reeducated the cook the foods that should have been served on a pureed diet. *Resident 4's appetite had been poor, and she had not eaten the fruit cup.</p> <p>3. Observation on 12/3/14 at 6:00 p.m. of resident 10 revealed he received pineapple chunks on his supper tray. He stated he did not like them and did not eat them.</p> <p>Review of resident 10's diet card revealed he was on a soft texture diet.</p>	F 224			

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F 224	Continued From page 9  Interview on 12/4/14 at 10:00 a.m. with the CDM and the dietitian regarding resident 10 revealed: *He should not have received the pineapple chunks on the soft texture diet. *The cook stated he used to like pineapple chunks, and she was honoring his request. *The cook was re-educated on what foods should have been served on a soft texture diet.  4. Review of licensed nurses C, F, G, H, R, and S's personnel files revealed no current CPR certification: *RN C- Expired 9/24/14. *RN F- Expired November 2014. *RN G- There was not any CPR certification. *RN H- There was not any CPR certification. *RN M- There was not any CPR certification. *RN R- Expired 10/28/14.  Interview on 12/3/14 at 3:30 p.m. with the DON regarding the above employees revealed: *She was unsure why RNs G and H had no CPR certification. *RN M was a new employee and was to have brought in her CPR certification. She had been hired on 8/12/14. *She knew RN C, F, and R's CPR certification had expired. They had set-up CPR recertification dates because of that incident on 12/9/14 and 12/16/14. *They had not looked at the schedule to see if a nurse that had current CPR certification was on duty until all the nurses had been recertification.  5. Interview on 12/2/14 at 11:30 a.m. with RN F regarding emergency equipment revealed she: *Had only worked on a "as needed" basis for the last few months.	F 224		

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F 224	<p>Continued From page 10</p> <p>*Was unsure where the suction machines in the building were located.</p> <p>*Did not think they had any crash carts that contained CPR masks or any other emergency equipment.</p> <p>Interview on 12/2/14 at 11:45 a.m. with RN B regarding emergency equipment revealed she:</p> <p>*Knew the suction machines were in the locked medication rooms on 2nd and 3rd floor. There was not a suction machine on the first floor in the dining room.</p> <p>*Only the nurses were allowed in the medication rooms. In an emergency in the dining room the nurse would need to leave the dining room to get a suction machine if it was needed.</p> <p>*Knew they did not have emergency crash carts or a back board that should be used if CPR was administered.</p> <p>*Thought the CPR masks were in the medication carts. She was unable to find one in her medication cart when she looked.</p> <p>Interview on 12/2/14 at 3:10 p.m. with the DON regarding emergency equipment revealed she:</p> <p>*Was aware there was not a suction machine in the dining room that if it was needed for choking.</p> <p>*Had talked about it with the executive director one was needed where residents were eating.</p> <p>*Agreed in an emergency situation time would be lost to start CPR if the nurse had to run to 2nd or 3rd floor to get a suction machine.</p> <p>*Agreed they never had a back board for CPR use. They used the bed or the floor to put the resident on to start CPR.</p> <p>*Agreed they did not have a crash cart to be used for emergency situations that contained a stethoscope, a back board, or a CPR mask.</p> <p>*Did not know where the CPR masks were in the</p>	F 224		

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F 224	<p>Continued From page 11</p> <p>facility or if there was one in the dining room. *Was surprised the surveyor found a CPR mask in the closet in the chapel adjoined to the dining room.</p> <p>6. Review of RN C, F, G, and H's personnel files revealed no nursing orientation checklist: *RN C- Hired on 11/4/13. *RN F- Hired on 1/29/13. *RN G- Hired on 5/20/1995. *RN H- Hired on 6/5/12.</p> <p>Interview on 12/2/14 at 2:30 p.m. with the executive director and the DON regarding the above nurses' orientation training revealed: *She confirmed there was no nurse orientation training in their files. *There used to be a specific nurse orientation form that had been used, but someone had stopped using them consistently. *The nursing department charge nurse skills checklist covered the following areas: -General information. -Emergency policies and procedures. -Miscellaneous policies and procedures. -Charting/medical records. -Taking orders. -Admissions, transfers, discharges, and deaths of patients (residents). -Medication and treatment passes. -Supervisory skills. -Nursing skill checklist. -Information for RNs only.</p> <p>7. Review of the list of residents on mechanically soft diets provided to the surveyors by the CDM revealed residents 10, 11, 12, and 13 were identified as being on mechanically soft diets.</p>	F 224			

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F 224	Continued From page 12 Interview on 12/3/14 at 9:30 a.m. with the dietitian and the CDM regarding the above residents revealed they felt the above residents were receiving the appropriate foods after resident 1's choking incident. Thus they had not evaluated the above resident's diets.  Interview on 12/3/14 at 10:30 a.m. with the executive director regarding the above revealed: *Residents 10, 11, 12, and 13 should have been evaluated after resident 1's choking episode to make sure they were receiving the appropriate foods for their diet. *If there were any deviations or resident requests a negotiated risk form should have been completed with the resident. The negotiated risk form would include the risks of not following the mechanical soft diet with the resident and/or family.  Review of the provider's 2012 Abuse and Neglect policy revealed "Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."	F 224			
F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE  The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, record review, interview,	F 250			

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F 250	<p>Continued From page 13 and job description, the provider failed to ensure medically related social services were provided for two of two sampled residents (2 and 7). Findings include:</p> <p>1. Review of resident 2's medical record revealed:            *An admission date of 9/23/14.            *Diagnoses included revision of gastric bypass (surgical procedure to treat obesity) on 8/27/14, insulin dependent diabetic (unstable blood sugar levels), insomnia (difficulty sleeping), esophageal reflux (backup of stomach contents), acute pain, and morbid obesity.            *She had been admitted for strengthening through therapies with the goal to return home.            *Prior to admission she had lived at home with her daughter.            *She had been emergency admitted to another facility on 10/23/14 for thoughts of committing suicide (ending ones life).            *On 10/27/14 she was readmitted to the facility with the following additional diagnoses of addiction (compulsiveness to seek and take substances that are harmful to oneself), depression (sadness), and anxiety (nervousness).</p> <p>Review of resident 2's progress notes from 9/23/14 through 12/2/14 revealed:            *She was alert, oriented, and capable of making her needs known.            *She required staff to crush her medications, place them in applesauce, and administer them to her.            *She frequently had nausea (upset stomach) and vomiting.            *No social services or nursing interventions and documentation to support the resident:</p>	F 250	<p>F250            The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusion set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:            1. Resident #2 has discharged to an Assisted Living on 12/1/14. Follow up on December 9<sup>th</sup> revealed she is doing well. Resident #7 began coming to the main dining room on 12/5/14 which is being monitoring for effectiveness. Resident #7 was re-assessed for elopement risk on 12/19/14 and the care plan was updated on 12/19/14.</p>	

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F 250	<p>Continued From page 14</p> <ul style="list-style-type: none"> <li>-Had known what her medications were for and if she was capable of safely administering them on her own.</li> <li>-Was able to safely check her blood sugar levels and administer her insulin (stabilizes blood sugar levels in the body).</li> <li>-Had been independently administering her medications at home.</li> <li>-Understood her diet restrictions.</li> </ul> <p>*On 10/22/14:</p> <ul style="list-style-type: none"> <li>-Social services had interviewed the resident who became upset and stated she had suicidal thoughts.</li> <li>-She had been placed on suicidal watch per facility protocol.</li> </ul> <p>*On 10/23/14:</p> <ul style="list-style-type: none"> <li>-The interdisciplinary team met with the resident and her family to discuss possible discharge in the near future to independent living with possible outside services to assist her.</li> <li>-The family voiced concerns regarding the resident continuing to have suicidal thoughts and felt she should be evaluated.</li> <li>-The discharge planning was placed on hold.</li> </ul> <p>*On 10/24/14:</p> <ul style="list-style-type: none"> <li>-The resident went for a psychological (mental) evaluation.</li> <li>-Returned later in the day with the additional diagnoses of addiction, depression, and anxiety.</li> </ul> <p>The above progress notes had no documentation to support the following:</p> <ul style="list-style-type: none"> <li>-The resident had suicidal or mental instability prior to 10/22/14.</li> <li>-The provider had fully investigated the resident's health background and capabilities at home prior to 10/22/14.</li> <li>-The resident had been informed that she was not able to return home with family prior to</li> </ul>	F 250	<p>2. All residents eating on second and third level were re-assessed for dining placement on 12/19/14. All resident medical records were reviewed to assure discharge potential and discharge planning is documented by 12/22/14.</p> <p>3. Discharge planning guidelines were reviewed/ revised and then implemented on 12/22/14. Social Services Coordinator to complete a resident review summary quarterly and with a significant change of condition effective 12/19/14 regarding resident status. Re-education regarding discharge planning and a job description was reviewed with the Social Services Coordinator on 12/23/14.</p> <p>4. The Administrator will audit two resident's per week for discharge planning including discharge potential for one month and then one resident per week for two months. The Administrator will audit two resident records for Social Services summaries completed</p>		

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F 250	<p>Continued From page 15 10/23/14.</p> <p>-She had been appropriate for independent living. *After 10/27/14 the local ombudsman (resident representative) had become involved with the provider in assisting the resident in finding appropriate placement in an assisted living environment.</p> <p>Review of resident 2's 10/16/14 care conference summary sheet revealed: *Discharge plan: "Plans unknown." *Long term goal: "Unknown at this time."</p> <p>Review of resident 2's 10/27/14 care plan revealed no documentation to support any discharge planning had occurred prior to that date.</p> <p>Interview on 12/2/14 at 4:50 p.m. with the director of nursing (DON) and administrator revealed: *The administrator had assisted the resident with her admission paperwork. *Upon admission the resident had informed the administrator she wanted the staff to administer her medications. The administrator stated "She had wanted a break from all of that." *The goal was for her to gain strength with therapies and return home with family. *Both the DON and administrator: -Could not provide documentation to support any discharge planning had been initiated prior to the meeting on 10/23/14. -Could not provide documentation to support a full investigation had been done with the resident, family, and primary physician regarding her health history prior to admission. *The provider did not have a good discharge policy in place.</p>	F 250	<p>quarterly or with a significant change of condition per week for one month and then one resident record per week for two months. The data collected will be presented to the Quarterly Quality Assurance committee by the Administrator. It will be reviewed/discussed and at this time the QA committee will make the decision/recommendation regarding follow-up or changes.</p>	1-1-15	

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F 250	<p>Continued From page 16</p> <p>Interview on 12/3/14 at 2:50 p.m. with the social worker regarding resident 2 revealed: *They had not documented any discharge planning prior to the meeting on 10/23/14. *She confirmed the care plan should have reflected discharge planning upon admission on 9/23/14. *She confirmed the provider had no discharge plan policy in place.</p> <p>Interview on 12/4/14 at 11:30 a.m. with licensed practical nurse (LPN) A revealed the provider had nothing in place to ensure proper discharge planning occurred with admissions. She had not been involved in any education for resident 2 to ensure appropriate discharge planning occurred.</p> <p>2. Review of resident 7's complete medical record revealed: *An admission date of 11/11/13. *Diagnoses of anxiety, dementia (forgetfulness) with behavioral disturbances, diabetes, and episodic mood disorder (fluctuation of emotions). *Resided on the second floor and remained up there for all meals and most activities. *There had been no formal dining room on the second floor. *She sat alone at a table located in the lounge area for all meals. *She was on a therapeutic diet of ground meat, and required staff to set-up her meal and cue her to eat. *She had visited a psychiatrist (mental health physician) on a routine basis to ensure appropriate medication management. *She had an increase in behaviors upon admission requiring several medication adjustments. Those behaviors had included: -Verbal outbursts.</p>	F 250		

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F 250	<p>Continued From page 17</p> <ul style="list-style-type: none"> <li>-Resistive with care.</li> <li>-Smearing of food and bowel movement on the tables.</li> <li>-Wandering.</li> <li>-Refusal to eat.</li> </ul> <p>Observation on 12/2/14 at 12:10 p.m. of resident 7 revealed she had been resting in bed and refused to eat her lunch.</p> <p>Random observations on 12/3/14 from 8:30 a.m. through 11:15 a.m. of resident 7 revealed:</p> <ul style="list-style-type: none"> <li>*She had been sitting at a table in the lounge area on second floor.</li> <li>*She had been sleeping.</li> <li>*An unidentified staff member had delivered her breakfast tray to her table. He had not attempted to set-up her tray or awaken her.</li> <li>*The DON and certified nursing assistant (CNA) L had been observed attempting to awaken her twice to eat her meal. After each attempt she had fallen back to sleep.</li> <li>*No wandering, loud outbursts, or smearing of food had been observed.</li> </ul> <p>Random observations on 12/3/14 from 2:30 p.m. through 4:30 p.m. of resident 7 revealed:</p> <ul style="list-style-type: none"> <li>*She had been sitting at a table in the lounge area on second floor.</li> <li>*She had been sleeping.</li> <li>*No wandering or loud outbursts had been observed.</li> </ul> <p>Random observations from 12/2/14 through 12/4/14 of resident 7 revealed she had remained on the second floor at all times.</p> <p>Review of resident 7's mood and behavior flow sheet from July through November 2014</p>	F 250		

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F 250	<p>Continued From page 18 revealed:</p> <p>*August 2014 she had exhibited: -Verbal outbursts twenty-six times. -Refusing to eat thirty-six times. -Wandering sixteen times.</p> <p>*September 2014 she had exhibited: -Verbal outbursts thirty-two times. -Refusing to eat forty-five times. -Wandering twelve times.</p> <p>*October 2014 she had exhibited: -Verbal outbursts six times. -Smearing of food and spitting forty-seven times. -Refusing to eat forty-eight times. -Wandering four times.</p> <p>*November 2014 she had exhibited: -Verbal outbursts and spitting forty-seven times. -Refusing to eat forty-two times. -Wandering five times.</p> <p>Review of resident 7's 11/5/14 care plan revealed: *She had been an elopement risk due to her history of wandering and pacing. *She was to have been "attended" by staff upon leaving the second floor. *Nothing that she was to have remained on the second floor for meals. *No documentation to support the resident's behaviors would have worsened upon leaving the second floor.</p> <p>Interview on 12/3/14 at 10:20 a.m. with registered nurse (RN) B regarding resident 7 revealed: *She had a history of the above mentioned behaviors with an increase in agitation. *In the past she had exhibited an increase in agitation upon going downstairs. During those times she would have required one-on-one supervision for her safety. *She could not recollect the last time the staff had</p>	F 250		

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F 250	<p>Continued From page 19</p> <p>attempted to take her downstairs for a meal or activity.</p> <p>*She confirmed the resident's behaviors had not improved by having her remain on the second floor at all times.</p> <p>*She had a history of wandering but not exit seeking.</p> <p>Review of resident 7's progress notes from 6/18/14 through 12/2/14 revealed no documentation to support:</p> <p>*Her behaviors had improved upon having her remain on the second floor at all times.</p> <p>*Her behaviors had worsened when and if she had been taken to a different floor.</p> <p>*If the staff had attempted to take her back downstairs for meals.</p> <p>Interview on 12/4/14 at 5:00 p.m. with social services, the dietary manager, and the dietician regarding resident 7 revealed:</p> <p>*They had been aware that resident 7 remained on the second floor at all times.</p> <p>*They had no documentation to support:</p> <p>-Her behaviors had improved by having her remain on the second floor.</p> <p>-Social services had been involved in ensuring she had to remain upstairs for all meals.</p> <p>*They could not remember the last time the staff had attempted to take her downstairs for meals.</p> <p>*She had been placed on the nutrition at risk list for supplementation due to her increase in weight loss.</p> <p>*The dietician stated "We have become complacent with her."</p> <p>Review of the provider's undated Social Services Coordinator job description revealed:</p> <p>***Identify and provide for each resident's social,</p>	F 250			

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F 250	Continued From page 20 emotional, and psychological needs and the continuing development of the resident's full potential during his/her stay at the facility and to assist in the planning for his/her discharge." **"Develop a social history, social assessment and care plan which identifies pertinent problems and needs, realistic goals to be accomplished and the specific action to be taken in resolution of the problems and/or needs upon admission of each new resident." **"Document progress notes which relate to each resident's care plan when necessary and within policy timeframes."	F 250			
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280			

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F 280	<p>Continued From page 21</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355</p> <p>Based on record review, interview, and policy review, the provider failed to ensure 5 of 9 sampled residents' (2, 4, 5, 8, and 9) care plans were reviewed and revised as changes in care needs occurred. Findings include:</p> <p>1. Review of resident 2's medical record revealed: *An admission date of 9/23/14. *Diagnoses included a revision of gastric bypass (surgical procedure to treat obesity) on 8/27/14, insulin dependent diabetic (unstable blood sugar levels), insomnia (difficulty sleeping), esophageal reflux (backup of stomach contents), acute pain, and morbid obesity. *She had been admitted for strengthening through therapies with the goal to return home. *She had lived at home with her daughter prior to the admission. *She had been emergency admitted to another facility on 10/24/14 for thoughts of committing suicide (ending ones life). *On 10/27/14 she was readmitted to the facility with the following additional diagnoses of addiction (compulsiveness to seek and take substances that are harmful to oneself), depression (sadness), and anxiety (nervousness). *She had taken the medication Hydromorphone 12 milligrams (mg) every 4 hours for pain.</p> <p>Review of resident 2's 10/27/14 care plan revealed no documentation to support any discharge planning had occurred prior to that date.</p>	F 280	<p>F280</p> <p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:</p> <p>1. Resident #2 has been discharged. Resident #8's care plan was reviewed/revised on 12/19/14 and includes non-pharmacologic interventions for pain. Resident #9's care plan was reviewed/revised on 12/15/14 and includes non-pharmacologic interventions for pain. Resident #4's care plan was reviewed/revised on 12/18/14 and included a trial scheduled toileting plan after a three day B&amp;B had been completed on 12/16/14 based on that assessment the care plan was revised to reflect current status and toileting</p>	
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F 280	<p>Continued From page 22</p> <p>Interview on 12/3/14 at 2:50 p.m. with the social worker regarding resident 2 revealed: *The care plan should have reflected discharge planning upon admission on 9/23/14. *The provider had no discharge plan policy in place.</p> <p>2. Review of resident 2's 9/29/14 admission Minimum Data Set (MDS) assessment for section J (pain management) revealed she had: *Received pain medications during the assessment period. *Not received any non-medication interventions for pain.</p> <p>Review of resident 2's 10/20/14 thirty day MDS assessment for section J revealed the same the as above.</p> <p>Review of resident 2's 11/3/14 significant change MDS assessment for section J revealed the same as the above.</p> <p>Review of resident 2's 10/27/14 care plan revealed she had a focus area for pain management. No non-medication interventions had been listed to assist her with further pain management.</p> <p>3. Review of resident 8's medical record revealed: *An admission date of 3/15/10. *Diagnoses of dementia-Alzheimer's type (memory loss) and arthritis (swelling, pain, and inflammation of the joints). *She had: -Been dependent upon staff to meet all of her activities of daily living (ADL). -Contractures (restricted movement in arms and</p>	F 280	<p><del>plan. In addition, oxygen</del> needs and lower extremity edema and assistance with TED hose. Resident #5's care plan was reviewed/ revised on 12/19/14 and includes a trial scheduled toileting plan after a three day B&amp;B had been completed on 12/16/14 based on that assessment the care plan was revised to reflect current status and toileting plan. In addition the care plan has been revised to include non pharmacologic interventions for pain.</p> <p>2. Care plans have been reviewed/ revised to reflect specific direction to staff and identify current needs. Residents will be monitored for effectiveness of non pharmacologic interventions for pain, plans for maintaining/managing continence/incontinence, oxygen use and edema, which shall be documented in the medical record.</p> <p>3. The MDS Consultant provided re-education to the IDT team on care planning. The MDS Coordinators have been re-educated to the expectation of accurate comprehensive assessments including care plans reflecting individual</p>	

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F 280	<p>Continued From page 23</p> <p>legs) to both arms and legs. -Taken Tramadol 100 mg at bedtime and Acetaminophen 650 mg twice a day for pain management.</p> <p>Review of resident 8's 11/18/14 annual MDS assessment for section J revealed she had: *Received pain medications during the assessment period. *Not received any non-medication interventions for pain.</p> <p>Review of resident 8's 11/19/14 care plan revealed she had a focus area for pain management. No non-medication interventions had been listed to assist her with further pain management.</p> <p>4. Review of resident 9's medical record revealed: *An admission date of 12/5/13. *Diagnoses of arthritis, osteoporosis (brittle bones), and generalized pain. *She had a decrease in range of motion (movement) to both arms and legs. *She had required extensive assistance of one or two staff members to assist her with ADLs.</p> <p>Review of resident 9's 11/18/14 annual assessment for section J revealed she had: *Received pain medications during the assessment period. *Not received any non-medication interventions for pain.</p> <p>Review of resident 9's 11/19/14 care plan revealed she had a focus area for pain management. No non-medication interventions had been listed to assist her with further pain</p>	F 280	<p>needs with specific direction to staff through assignment sheets.</p> <p>4. The DNS or designee will audit three care plans for non-pharmacologic interventions for pain, plans for maintaining/managing continence/incontinence, oxygen use and edema, per week for one month, then two care plans per week for two months including assignment sheets. The data collected will be presented to the Quarterly Quality Assurance committee by the DNS. It will be reviewed/discussed and at this time the QA committee will make the decision/recommendation regarding follow-up or changes.</p>	1-1-15

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F 280	<p>Continued From page 24 management.</p> <p>Interview on 12/8/14 at 4:20 p.m. with registered nurse A revealed there had been no non-medication interventions in place for residents besides air mattresses or gel cushions in wheelchairs.</p> <p>Interview on 12/8/14 at 6:20 p.m. with the director of nursing confirmed she would have expected to find non-medication interventions on the resident's care plans.</p> <p>Surveyor: 22452 4. Review of resident 4's 11/12/14 transfer form revealed: *An 11/12/14 admission date from an acute care hospital. *Admission diagnoses included: pneumonia, congestive heart failure, lung/breathing problems. *She was to be on oxygen (O2) 2 liters continuously. *She was alert and anxious. *She had edema (swelling) in her lower extremities (legs).</p> <p>Review of resident 4's 11/12/14 through 11/14/14 three day bowel and bladder monitoring assessment completed by the certified nursing assistants (CNA) revealed she: *Was coded as dry (continent of bladder) seventy times out of seventy-two times. *Was coded as most of pad (adult incontinent brief) wet two times out of seventy-two times. *Was not coded for any bowel movements (unable to determine if she was continent or incontinent of bowels).</p>	F 280			

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F 280	<p>Continued From page 25</p> <p>Review of resident 4's 11/12/14 through 12/3/14 nurses' notes revealed:</p> <p>*11/12/14- "Requested to use bathroom as soon as she arrived. Garbled speech."</p> <p>*11/16/14- "Difficulty making needs clear. Intermittent confusion and at times garbled speech. Refuses to leave O2 on. O2 saturations (level of O2 in blood) drop when O2 off. Places O2 canula on her head or on her chin."</p> <p>*11/19/14- "Used call light for assistance two times during the night. Incontinent of urine once. Does not always leave O2 canula on."</p> <p>*11/21/14- "Incontinent of urine. Orders received for knee high ted hose."</p> <p>*11/27/14- "Incontinent of urine."</p> <p>*11/30/14- "Resident denying being in need of toilet. Then incontinent of urine."</p> <p>*12/2/14- "Incontinent of urine."</p> <p>Review of resident 4's 11/12/14 care plan revealed there was no documentation regarding:</p> <p>*Toilet assistance or plan to maintain urine continence. There was only documentation "brief" and "incontinent."</p> <p>*The need for O2 or the resident's frequent removal of the O2 cannula.</p> <p>*Her confusion, garbled speech, or anxiety.</p> <p>*Her lower extremity edema and the need for staff assistance with Ted hose (support hose for legs).</p> <p>5. Review of resident 5's 11/21/14 physician's admission orders revealed:</p> <p>*He was admitted from a home setting on 11/24/14.</p> <p>*Admission diagnoses included severe dementia (memory loss), kidney mass, prostate cancer, weakness, urinary incontinence, chronic kidney disease stage III.</p> <p>*He was on Tramadol (narcotic) pain medication</p>	F 280			

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F 280	<p>Continued From page 26 daily and Tylenol twice a day.</p> <p>Review of resident 5's 11/24/14 through 11/26/14 three day bowel and bladder monitoring assessment completed by the CNAs revealed he: *Was coded as "dry" fifty-eight times out of seventy-two times. *Was coded as "slightly wet" thirteen times out of seventy-two times. *Was coded as "most of pad wet" one time out of seventy-two times. *Was coded as "clothes wet" one time out of seventy-two times. *Was not coded for any bowel movements.</p> <p>Review of resident 5's 11/24/14 through 12/8/14 nurses' notes revealed: *11/25/14- "Was awake during the night. Would get up and walked with walker looking for bathroom. Did not always have walker correctly in front of him. Incontinent of urine." *11/26/14- "Asking where to get to the bathroom. At times pushes walker backwards. Was extremely combative with CNAs during a.m. cares. Hit, kicked, and swore at staff. Especially annoyed with the use of the gait belt." *11/27/14- "Did get up and ambulate with walker into another resident's room. Was incontinent of urine." *11/28/14- "Found on floor in room. Attempted self-transfer and fell. Call bell given to resident and instructed on use." *11/29/14- "Cries out at times. Was incontinent of urine." *12/5/14- "Needed to be guided out of others rooms. Does voice a repetitive hum when awake almost moan like. Found on floor at 9:35 p.m. 0.5 centimeter bruise noted to right elbow. Found on floor at 11:35 p.m. beside his bed."</p>	F 280		

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F 280	Continued From page 27 *12/7/14- "Appetite is poor. Does like eating cheerios cereal in milk."  Review of resident 5's 11/24/14 care plan revealed there was no documentation regarding: *Toilet assistance or plan to maintain continence. There was documentation by bladder "incontinent and brief." *No non-pharmalogical approaches to pain. There was documentation "pain all over most days."  6. Interview on 13/4/14 at 10:00 a.m. with licensed practical nurse A regarding residents 4 and 5 revealed: *A specific toileting plan should have been documented on their care plan to maintain as much continence as possible. *All residents were usually assisted with toileting before and after meals and at bedtime. *All nurses were responsible to keep residents' care plans updated and current.  7. Review of the provider's 4/7/12 Care Planning policy revealed: **"The interdisciplinary team and professional nursing staff are responsible for the development of an individualized comprehensive care plan including updates for each resident." **"Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition changes." **"Resident's care plans will reflect the resident's current condition and interventions." **"Care plans are to be updated /reviewed as changes occur and quarterly."	F 280			
F 309 SS=H	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309			

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F 309	Continued From page 28  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, interview, and policy review, the provider failed to ensure: *One of one sampled resident (4) with an acute respiratory incident received the necessary care and services in a timely manner. *Three of six sampled residents (2, 5, and 8) received adequate pain control. *One of one sampled resident (5) with multiple falls was thoroughly assessed for safety. *One of one sampled resident (7) with behaviors was monitored, evaluated, assessed, and documented on for the appropriate environment during meals. Findings include:  1. Observation and interview on 12/2/14 at 11:00 a.m. of resident 4 revealed: *She was lying in bed. The head of her bed was elevated approximately 45 degrees. *Her body was sunk down in the bed with her feet touching the footboard. *Her oxygen (O2) nasal cannula was up on her forehead. The O2 concentrator was running at 2 liters. *Her window was cracked with cold air blowing in. *She had a frequent congested cough.	F 309	F309 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusion set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. Resident #4 asks overnight staff to open her window at times; this was added to the care plan on 12/10/14. Resident #4 frequently removes her oxygen nasal cannula. Her care plan was updated on 12/18/14 to include this behavior and lists interventions. Resident #4's nebulizer time was changed. Physical therapy assistant M was re-educated on notifying		

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F 309	<p>Continued From page 29</p> <p>*She said she did not feel well and could not get her breath.</p> <p>*She was not sure who opened her window, but she had asked someone as she could not breathe.</p> <p>Review of resident 4's December 2014 medication administration record revealed:</p> <p>*She should have received an Albuterol inhalation (medication for asthma or chronic obstructive pulmonary disease) at 8:00 a.m.</p> <p>*There was no documentation the medication had been administered at 8:00 a.m.</p> <p>*She should have been on O2 at 2 liters continuously for pneumonia and breathing problems.</p> <p>Interview on 12/2/14 at 11:05 a.m. with registered nurse (RN) F regarding resident 4 revealed she:</p> <p>*Was not aware she was having increased trouble breathing this morning. Whoever opened the window in her room for her had not told her.</p> <p>*Did not know the resident well. She only worked on an as needed (PRN) basis.</p> <p>*Had not given her the 8:00 a.m. Albuterol inhalation yet as she was running behind.</p> <p>*Confirmed the resident often would pull off her O2 canula due to her memory loss.</p> <p>*Was not aware who had opened the window. The four CNAs on the floor had denied opening the window or putting her in bed after breakfast.</p> <p>Observation on 12/2/14 at 11:10 a.m. of resident 4 revealed RN F:</p> <p>*Checked her O2 saturation (amount of O2 in the blood). Her O2 saturation was 76 percent (%) to 78% (normal is greater than 90%).</p> <p>*Put her O2 nasal canula back in her nose with the O2 running at 2 liters. Her O2 saturation was</p>	F 309	<p>the nurse if a resident is short of breath on 12/2/14.</p> <p>Resident #5 was reassessed for pain and is currently using a Fentanyl Patch and is being monitored. Resident #5's care plan was updated on 12/19/14 to include non-pharmacologic pain interventions, behaviors, falls and fall interventions. Resident #2 has been discharged. Resident #8 was reassessed for pain and the care plan was reviewed/revised on 12/19/14 to include non-pharmacologic. Resident continues to receive pain medication and is being monitored. Resident #7 began coming to the main dining room on 12/5/14 which we are monitoring for effectiveness. Resident #7 was re-assessed for elopement risk on 12/19/14 and the care plan was updated on 12/19/14 to reflect these areas.</p> <p>2. All resident charts were reviewed for oxygen use, nebulizer times and non pharmacologic pain</p>	

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NAME OF PROVIDER OR SUPPLIER  <b>VIOLET TSCHETTER MEMORIAL HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350</b>		
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F 309	<p>Continued From page 30 then 92%. *Administered her 8:00 a.m. Albuterol nebulizer treatment. *Lifted the resident up in bed with the assistance of an unidentified certified nursing assistant (CNA). The resident told her she felt much better and was now able to breathe.</p> <p>Interview on 12/2/14 at 11:30 a.m. with physical therapy assistant M regarding resident 4 revealed she: *Had worked with the resident after breakfast doing her exercises. *Had put her in bed after her exercises, but she had not opened the window. *Did not know who had opened the window. *Confirmed the resident had told her she was a little short of breath, but she had not informed RN F of that.</p> <p>2. Observation on 12/3/14 at 5:30 p.m. and on 12/8/14 at 4:15 p.m. of resident 5 revealed he was propelling his wheelchair in the hall calling out in a loud voice "ow, ow, ow."</p> <p>Interview on 12/8/14 at 9:00 a.m. with resident 5 revealed he: *Was in pain all the time. *Rubbed his abdominal area repeatedly when asked where his pain was.</p> <p>Interview on 12/8/14 at 9:15 a.m. with licensed practical nurse (LPN) T regarding resident 5 revealed: *He had refused his Tramadol and Tylenol at 8:00 a.m. *She would offer them again to him with his noon meal.</p>	F 309	<p>interventions. All resident's medication administration records have been reviewed for PRN use pain medication and re-evaluated for routine pain medication, pain assessments completed as needed, physician notified as needed and addressed in care plan. All residents were assessed for discharge potential.</p> <p>3. System changes include education for licensed nurses on respiratory therapy, expectation of accurate comprehensive assessments including MAR review of pain medications used, effectiveness, need for physician notification, and care planning of pain and non pharmacologic interventions.</p> <p>4. DNS and/or designee will audit two MDS assessments weekly for one month and then one MDS assessment for two months for accuracy regarding pain assessment, documentation in care plan and interventions including oxygen and nebulizer use. The data collected will be</p>		

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F 309	<p>Continued From page 31</p> <p>Review of resident 5's 11/21/14 admission physician's orders revealed: *His prognosis (health outcome) was poor. *Diagnoses included severe dementia (memory loss), kidney mass, chronic renal disease stage III, prostate cancer, and weakness. *He was on Tramadol (narcotic pain medication) every day in the morning and Tylenol twice a day in the morning and the evening.</p> <p>Review of resident 5's 11/24/14 care plan revealed: **"States pain all over most days. None at time of interview." *There were no non-pharmalogical interventions for pain documented. **"Alert (oriented) to self and family only." **"Can get aggressive with cares. Ensure safety and come back at another time."</p> <p>Review of resident 5's 11/24/14 through 11/30/14 behavior flow sheet completed by the CNAs revealed: *Five days of physical (hit, kicked, scratched, grabbed, or made sexual advances to others) behavioral symptoms. *Seven days of verbal (threatened, screamed, or cursed at others) behavioral symptoms. *Seven days of rejection of care. *Six days of wandering (moving from place-to-place with no specific purpose or known direction or regard to safety). *Three days of hallucinations (false perceptions seeing, hearing, tasting, feeling, or smelling something that is not there). *One day of delusions (false beliefs the person is convinced is true).</p> <p>Review of resident 5's 11/24/14 through 12/8/14</p>	F 309	<p>presented to the Quarterly Quality Assurance committee by the DNS. It will be reviewed/discussed and at this time the QA committee will make the decision/recommendation regarding follow-up or changes.</p>	1-1-15

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F 309	Continued From page 32 nurse's notes revealed: *11/24/14- "Upon admission was very nervous and shaking a little. Kept saying he was bad. Was reinforced he was not bad and we were happy he was here and we would take care of him." *11/25/14- "Alert (oriented) but unable to voice needs to staff. Speech is at times garbled." *11/26/14- "Was extremely combative with CNAs during a.m. cares. Especially annoyed with the use of the gait belt. When attempting to ambulate with two staff resident became weak and just buckles his knees. Unable to console or redirect the resident. Resident was weepy and repeated they tried to kill me." *11/28/14- "Found on floor in room at 1:45 a.m. Attempted to transfer and fell. Some swelling to forehead. Tylenol at 6:30 a.m. for vocal complaints of pain. Alert to person only. Irritable with activities of daily living assistance. No complaints of pain at rest at 1:30 p.m." *11/29/14- "States always has a headache. Taking oral Tylenol whole without difficulty." *11/30/14- "No complaints of break-through pain. Reported to staff he wished he could die." *12/2/14- "Bruise top of left forehead. Complaints of pain noted and given Tylenol. When doing his Patient Health Questionnaire [test that identifies severity of depression] staff noted he says his life is not worth living and wishes for death daily. His score is 21 which indicates severe depression. Daughter states he has done that for years. Received order for Zoloft [sertraline] for depression." *12/5/14- "Does voice a repetitive hum when awake almost moan like. Found on floor at 9:30 p.m. Bruise noted to right elbow. Found on the floor at 11:35 p.m. Daughter notified of falls and stated she understood. She was sorry he was	F 309			

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F 309	<p>Continued From page 33 awake so much at night." *12/6/14- "Refused medications (including Tylenol and Tramadol) at breakfast and at lunch." *12/7/14- "Mumbles words and at times is difficult to understand. He then becomes agitated due to frustration. Does make disruptive sounds at mealtime so as needed [PRN] Tylenol offered and declined."</p> <p>Review of resident 5's 11/24/14 care plan revealed: *No documentation regarding the fall on 11/28/14 and the two falls on 12/5/14. *There was no documentation regarding any non-pharmacological interventions for pain control.</p> <p>Review of resident 5's December 2014 medication administration record (MAR) revealed he was to receive: *Melatonin (sleep inducing medication) at bedtime. There was no documentation he had received the Melatonin on 12/5/14 and the medication was circled on 12/6/14 with no explanation. *Tramadol every morning. There was no documentation of his pain level on 12/1/14, and 12/5/14. There was documentation of his pain being between 3 and 7 (on a 1 to 10 scale with 0 being no pain and 10 being severe pain) when the Tramadol was administered to him on the other days. -He had refused his Tramadol on 12/6/14. *Tylenol twice a day. There was no pain rating documented for eight of the fourteen doses. -There was documentation of his pain being between 3 and 7 when the Tylenol had been administered to him for the other doses. -He had refused the Tylenol on 12/6/14 at 8:00</p>	F 309			

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F 309	<p>Continued From page 34 a.m.</p> <p>Interview on 12/8/14 at 10:00 a.m. with LPN A regarding resident 5 revealed:            *He typically did not say "ow, ow, ow, ow."            *His memory was very poor, and he would often say things that did not make sense.            *He had been denying pain when he had been questioned.            *She agreed due to his severe dementia and depression he might not be able to identify when he was actually having pain.            *They had not let the physician know he was not consistently taking his pain medications.            *They had not been consistently filling in the area on the MAR where they should have been documenting his pain control.</p> <p>Interview on 12/8/14 at 11:00 a.m. with the director of nurses regarding resident 5 revealed they:            *Had attributed his falls due to his need for wandering.            *Had not really looked at his medications being a potential cause of his frequent behaviors, depressed mood, or falls.            *Were unsure how long he had been on Melatonin at bedtime to help his restless and sleep. It had not appeared to help since his admission.            *Thought his behaviors were more related to his dementia instead of the potential his pain was not controlled.            Refer to F428, finding 1.</p> <p>Surveyor: 32355 3. Review of resident 2's medical record</p>	F 309		
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F 309	<p>Continued From page 35</p> <p>revealed:</p> <ul style="list-style-type: none"> <li>*An admission date of 9/23/14.</li> <li>*Diagnoses included revision of gastric bypass (surgical procedure to treat obesity) on 8/27/14, insulin dependent diabetic (unstable blood sugar levels), insomnia (difficulty sleeping), esophageal reflux (backup of stomach contents), acute pain, and morbid obesity.</li> <li>*She had been admitted for strengthening through therapies with the goal to return home.</li> <li>*Prior to admission she had lived at home with her daughter.</li> <li>*She had been emergency admitted to another facility on 10/23/14 for thoughts of committing suicide (ending ones life).</li> <li>*On 10/24/14 she was readmitted to the facility with the following additional diagnoses of addiction (compulsiveness to seek and take substances that are harmful to oneself), depression (sadness), and anxiety (nervousness).</li> <li>*A physician's order for the following: <ul style="list-style-type: none"> <li>-Hydromorphone (pain medication) 12 milligrams (mg) every four hours for pain.</li> <li>-Lorazepam (antianxiety medication) 1.5 mg every four hours as needed (PRN) for abdominal cramping.</li> </ul> </li> </ul> <p>Review of resident 2's nurse's notes from 9/23/14 through 10/24/14 revealed:</p> <ul style="list-style-type: none"> <li>*On 9/24/14: <ul style="list-style-type: none"> <li>-Received permission from the primary physician to give the Lorazepam every four hours with the pain medication.</li> <li>-The charge nurse had documented "Requested Lorazepam be given every 4 hours. It does help the pain pills work better and does get anxious that the pain meds won't work."</li> </ul> </li> <li>*The resident frequently had:</li> </ul>	F 309			

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F 309	<p>Continued From page 36</p> <ul style="list-style-type: none"> <li>-Taken the Lorazepam with the pain medication to help with abdominal cramping.</li> <li>-Complaints of pain and had rated her pain level at a 6 to 7. Ten would have been the worst pain. Her pain relief had been charted at a level 5.</li> <li>*On 10/7/14: <ul style="list-style-type: none"> <li>-She had reported her pain level above a 10.</li> <li>-The physician had been contacted with a one time order for Toradol (pain medication) 60 mg intramuscular injection to be given. Relief from pain had been provided.</li> </ul> </li> <li>*No documentation to support: <ul style="list-style-type: none"> <li>-The doctor had been notified her pain level was not lower than a 5.</li> <li>-The resident never had good pain relief from her scheduled pain medication and prn Lorazepam.</li> <li>-The resident had never been offered any non-medication interventions to help further relieve her pain.</li> </ul> </li> </ul> <p>Review of resident 2's occupational therapy (OT) notes from 9/23/14 through 10/23/14 revealed:</p> <ul style="list-style-type: none"> <li>*The resident had pain and required rest periods when performing activities of daily living tasks.</li> <li>*The OT had documented her pain level was at a 4 to 5.</li> <li>*No documentation to support the nursing staff had been informed of the resident's complaints of pain during therapy.</li> </ul> <p>Review of resident 2's 9/29/14 11/3/14 Minimum Data Set (MDS) assessments for section J (pain management) revealed she had:</p> <ul style="list-style-type: none"> <li>*Received pain medications during the assessment period.</li> <li>*Not received any non-medication interventions for pain.</li> <li>*Rated her pain level from a level 7 to a 9.</li> <li>*Pain which had interfered with sleep at night and</li> </ul>	F 309			

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F 309	<p>Continued From page 37 day-to-day activities. *Three out of the four assessments revealed she constantly had pain.</p> <p>Review of resident 2's Care Area Assessment charting for the above MDS assessments revealed: *The resident had been content with a pain level of a 4 or 5. *No documentation to support any non-medication interventions had been discussed or attempted for further pain relief. *No documentation to support the physician or family had been notified of the continual complaints of pain and inconsistent relief from her current pain medication regimen.</p> <p>Review of resident 2's 10/27/14 care plan revealed she had a focus area for pain management. No non-medication interventions had been listed to assist her with further pain management.</p> <p>Review of resident 2's 10/24/14 admission note to the hospital revealed she had reported her pain level at a 15.</p> <p>Interview on 12/4/14 at 11:40 a.m. with licensed practical nurse (LPN) A revealed "I felt that the resident's pain was adequately controlled. Her issues were her mental health and family."</p> <p>3. Review of resident 8's medical record revealed: *An admission date of 3/15/10. *Diagnoses of dementia-Alzheimer's type (memory loss) and arthritis (swelling, pain, and inflammation of the joints). *She had:</p>	F 309		
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F 309	<p>Continued From page 38</p> <ul style="list-style-type: none"> <li>-Been dependent upon staff to meet all of her activities of daily living (ADL).</li> <li>-Contractures (restricted movement in arms and legs) to both arms and legs.</li> <li>-Taken Tramadol 100 mg at bedtime and acetaminophen 650 mg twice a day for pain management.</li> <li>-Difficulties communicating with the staff. The staff would have had to anticipate her needs.</li> <li>-A Foley catheter (tube to drain urine from the bladder).</li> <li>-Participated in restorative activities for range of motion to her legs and arms six to seven times a week.</li> </ul> <p>Review of resident 8's 11/18/14 annual MDS assessment of section J revealed she had: *Received pain medications during the assessment period. *Not received any non-medication interventions for pain.</p> <p>Review of resident 8's 11/19/14 care plan revealed she had a focus area for pain management. No non-medication interventions had been listed to assist her with further pain management.</p> <p>Interview on 12/8/14 at 12:35 p.m. with registered nurse (RN) D regarding resident 8 revealed: *The RN had been responsible for the pain interviews. *She had been on the above medications for pain a long time. *RN D had no concerns with the staff interview results and that the current pain medications were not effective. *Her Foiey catheter had required changing every month.</p>	F 309		

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F 309	<p>Continued From page 39</p> <p>*Her legs had to be pulled apart by the staff when changing the catheter. She would laugh/giggle during that procedure.</p> <p>*RN D could not confirm the laughing/giggling had not been a sign of pain.</p> <p>*Resident 8 had not shown any signs of pain when resting. She would only become vocal with any type of movement.</p> <p>*The son had been very involved with resident 8's medication and care. He had not wanted her to have any further pain medication or change.</p> <p>*She had no documentation to support the above conversation with the resident's son occurred.</p> <p>*She would have informed the family or physician if she any concerns regarding ineffective pain management.</p> <p>Review of resident 8's 11/17/14 pain note by RN D revealed: **[resident name] had a pain assessment completed." **"Resident is not able to communicate pain verbally." **"No complaints of pain at rest." **"No complaints of pain with movement." **"Pain is not precipitated from activity, cares, and treatment." **"Is unable to express complaints of pain." **"[resident name] is on scheduled medications for pain control and has not received any prn medications for breakthrough pain during the look back period." **"According to staff, she does grimace when arms are moved but staff is unsure if this is pain related or not." **"Refer to pain assessment for full details."</p> <p>Review of resident 8's Care Conference Summary Sheets dated 6/4/14, 9/4/14, and</p>	F 309			

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F 309	<p>Continued From page 40</p> <p>12/4/14 revealed: *On 6/4/14 and 9/4/14 the son had been present for the meetings. *The conference note for all three meetings revealed "No concerns at this time." *No documentation to support pain management for the resident had been reviewed.</p> <p>Review of resident 8's 11/13/14 restorative nursing evaluation revealed: *Body control problems documented as rigid (stiff). *Evaluation of restorative care, "Resident identifies some pain during passive range of motion (PROM). Contractures seem to be worsening. Will continue with current program and re-evaluate next month."</p> <p>Observation of resident 8 on 12/8/14 at 3:56 p.m. revealed: *Her appearance was thin and frail. *Her arms had been bent, crossed over each other, and rested on her chest. *Her left leg crossed over the right leg. She had a round pressure relieving cushion on her left leg. *No vocalization with this surveyor with attempt to visit with her.</p> <p>Interview on 12/8/14 at 4:00 p.m. with certified nursing assistants (CNA) P and Q regarding resident 8 revealed: *She had: -Been dependent upon the staff to meet all of her ADL needs. -Very little communication with the staff. She would occasionally laugh or attempt to repeat what they said. -Frequently yelled or grimaced with personal care and dressing.</p>	F 309		
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F 309	<p>Continued From page 41</p> <p>-Her arms and legs were stiff and hard to move with personal care and dressing.</p> <p>-Had been more vocal when moving her arms when dressing her. All of her shirts had to be pulled over her head.</p> <p>-Yelled out or grimaced when placing the sling underneath of her to assist with her transferring.</p> <p>-Grimaced with leg movement by the staff to assist her with personal care and dressing.</p> <p>Review of resident 8's nurses notes from July 2014 through December 2014 revealed no documentation to support the resident had been monitored for increase of pain with care, treatments, and movement.</p> <p>Interview on 12/8/14 at 4:20 p.m. with LPN A regarding resident 8 revealed:</p> <p>*She had been on the current pain medications for three years.</p> <p>*She had not shown any signs and symptoms of pain at rest.</p> <p>*She had grimaced, giggled, or yelled out when changing her Foley catheter.</p> <p>*If the resident had shown any signs of pain she would have been able to tell.</p> <p>*Her son was very involved with her care and would have voiced concerns if her pain was not controlled.</p> <p>*The only non-medication intervention the resident had in place was an air-flow mattress and a gel cushion in her wheelchair.</p> <p>*LPN A had not been aware of any pain issues or increase in contractures observed with restorative care. She should have been informed of that.</p> <p>Multiple interviews from 12/2/14 through 12/4/14 with the DON revealed:</p> <p>*The staff were to have monitored the residents</p>	F 309		
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F 309	<p>Continued From page 42 for pain on an on-going basis. *At the first request for the provider's pain policy she had stated "We have no pain policy. Pain is monitored as an on-going basis." *On 12/3/14 she had been able to provide a pain policy. *The staff had not been following the provider's pain policy.</p> <p>Review of the provider's undated Pain Management guidelines revealed: *Purpose: "To provide guidelines for consistent assessment, management and documentation of pain in order to provide maximum comfort and enhanced quality of life." *Guidelines: "Functions of appropriate pain management include, but are not limited to:" -"Identify and treat underlying causes of pain if possible." -"Recognizing and reporting pain as a 5th vital sign." -"Assessing pain and evaluating response to pain management interventions using a pain management scale based on resident self-repot or objective assessment for the cognitively impaired." -"Intervening to treat pain before the pain becomes severe." -"Using non-drug interventions to assist in pain management." -"Documenting pain assessment, intervention, and evaluation activities in a clear and concise manner per the plan of care." **"Pain management to be addressed at each individual's care conference." *Assessment: "Behavioral indicators include cues foe nurse can see or hear such as frowns, grimacing, guarding, groaning, moaning, and crying. The numeric score for the behavioral</p>	F 309			

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F 309	<p>Continued From page 43</p> <p>indicators is totaled to derive the overall pain rating. This numeric score is then compared to the numeric pain rating scale to determine their actual level of pain." *A list of several non-medication interventions to assist with relieving pain.</p> <p>4. Review of resident 7's complete medical record revealed: *An admission date of 11/11/13. *Diagnoses of anxiety, dementia (forgetfulness) with behavioral disturbances, diabetes, and episodic mood disorder (fluctuation of emotions). *Resided on second the floor and remained up there for all meals and most activities. *She was on a therapeutic diet of ground meat, and required staff to set-up her meal and cue her to eat. *She had visited a psychiatrist (mental health physician) on a routine bases to ensure appropriate medication management. *She had an increase in behaviors upon admission requiring several medication adjustments. Those behaviors had included: -Verbal outbursts. -Resistive with care. -Smearing of food and bowel movement on the tables. -Wandering. -Refusal to eat.</p> <p>Observation on 12/2/14 at 12:10 p.m. of resident 7 revealed she had been resting in bed and refusing to eat her lunch.</p> <p>Random observations on 12/3/14 from 8:30 a.m. through 11:15 a.m. revealed: *She had been sitting at a table in the lounge area on second floor.</p>	F 309		

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F 309	<p>Continued From page 44</p> <p>*She had been sleeping.</p> <p>*An unidentified staff member had delivered her breakfast tray to her table. He had not attempted to set-up her tray, awaken her, or notify the staff that her tray had arrived.</p> <p>*The DON and certified nursing assistant (CNA) L had been observed attempting to awaken her twice to eat her meal. After each attempt she had fallen back to sleep.</p> <p>*Neither the DON or CNA L had:</p> <ul style="list-style-type: none"> <li>-Opened her cereal, placed it in her bowl, and prepared it for eating.</li> <li>-Sat down with the resident to cue or attempt to assist her with eating.</li> </ul> <p>*Her banana had been opened and placed on the table in front of her.</p> <p>*She had drank 3/4 of a glass of milk. No other part of her meal had been consumed.</p> <p>*No wandering, loud outbursts, spitting, or smearing of food had been observed.</p> <p>Interview on 12/3/14 at the time of the observation with the DON revealed:</p> <p>*The resident had been:</p> <ul style="list-style-type: none"> <li>-Resistive to any type of assistance with eating stating "if she didn't want to eat, she didn't."</li> <li>-A poor eater and liked her cereal and milk.</li> </ul> <p>Random observations on 12/3/14 from 2:30 p.m. through 4:30 p.m. of resident 7 revealed:</p> <ul style="list-style-type: none"> <li>*She had been sitting at a table in the lounge area on second floor.</li> <li>*She had been sleeping.</li> <li>*No wandering or loud outbursts had been observed.</li> </ul> <p>Random observations from 12/2/14 through 12/4/14 of resident 7 revealed she had remained on the second floor at all times.</p>	F 309			

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F 309	<p>Continued From page 45</p> <p>Review of resident 7's mood and behavior flow sheet from July through November 2014 revealed:</p> <p>*August 2014 she had exhibited: -Verbal outbursts twenty-six times. -Refusing to eat thirty-six times. -Wandering sixteen times.</p> <p>*September 2014 she had exhibited: -Verbal outbursts thirty-two times. -Refusing to eat forty-five times. -Wandering twelve times.</p> <p>*October 2014 she had exhibited: -Verbal outbursts six times. -Smearing of food and spitting forty-seven times. -Refusing to eat forty-eight times. -Wandering four times.</p> <p>*November 2014 she had exhibited: -Verbal outbursts and spitting forty-seven times. -Refusing to eat forty-two times. -Wandering five times.</p> <p>Review of resident 7's 11/5/14 care plan revealed: *She had been an elopement risk due to her history of wandering and pacing. *She was to have been "attended" by staff upon leaving the second floor. *Nothing that she was to have remained on the second floor for meals. *No documentation to support the resident's behaviors would have worsened upon leaving the second floor.</p> <p>Interview on 12/3/14 at 10:20 a.m. with registered nurse (RN) B regarding resident 7 revealed: *She had a history of the above mentioned behaviors with an increase in agitation. *In the past she had exhibited an increase in agitation upon going downstairs. During those</p>	F 309		
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F 309	<p>Continued From page 46</p> <p>times she would have required one-on-one supervision for her safety.</p> <p>*She could not recollect the last time the staff had attempted to take her downstairs for a meal or activity.</p> <p>*She confirmed the resident's behaviors had not improved by having her remain on the second floor at all times.</p> <p>*She had a history of wandering, but not exit seeking.</p> <p>Review of resident 7's progress notes from 6/18/14 through 12/2/14 revealed no documentation to support:</p> <p>*Her behaviors had improved upon having her remain on the second floor at all times.</p> <p>*Her behaviors had worsened when and if she had been taken to a different floor.</p> <p>*If the staff had attempted to take her back downstairs for meals.</p> <p>*Her eating and weight had improved by having her remain on the second floor for all meals.</p> <p>Interview on 12/4/14 at 5:00 p.m. with social services, the dietary manager, and the dietician regarding resident 7 revealed:</p> <p>*They had been aware that resident 7 remained on the second floor at all times.</p> <p>*They had no documentation to support:</p> <p>-Her behaviors had improved by having her remain on the second floor.</p> <p>-Social services had been involved in ensuring she had to remain upstairs for all meals.</p> <p>*They could not remember the last time the staff had attempted to take her downstairs for meals.</p> <p>*She had been placed on the nutrition at risk list for supplementation due to her increase in weight loss.</p> <p>*She was to have had supplements between</p>	F 309		
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F 309	<p>Continued From page 47</p> <p>meals for weight loss.</p> <p>*The staff were to have set-up her meal and assisted her as she allowed.</p> <p>*Her eating and weight had not improved by remaining on the second floor for all meals.</p> <p>*They should have attempted to bring her back downstairs for meals.</p> <p>*She required a more structured and assistive environment for eating due to her therapeutic diet, weight loss, and assistance needed with eating.</p> <p>*The dietician stated "We have become complacent (unconcerned) with her."</p> <p>Review of the provider's 4/19/11 Identifying Residents at Nutritional Risk policy revealed:</p> <p>*Policy: "Residents identified to be at nutritional risk will be placed on the nutrition risk program which will consist of weekly, weights, meal monitoring if necessary, and evaluated for between meal nourishments."</p> <p>*Procedure:</p> <p>- "The Nutritional Professional (Registered Dietician or Dietary Manager) will indicate that the resident is at nutritional risk on the "nutrition tracking form."</p> <p>- "Evaluation of between-meal nourishments/snacks by the Nutritional Professional. Snacks are sent from the main kitchen and offered by nursing staff."</p> <p>- "The Nutrition Professional will review the list of residents at nutritional risk monthly, will update the identification of those residents at risk as needed; and will document in the medical record as appropriate."</p> <p>- "The Nutrition Professional will record the nutritional intake status and progress of the nutritional plan of care in the resident's medical record."</p>	F 309			

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F 309

Continued From page 48

F 309

Review of the provider's undated Dietary Service Manager job description revealed:  
\*Administrative functions:  
-"Review and process diet changes and ensure menus are maintained and followed in accordance with established procedures."  
-"Coordinate dietary services with other departments."

Review of the provider's undated Dietary Administrator job description revealed "Review residents diet information and care plans, discuss with resident, family and other staff as necessary to make appropriate changes."

F 368  
SS=E

Refer to F368, finding 1.  
483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME

F 368

Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.

There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.

The facility must offer snacks at bedtime daily.

When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.

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F 368	Continued From page 49  This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on interview, record review, and policy review, the provider failed to ensure one of two nursing floors (second) received daily supplements to manage weight control, hydration, and wound healing for ten randomly reviewed residents. Findings include:  1. Review of resident 7's 11/22/14 through 12/2/14 supplement intake sheets which included nine other randomly observed residents revealed: *On 11/22/14: -No supplements had been documented as given to all ten of the residents listed on the form. -They were scheduled to have a supplement in the morning, afternoon, and evening. -A handwritten note at the bottom of the page had stated "No opportunity---resident calls and cares." It was initialed by an unidentified staff member. *On 11/23/14: -The form indicated six of the listed residents had not been given a morning supplement. -No supplements had been given to all ten of the residents listed on the form that evening. -A handwritten note at the bottom of the page had stated "Had to stop for resident cares." It was initialed by an unidentified staff member. *On 11/24/14: -No supplements had been documented as given to all ten of the residents for that morning or evening. -No explanation had been provided on the form. *On 11/26/14: -The ten listed residents had no documentation to support they had received a supplement that morning or evening.	F 368	F368 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusion set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. Resident #7 began coming to the main dining room on 12/5/14 and is being monitored for supplement and snack intake. 2. All residents eating on second and third level were re-assessed for appropriate dining placement on 12/19/14. All residents were reviewed for planned supplements and are being monitored for intake.		

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NAME OF PROVIDER OR SUPPLIER  VIOLET TSCHETTER MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 368	<p>Continued From page 50</p> <p>-A handwritten note at the bottom of the page had stated "No opportunity--way behind with resident cares." It was initialed by an unidentified staff member.</p> <p>*On 11/27/14: -The ten listed residents had no documentation to support they had received a supplement that morning.</p> <p>-A handwritten note at the bottom of the page had stated "No opportunity." It was initialed by an unidentified staff member.</p> <p>*On 11/28/14: -No afternoon snack had been documented as given to all ten of the listed residents. -No explanation had been provided on the form.</p> <p>*On 11/29/14: -No morning, afternoon, or evening supplement had been documented as given to all ten of the listed residents.</p> <p>-A handwritten note at the bottom of the page had stated "No opportunity." It was initialed by an unidentified staff member.</p> <p>Interview on 12/4/14 at 10:05 a.m. with the director of nursing revealed she: *Had not been aware supplements were not consistently given to the residents. *The charge nurses were responsible to ensure all supplements had been given. *The dietary manager had been responsible for reviewing the forms to ensure all supplements were given. *Those ten residents had been a part of the nutrition at risk list. Those residents were at risk for weight loss, dehydration, or needed a supplement to assist with wound healing.</p> <p>Interview on 12/4/14 at 10:45 a.m. with licensed practical nurse A confirmed the charge nurse was</p>	F 368	<p>3. System change includes the revision of new supplement and snack documentation forms. Re-education was provided on the supplement and snack guidelines to all staff serving snacks.</p> <p>4. The DNS and/or designee will audit supplement and snack documentation forms three times per week for one month and then two times per week for two months for completion and accuracy. The data collected will be presented to the Quarterly Quality Assurance committee by the DNS. It will be reviewed/discussed and at this time the QA committee will make the decision/recommendation regarding follow-up or changes.</p>	1-1-15

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F 368	<p>Continued From page 51</p> <p>responsible to ensure supplements were given to the residents.</p> <p>Interview on 12/4/14 at 2:50 p.m. with the dietary manager and dietician revealed:</p> <p>*The dietician:</p> <ul style="list-style-type: none"> <li>-Helped to identify those residents who were considered nutritionally at risk.</li> <li>-Would have put those residents who were nutritionally at risk on the supplement pass form.</li> <li>-Would not have reviewed the supplement pass form to ensure those residents consistently received those supplements.</li> </ul> <p>*The dietary manager:</p> <ul style="list-style-type: none"> <li>-Was responsible for the updating, supplying, and reviewing that supplement pass form.</li> <li>-Had been aware the nursing staff had not been consistently providing the necessary supplements for those residents.</li> <li>-Had visited with the charge nurse and staff in the past regarding that issue. It had continued to be unresolved.</li> <li>-Had not visited with the administrator or DON regarding the supplements not being consistently given to the residents on the list.</li> </ul> <p>Review of the provider's 4/19/11 Identifying Residents at Nutritional Risk policy revealed:</p> <p>*Policy: "Residents identified to be at nutritional risk will be placed on the nutrition risk program which will consist of weekly, weights, meal monitoring if necessary, and evaluated for between meal nourishments."</p> <p>*Procedure:</p> <ul style="list-style-type: none"> <li>-"The Nutritional Professional (RD or Dietary Manager) will indicate that the resident is at nutritional risk on the nutrition tracking form.</li> <li>-"Evaluation of between-meal nourishments/snacks by the Nutritional</li> </ul>	F 368			

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F 368	Continued From page 52 Professional. Snacks are sent from the main kitchen and offered by nursing staff." -"The Nutrition Professional will review the list of residents at nutritional risk monthly, will update the identification of those residents at risk as needed;and will document in the medical record as appropriate." -"The Nutrition Professional will record the nutritional intake status and progress of the nutritional plan of care in the resident's medical record."	F 368		
F 428 SS=G	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.  This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, interview, and policy review, the provider failed to ensure: *The dispensing pharmacy followed their policy for one of one sampled resident (5) who had a drug-to- drug interaction. *The consultant pharmacist reviewed medications for the appropriate diagnoses and monitored adverse side effects of medications for one of one sampled resident (2).	F 428		

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F 428	<p>Continued From page 53 Findings include:</p> <p>1. Review of resident 5's 11/21/14 physician's orders revealed he was on Tramadol (narcotic) pain medication.</p> <p>Review of resident 5's 12/2/14 physician's telephone order revealed he was started on Sertraline (antidepressant) medication.</p> <p>Review of the Jones and Bartlett Learning Nursing 2013 Drug Handbook, July 18, 2012 ED., written by Lippincott, Williams &amp; Wilkins, revealed the following for sertraline: *Drug-to-drug interaction with Tramadol. *May increase the risk of serotonin syndrome (restlessness, loss of coordination, hallucinations (hearing things that were not there), or rapid changes in blood pressure). *Monitor patient (resident) closely if used together. *Use cautiously with close monitoring especially at the start of treatment and during dosage adjustments. *Advise families and caregivers to closely observe the patient for increased suicidal thinking and behavior. *Advise patient to use caution when performing hazardous tasks that require alertness.</p> <p>Review of resident 5's 11/24/14 care plan revealed undated documentation "On Zoloft (sertraline) related to periods of saying he wishes for death. Please redirect to a different task/subject."</p> <p>Review of resident 5's 12/3/14 through 12/6/14 nurses' notes revealed: *12/3/14- "Initial dose of Zoloft (sertraline)</p>	F 428	<p>F428 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusion set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:</p> <p>1. Resident #5's medications were reviewed for possible interactions on 12/23/14. Resident #5's Tramadol was discontinued on 12/10/14. Resident #2 has been discharged.</p> <p>2. All residents using the secondary pharmacy had their medications reviewed for possible interactions on 12/23/14 by the consulting pharmacist. Side effect monitoring guidelines were</p>	

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F 428

Continued From page 54  
received. No ill effects noted."  
\*12//5/14- "Found on floor at 9:35 p.m. 0.5 centimeter bruise noted to right elbow. Found on floor at 11:35 p.m."  
\*12/6/14- "Wanders in and out of others rooms. Needs cueing to use walker correctly."  
  
Review of resident 5's 11/24/14 through 11/30/14 behavior flow sheet completed by the CNAs revealed:  
\*Five days of physical (hit, kicked, scratched, grabbed or made sexual advances to others) behavioral symptoms.  
\*Seven days of verbal (threatened, screamed, or cursed at others) behavioral symptoms.  
\*Seven days of rejection of care.  
\*Six days of wandering (moving from place-to-place with no specific purpose or known direction or regard to safety).  
\*Three days of hallucinations (false perceptions seeing, hearing, tasting, feeling, or smelling something that is not there).  
\*One day of delusions (false belief the person is convinced is true).  
  
Review of resident 5's 12/5/14 incident report revealed:  
\*Diagnosis prior to incident dementia (memory loss) and weakness.  
\*Root cause of fall physical function (balance, weakness, and gait).  
\*Antidepressant medication administered in the last twenty-four hours prior to the fall.  
\*\*"Discussed wandering need in 12/8/14 morning meeting. Behavior care plan for wandering will be developed to include locomotion (moving about) in wheelchair to allow him to safely meet his wandering need if appears restless."

F 428

reviewed/ revised on 12/22/14.  
3. System change includes implementing a guideline on pharmacy notification to facility on all possible interactions. A side effect monitoring system was implemented for those using a secondary pharmacy. Re-education of all nursing staff was completed and information has been added to the new staff orientation program.  
4. The DNS and/or designee will audit medication interaction pharmacy notification and side effect monitoring documentation two resident new medications from secondary pharmacy each week for one month and then one resident's new medication each week for 2 months. The data collected will be presented to the Quarterly Quality Assurance committee by the DNS. It will be reviewed/discussed and at this time the QA committee will make the

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F 428	<p>Continued From page 55</p> <p>Interview on 12/8/14 at 10:00 a.m. with licensed practical nurse A revealed: *The pharmacy had sent nothing to the facility regarding the drug-to-drug interaction of sertraline with Tramadol. *She was unsure if all the nurses were aware of the potential drug-to-drug interaction of Tramadol and sertraline. *Their consulting pharmacy usually always notified the nursing staff if there was a potential concern to be monitored when a new medication was started.</p> <p>Phone interview on 12/8/14 at 10:30 a.m. with pharmacist O regarding resident 5 revealed: *They were not the provider's consulting pharmacy. They relied on the consultant pharmacist to review all the residents' drug regimens for concerns during their monthly visits. *Their pharmacy did not usually send out information to the provider's regarding potential drug-to-drug interactions. *It was likely resident 5 was experiencing symptoms of a drug-to-drug interaction. It occurred rarely but appeared apparent in his situation. *They had dispensed his Tramadol to the provider when he had been admitted on 11/24/14. They were aware he was on Tramadol when they had dispensed the sertraline.</p> <p>Interview on 12/8/14 at 11:00 a.m. with the director of nursing regarding the above revealed: *They thought the pharmacy was providing services according to their policy. *Fifteen of the fifty-two residents utilized that pharmacy for their medications.</p> <p>Review of the dispensing pharmacy's February</p>	F 428	decision/recommendation regarding follow-up or changes.	1-1-15
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F 428	<p>Continued From page 56</p> <p>2003 Resolution of Denial of Care Conflicts policy revealed:</p> <p>**All orders will be filled in accordance with state and federal laws."</p> <p>**All orders will be filled with the safety of the patient of the utmost concern."</p> <p>**We will provide supporting information on drug interactions and allergies and contraindications to drug usage the patient may have."</p> <p>**We will let facility know that we will not send out order with the above concerns."</p> <p>**If the doctor still wants to send it out it will be at the pharmacist's discretion to note the doctors reasoning or to decline based on safety at which time it may involve a discussion with the practitioner."</p> <p>Surveyor: 32355</p> <p>2. Review of resident 2's medical record revealed:</p> <p>*An admission date of 9/23/14.</p> <p>*Diagnoses included a revision of gastric bypass (surgical procedure to treat obesity) on 8/27/14, insulin dependent diabetic (unstable blood sugar levels), insomnia (difficulty sleeping), esophageal reflux (backup of stomach contents), acute pain, and morbid obesity.</p> <p>*Frequently had nausea (upset stomach) and vomiting.</p> <p>*Had trouble sleeping at night.</p> <p>*She had reported thoughts of suicide on 10/22/14 and 10/23/14 to the social services department interdisciplinary department team during discharge planning.</p> <p>*On 10/24/14 had been admitted to another facility for mental health evaluation due to suicidal thoughts (ending ones life).</p> <p>*Viibryd 40 milligrams (mg) once a day for insomnia.</p>	F 428		
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F 428	<p>Continued From page 57</p> <p>*Lorazepam 2 mg once a day at bedtime for insomnia.</p> <p>*Lorazepam 1.5 mg every 4 hours as needed (PRN) for abdominal cramping.</p> <p>Review resident 2's pharmacy consultation reports for the primary physician to review for October 2014 and November 2014 revealed no documentation questioning the diagnoses, side effects, and use of the Viibryd and Lorazepam.</p> <p>Review of the April 2014 Omniview drug information given to the provider on Viibryd revealed it:</p> <p>*Was used to treat depression (feelings of sadness).</p> <p>*Had multiple side effects including:</p> <ul style="list-style-type: none"> <li>-Nausea.</li> <li>-Vomiting.</li> <li>-Insomnia.</li> <li>-Suicidal ideations.</li> </ul> <p>Interview on 12/4/14 at 8:30 a.m. with the director of nursing revealed:</p> <p>*The provider did not have a good policy for side effect monitoring of medications.</p> <p>*She agreed there should have been better side effect monitoring of medications by the staff and pharmacy.</p> <p>*They had relied upon the consultant pharmacist for monitoring for appropriate diagnoses of medications and side effects.</p> <p>Interview on 12/4/14 at 11:35 a.m. with the consultant pharmacist revealed she:</p> <p>*Would have reviewed the above medications for the proper diagnoses and side effects.</p> <p>*Had not been concerned about resident 2's nausea and vomiting. She stated "Almost all</p>	F 428		
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F 428	Continued From page 58 medications have the side effects of nausea and vomiting." *Offered no comment regarding resident 2's suicidal ideations on 10/23/14 and 10/24/14. *Had not questioned the diagnoses of those medications. *Was used to some doctors using different medications for different diagnoses.	F 428		
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  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.  This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, interview, policy review, and job description review, the provider failed to make sure the facility was operated and administrated in a manner that maintained the safety and overall well-being for all its fifty-two residents by ensuring: *One of one sampled resident (1) who was on a therapeutic diet was completely assessed and evaluated for the appropriate diet consistency.	F 490	F490 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusion set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to F224, F250, F280, F309 and F428 please refer to the previous responses documented.	1-1-15

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F 490	<p>Continued From page 59</p> <ul style="list-style-type: none"> <li>*Six of sixteen sampled nurses (C, F, G, H, R, and S) were certified in cardiopulmonary resuscitation (CPR).</li> <li>*Emergency equipment was readily available on all three floors (first where dining room was located, 2nd, and 3rd floor).</li> <li>*Four of sixteen sampled nurses (C, F, G, and H) had received a thorough nursing orientation.</li> <li>*Four of four sampled residents (10, 11, 12, and 13) on mechanical soft diets were thoroughly assessed for the appropriate foods on their diet.</li> <li>*Medically related social services was provided for two of two sampled residents (2 and 7).</li> <li>*Five of nine sampled residents' (2, 4, 5, 8, and 9) care plans were reviewed and revised with changes in their care needs.</li> <li>*One of one sampled resident (4) with an acute respiratory incident received the necessary care and services in a timely manner.</li> <li>*Three of six sampled residents (2, 5, and 8) received adequate pain control.</li> <li>*One of one sampled resident (5) who had multiple falls was thoroughly assessed.</li> <li>*One of one sampled resident (7) who had behaviors was monitored, evaluated, assessed, and documented on for the appropriate environment during meals.</li> <li>*Residents on one of two nursing floors (2nd) received daily supplements to manage weight control, hydration, and wound healing.</li> <li>*The consultant pharmacist reviewed medications for the appropriate diagnoses and monitored adverse side effects of medications for one of one sampled resident (2).</li> </ul> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Interview on 12/3/14 at 11:00 a.m. with the director of nursing (DON) and executive director revealed:</li> </ol>	F 490		
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F 490	<p>Continued From page 60</p> <p>*The DON had been in that role about one and one-half months. The previous DON was not good about letting the executive director know when there were concerns.</p> <p>*They had a pain policy but confirmed they had not been following it consistently.</p> <p>*The previous DON had not been consistent in using the nursing orientation and skills checklist.</p> <p>*They were aware some of the nurses CPR had expired, but they were not aware some of the nurses had no certification in their personnel file.</p> <p>*They had discussed the need for emergency equipment in the dining room, but they had planned to talk to their medical director first.</p> <p>*Confirmed they had not evaluated the other residents who were on mechanically soft diets after resident 1's choking incident.</p> <p>Review of the provider's undated DON job description revealed:</p> <p>**"Establish procedures for the care, use and stock level of all nursing supplies and equipment."</p> <p>**"Assist in development of patient (resident) care plans for individual residents including rehabilitative and restorative activities. In cooperation with the social worker, food service director, and activities director meet weekly to keep patient care plans current."</p> <p>**"Develop and maintain nursing care objectives and standards of nursing care practices for the facility in cooperation with the assistant DON."</p> <p>**"Plan, organize and direct in cooperation with the assistant DON, effective administration of nursing unit and patient (resident) care given based on the established goals and objectives, standards, policies, and procedures of this facility."</p> <p>Review of the provider's undated Executive</p>	F 490		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435126</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/08/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>VIOLET TSCHETTER MEMORIAL HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	<p>Continued From page 61</p> <p>Director job description revealed:                      **"Oversees regular rounds to monitor delivery of nursing care, operation of support departments, cleanliness and appearance of the facility, moral of the staff, and ensures resident needs are being addressed."                      **"To lead and direct the overall operations of the facility in accordance with customer needs, government regulations and company policies, with focus on maintaining excellent care for the residents/patients while achieving the facility's business objectives."</p> <p>Refer to F224, finding 1; F250, findings 1 and 2; F280, findings 1, 2, 3, 4, and 5; F309, findings 1, 2, 3, and 4; and F428, findings 1 and 2.</p>	F 490		