

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

ORIGINAL

PRINTED: 01/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/16/2014
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NAME OF PROVIDER OR SUPPLIER FIRESTEEL HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 EAST 7TH AVENUE MITCHELL, SD 57301
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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
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F 000	INITIAL COMMENTS An extended/complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted on 12/11/14 and on 12/15/14 through 12/16/14. Areas surveyed included resident transfer safety with the use of mechanical lifts and resident neglect. Firesteel Healthcare Community was found not in compliance with the following requirements: F157, F224, F309, and F490.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or	F 157	F157 1. Resident #1 has expired. 2. All residents are potentially at risk. 3. a. Medical Director was made aware of policy review about physician and family notification of changes. Facility will in-service by 1/15/2015 all staff responsible for family/physician notification to ensure it is done on a timely basis regarding changes of condition. b. Director of Nursing or designee will complete written audits weekly x 4, then monthly x 2 on ensuring proper notification. Audit selection is random with a maximum of four. The following areas will be audited. 1. Proper notification to families. 2. Proper notification to physicians. 4. DON or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3.	1/15/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Carey Bruner</i>	TITLE <i>Administrator</i>	(X6) DATE <i>1/13/15</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 157	<p>Continued From page 1 regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, and interview, and policy review, the provider failed to ensure the family and physician were updated of an acute change in condition for one of one sampled resident (1) condition. Findings include:</p> <p>1a. Review of resident 1's medical record revealed an 10/8/14 admission date from an acute care hospital.</p> <p>Review of resident 1's 10/8/14 hospital discharge summary revealed: *Bilateral pneumonia that had improved. **At the time of discharge temperature 98.1 degrees (normal 98.6) and oxygen (O2) saturation (amount of O2 in the blood, normal greater than 90 percent [%]) was 98% on 2 liters of O2. **"Lung sounds have no wheezing or rhonchi [loud, abnormal lung sounds]." ***"We will put her back on her oral Ceftin (antibiotic) and Zithromax (antibiotic)."</p> <p>Review of resident 1's physician's admission orders revealed: *Admit for skilled care. *Full code-do cardiopulmonary resuscitation (CPR).</p>	F 157		
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F 157	Continued From page 2 Review of resident 1's 10/10/14 and 10/11/14 assessment report notes revealed: *10/10/14 at 8:23 a.m. by registered nurse (RN) D- "On room air O2 saturations were in the upper 70% to low 80%. After applying O2 resident recovers to the 90%. She is noncompliant with the O2 because she wants outdoors to smoke. Breath sounds left lung rhonchi. Breath sounds right lung rhonchi. Productive cough. Staff reported little sleep during the night. She did slide out of her chair a couple times during the night shift." *10/10/14 at 8:00 p.m. by licensed practical nurse (LPN) A- "Breath sounds left lung diminished. Breath sounds right lung diminished. Respirations a little shallow. Slides in chairs. Has a grippy pad placed in chairs to help with less movement. Shortness of breath (SOB)." *10/11/14 at 6:53 a.m. by RN B- "O2 saturation 76 % on room air. Breath sounds left lung wheezes, rhonchi, and diminished. Breath sounds right lung wheezes and rhonchi. SOB while sitting. Increasing respiratory distress. O2, 2 liters. Resident having increased difficulty breathing, reports feeling SOB, noted O2 saturations 76% on room air. Resident placed in bed with head of bed (HOB) elevated 60 degrees. Noted respirations evened and less labored and O2 saturations improved to 91%. Disoriented (confused). Resident noted to have change of level of consciousness (LOC) in comparison to yesterday per staff. Minimally alert and responding vaguely to yes or no questions until respiratory status stabilized. Then noted intermittent confusion. Resident unable to transfer from wheelchair to bed do to current change in LOC and respiratory status. Transferred with assist of three and total lift to bed. Resident having tremors in wheelchair,	F 157			

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F 157	Continued From page 3 noted arms and legs to flail [move randomly], transferred to low bed with bedside mat for safety until resident condition stabilizes." *10/11/14 at 8:00 a.m. by RN B- "Noted improvement in respiratory status at this time. Respirations even and shallow. O2 saturations 97% on 3 liters O2. Resident is alert and responding. States continues to feel SOB. Will administer a.m. medications and nebulizer [device used to deliver medication using a mask] and continue to monitor at this time." *10/11/14 at 6:22 p.m. [for incident that occurred at 8:30 a.m.] by RN B- "Housekeeping personnel informed certified nursing assistant [CNA] that resident is not breathing. CNA called RN to room immediately. Code green [in-house emergency call system for all emergencies]. Resident complains of SOB this a.m. and experiencing low O2 saturations on room air. Resident laying in bed with nebulizer. Color dusky [grey]. No pulse or respirations noted. Assessment performed, resident transferred to floor with assist of three and turn sheet." *10/11/14 at 8:35 a.m. by RN B- "Compressions [external stimulation of heart] started and assistance and crash cart were called for. Three rounds of compressions were completed, crash cart arrived and rescue breaths were given." *10/11/14 at 8:38 a.m. by RN B- "Continues without pulse or respirations. Staff continue to perform CPR and 911 was called." *10/11/14 at 8:40 a.m. by RN B- "Call placed to mother and update given. Emergency room [ER] called and updated of situation and resident's transfer." *10/11/14 at 8:45 a.m. to 8:50 a.m. by RN B- "Emergency services arrived on scene. Staff continue CPR and report given to emergency service staff. Emergency service staff applied	F 157			

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F 157	<p>Continued From page 4</p> <p>monitor and asystole [no heart beat] read on monitor." *10/11/14 at 11:26 a.m. by RN B- "Telephone call from ER. Code was stopped and time of death called at 9:22 a.m. in ER." *There was no documentation the physician or family had been contacted on 10/10/14 or on 10/11/14 at 6:53 a.m. when there was a change in the resident's lung sounds, increased SOB, or change in her mental status.</p> <p>Review of resident 1's 10/11/14 at 5:26 a.m. progress notes by LPN A revealed "Resident restless this evening. Felt her blood sugar was low. Blood sugar check done at 82 [normal 60 to 100]. Glass of orange juice given."</p> <p>Interview on 12/15/14 at 12:00 noon with LPN A regarding resident 1 revealed she: *Had worked on 10/10/14 at 6:00 p.m. through 10/11/14 at 6:30 a.m. with her. *Was orienting with RN C that night and had never worked with the resident. *Completed the nursing assessment on the resident that night. *Had not noticed anything unusual about the resident that night. *Was sure she had informed RN C about her assessment but had not documented she had. *Had assisted the resident with her midnight and 4:00 a.m. nebulizer treatments. She had to stay with the resident during the treatments, as she was very restless and kept pulling off the mask. The resident had complained of being SOB, but she thought that was usual for her. *Was unsure what time she had checked the resident's blood sugar, but she thought it was sometime between midnight and 5:00 a.m. on 10/11/14.</p>	F 157		

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F 157	<p>Continued From page 5</p> <p>*Thought she had rechecked the resident's blood sugar after she had given her the orange juice. *Had not documented a follow-up blood sugar.</p> <p>Interview on 12/15/14 at 4:00 p.m. with RN B regarding resident 1 revealed she: *Was the charge nurse on 10/11/14 at 6:00 a.m. *Knew the CNAs had called her down to the resident's room that morning between 6:00 a.m. and 6:30 a.m. *Said the night nurse went to the resident's room with her and said things were normal for the resident. *Said the CNAs had just gotten her up in her wheelchair for the day, and they thought the resident was acting differently. *Put the resident's O2 back on, and her O2 saturations improved. *Made several follow-up visits to the resident's room, and she was improving and doing better. *Said between 8:00 a.m. and 8:30 a.m. the resident said she needed her nebulizer. *Told medication aide F to go ahead and give her the nebulizer and her morning medications. *Got called back into the resident's room by the CNAs she was not breathing. *Helped the CNAs transfer her to the floor using a lift sheet from the low bed she was in. *Started chest compressions right away, and the crash cart arrived in the room shortly after. *Felt like it was five minutes before the crash cart arrived but was doubtful it was that long. *Said the staff member that grabbed the crash cart should have grabbed the Automatic External Defibrillator (AED) [delivers electric shock when the heart rhythm has stopped], and they had not. *Had not felt it necessary to contact the physician at 6:53 a.m. when she had done her assessment, as the resident's O2 saturations had improved when they put her O2 back on.</p>	F 157		

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F 157	<p>Continued From page 6</p> <p>*Contacted the family prior to her being transported to the ER. No one had felt it was necessary to contact the family prior to that.</p> <p>Interview on 12/16/14 at 9:30 a.m. with RN C regarding resident 1 revealed she:</p> <p>*Confirmed she was working with orientee LPN A from 10/10/14 at 6:00 p.m. through 10/11/14 at 6:30 a.m.</p> <p>*Knew that LPN A had done the resident's assessment (vital signs, lung sounds, and pain monitoring) that night.</p> <p>*Knew LPN A had voiced no concerns to her regarding the resident's assessment.</p> <p>*Had stopped in a couple times during the night to see the resident, and she found nothing alarming with her condition.</p> <p>*Felt there was no need to contact a physician during the night or when she had gone into the room on 10/11/14 at 6:53 a.m. with RN B.</p> <p>*Was amazed the resident died on the morning of 10/11/14.</p> <p>Interview on 12/16/14 at 11:32 a.m. with the director of nursing (DON) and the director of clinical services regarding resident 1 revealed:</p> <p>*The DON confirmed the physician should have been notified of the resident's significant change in condition on 10/11/14 at 6:53 a.m.</p> <p>*The director of clinical services had no comment if the physician should have been notified of the resident's change in condition prior to being sent to the ER on 10/11/14 when she was found without a pulse or respirations.</p> <p>Review of the provider's June 2013 Resident, Physician and Family Notification policy revealed:</p> <p>**To assure all necessary parties are notified promptly when a resident has had a change in</p>	F 157			

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F 157	Continued From page 7 condition which may necessitate orders from the physician." **"The facility will inform the resident, physician and family or legal representative when there is a change in condition such as but not limited to: -An accident involving the resident which results in injury and has the potential for requiring physician intervention. -A significant change in the resident's physical, mental, or psychosocial status; deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications. -A decision to transfer or discharge a resident from the facility. -A need to alter treatment significantly, such as discontinuing an existing treatment or commence a new treatment."	F 157			
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure: *The policy and procedure was followed for the use of an AED (automated external defibrillator) (delivers electric shock when the heart rhythm	F 224	F224 1. Resident #1 has expired. 2. All residents are potentially at risk. 3. a. Changes were made to AED policy and CPR policy. All licensed nursing staff were/will be educated on new policies prior to their first shift after the issuance of the immediate jeopardy. Subsequent in-servicing will be completed by the DON or designee on or before 1/15/15 on what may constitute abuse or negligence in care to all facility staff.		1/15/15

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F 224	<p>Continued From page 8</p> <p>has stopped) for one of one sampled resident (1) who required cardiopulmonary resuscitation (CPR).</p> <p>*A process was in place to identify each staff members responsibility/task during a CPR occurrence.</p> <p>NOTICE:</p> <p>Notice of immediate jeopardy was given to the executive director, director of nursing (DON), and clinical nurse specialist on 12/15/14 at 5:20 p.m. They were asked for a plan of correction to be given to the surveyors on 12/16/14 at 8:00 a.m. They were asked that the plan of correction include:</p> <ul style="list-style-type: none"> *The requirement to use the AED or not during CPR and follow the facility policy. *Review and update the policies and procedures for CPR and using the AED. *The education of all the licensed nursing staff regarding the provider's policy and procedure for CPR and the use of the AED. *The plan to identify each staff members responsibility and/or task during a code green (emergency situation). The plan should include and identify: <ul style="list-style-type: none"> -The lead nurse. -Who is to retrieve the crash cart and AED. -Who is responsible for the documentation of the events during a code green. <p>PLAN:</p> <p>A plan of correction was accepted on 12/16/14 at 11:43 a.m. regarding:</p> <ul style="list-style-type: none"> *The education and verbalized understanding of all the licensed nursing staff regarding the policy and procedures for CPR and the AED. 	F 224	<p>b. Director of Nursing or designee will complete written audits of potential abuse or negligence of residents weekly x 4, then monthly x 2. Audit selection is random with a maximum of four. The following areas will be audited 1. Proper CPR procedures are followed. 2. Proper AED procedures are followed. 3. Auditing will include a drill for appropriate CPR and/or AED use and understanding of policy conducted alternately on day or night shift weekly X 4, then monthly X 2. Should an actual Code occur it will be reviewed for appropriate care and response. 4. DON or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3.</p>	

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F 224	<p>Continued From page 9</p> <p>*The terminology code green had been changed to code blue for a cardiac or respiratory arrest.</p> <p>*Education began on the evening of 12/15/14. No start time was documented on the inservice training form. That education would continue through 12/20/14.</p> <p>*All nurses would be educated prior to working their next shift by the DON or designee.</p> <p>*The provider's protocols during a code blue situation. Those protocols reflected:</p> <p>- "The first licensed nurse on the scene will assess and start the code process and be the lead nurse until the first registered nurse (RN) arrives."</p> <p>- "The central wing nurse or designee will be in charge of obtaining the crash cart and AED to bring to the code."</p> <p>- "In the event the code is on the central unit, the west wing nurse will bring the crash cart and AED to the code."</p> <p>- "The east/south wing nurse or designee will be the designated recorder for the code."</p> <p>- "In the event that the code is on the east/south wing, then the west nurse will be the recorder."</p> <p>*Eleven of eighteen licensed nurses had been provided the above training and education at the time of the acceptance and removal of the immediate jeopardy on 12/16/14 at 11:43 a.m.</p> <p>Findings include:</p> <p>1a. Review of resident 1's medical record revealed an 10/8/14 admission date from an acute care hospital.</p> <p>Review of resident 1's 10/8/14 hospital discharge summary revealed:</p> <p>*Bilateral pneumonia had improved.</p> <p>**At the time of discharge temperature 98.1 degrees [normal 98.6] and oxygen [O2] saturation</p>	F 224		

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F 224	<p>Continued From page 10</p> <p>[amount of O2 in the blood normal greater than 90 percent [%] was 98 % on 2 liters of O2.]</p> <p>*Lung sounds had no wheezing or rhonchi [loud abnormal lung sounds].</p> <p>**"We will put her back on her oral Ceftin (antibiotic) and Zithromax (antibiotic)."</p> <p>**"On the day of discharge, she had another infectious disease telemedicine conference that felt three more days of oral antibiotics is all that is necessary and then they can simply follow. He recommended discharge also."</p> <p>**"She will need ongoing physical and occupational therapy."</p> <p>**"We will see back in the office on 10/13/14. Repeat her laboratory tests and chest x-ray then."</p> <p>**"Activity will be with assistance wheelchair or lift."</p> <p>Review of resident 1's physician's admission orders revealed:</p> <p>*Admit for skilled care.</p> <p>*Full code-do cardiopulmonary resuscitation (CPR).</p> <p>*Additional diagnoses: Insulin dependent diabetes (fluctuating blood sugars), tobacco abuse, and Charcot-Marie-Tooth disease (inherited neurological disorder affecting the motor and sensory nerves).</p> <p>Review of resident 1's 10/8/14 care plan revealed:</p> <p>**"I plan to stay here short-term with future plans to return to my own home."</p> <p>**"My short and long term memory are intact. I am able to communicate my needs to others."</p> <p>**"Assist me in creating a comfortable environment in my room."</p> <p>**"Observe me for changes in my cognitive [memory] functioning, an increase in my depression signs, and for any changes in</p>	F 224		

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F 224	<p>Continued From page 11 behavior."</p> <p>"*I want to sleep in my recliner."</p> <p>"*I was in hospital with pneumonia and am on oxygen [O2] as ordered." (There were no goals or interventions for her respiratory [breathing] status.)</p> <p>"*I have had falls in the past. I am at risk for falls due to my diagnosis of Charcot-Marie-Tooth disease. I am nonambulatory and EZ stand lift [mechanical lift that allowed the resident to bear weight on the legs] is used for transfers."</p> <p>"*I want to be able to smoke. A nicotine patch was offered and I declined. The doctor was updated and an order received to smoke. I would like to be able to go outside and smoke. I have been educated on the risk of smoking and the affect if can have on my health. I am aware I can not smoke with my O2 on or in the facility. A smoking assessment was completed."</p> <p>Review of resident 1's 10/9/14 smoking assessment revealed: *Scheduled smoking times 9:30 a.m., 1:30 p.m., 4:00 p.m., and 7:00 p.m. (if not dark). **Will have four scheduled times to smoke a day. Staff will take her outside to smoke within one-half hour before or after scheduled time depending on other issues happening on the floor."</p> <p>Review of resident 1's 10/10/14 and 10/11/14 assessment report notes revealed: *10/10/14 at 8:23 a.m. by registered nurse (RN) D- "On room air O2 saturations were in the upper 70% to low 80%. After applying O2 resident recovers to the 90%. She is noncompliant with the O2 because she wants outdoors to smoke. Breath sounds left lung rhonchi. Breath sounds right lung rhonchi. Productive cough. Staff</p>	F 224			

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F 224	Continued From page 12 reported little sleep during the night. She did slide out of her chair a couple times during the night shift." *10/10/14 at 8:00 p.m. by licensed practical nurse (LPN) A- "Breath sounds left lung diminished. Breath sounds right lung diminished. Respirations a little shallow. Slides in chairs. Has a grippy pad placed in chairs to help with less movement. Shortness of breath [SOB]. Is requesting a cigarette but has had her quota of 4 for today per CNA." *10/11/14 at 6:53 a.m. by RN B- "O2 saturation 76% on room air. Breath sounds left lung wheezes, rhonchi, and diminished. Breath sounds right lung wheezes and rhonchi. SOB while sitting. Increasing respiratory distress. O2, 2 liters. Resident having increased difficulty breathing, reports feeling SOB, noted O2 saturations 76% on room air. Resident placed in bed with head of bed [HOB] elevated 60 degrees. Noted respirations evened and less labored and O2 saturations improved to 91%. Disoriented [confused]. Resident noted to have change of level of consciousness [LOC] in comparison to yesterday per staff. Minimally alert and responding vaguely to yes or no questions until respiratory status stabilized. Then noted intermittent confusion. Resident unable to transfer from wheelchair to bed do to current change in LOC and respiratory status. Transferred with assist of three and total lift to bed. Resident having tremors in wheelchair, noted arms and legs to flail [move randomly], transferred to low bed with bedside mat for safety until resident condition stabilizes." *10/11/14 at 8:00 a.m. by RN B- "Noted improvement in respiratory status at this time. Respirations even and shallow. O2 saturations 97% on 3 liters O2. Resident is alert and	F 224			

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F 224	Continued From page 13 responding. States continues to feel SOB. Will administer a.m. medications and nebulizer [device used to deliver medication using a mask] and continue to monitor at this time." *10/11/14 at 6:22 p.m. [for incident that occurred at 8:30 a.m.] by RN B- "Housekeeping personnel informed certified nursing assistant [CNA] that resident is not breathing. CNA called RN to room immediately. Code green [in-house emergency call system for all emergencies]. Resident complains of SOB this a.m. and experiencing low O2 saturations on room air. Resident laying in bed with nebulizer. Color dusky [grey]. No pulse or respirations noted. Assessment performed, resident transferred to floor with assist of three and turn sheet." *10/11/14 at 8:35 a.m. by RN B- "Compressions [external stimulation of heart] started and assistance and crash cart were called for. Three rounds of compressions were completed, crash cart arrived and rescue breaths were given." *10/11/14 at 8:38 a.m. by RN B- "Continues without pulse or respirations. Staff continue to perform CPR and 911 was called." *10/11/14 at 8:40 a.m. by RN B- "Call placed to mother and update given. Emergency room [ER] called and updated of situation and resident's transfer." *10/11/14 at 8:45 a.m. to 8:50 a.m. by RN B- "Emergency services arrived on scene. Staff continue CPR and report given to emergency service staff. Emergency service staff applied monitor and asystole [no heart beat] read on monitor." *10/11/14 at 11:26 a.m. by RN B- "Telephone call from ER. Code was stopped and time of death called at 9:22 a.m. in ER." *There was no documentation the AED had been utilized during the code.	F 224			

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F 224	<p>Continued From page 14</p> <p>Review of the twenty-three RNs and the three LPNs (all licensed nurses in the facility) personnel files revealed all had current CPR certification and the use of the AED training.</p> <p>Interview on 12/15/14 at 12:00 noon with LPN A regarding resident 1 revealed she: *Had worked on 10/10/14 at 6:00 p.m. through 10/11/14 at 6:30 a.m. with her. *Was orienting with RN C that night and had never worked with the resident. *Completed the nursing assessment [vital signs, lung sounds, pain control, and activities of daily living assistance] on the resident that night. *Had not noticed anything unusual about the resident that night. *Stated the resident was restless and kept trying to get out of her recliner and was sitting on the footrest. *Was sure she had informed RN C about her assessment but had not documented she had. It was not normal to document she had reported her assessment to the RN. *Had assisted the resident with her 12:00 midnight and 4:00 a.m. nebulizer treatments. She had to stay with the resident during the treatments as she was very restless and kept pulling off the mask. The resident had complained of being SOB, but she thought that was usual for her. *Was unsure what time she had checked the resident's blood sugar, but she thought it was sometime between 12:00 midnight and 5:00 a.m. on 10/11/14. *Thought she had rechecked the resident's blood sugar after she had given her the orange juice. *Had not documented a follow-up blood sugar. *Was not sure if the staff had assisted her with a</p>	F 224		

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F 224	<p>Continued From page 15</p> <p>cigarette on her shift when the resident had requested one at 8:00 p.m. She was anxious then. The CNAs did not document anywhere when they assisted a resident with a cigarette. She had not checked with the CNA but had assumed they had assisted her to smoke.</p> <p>Interview on 12/15/14 at 1:10 p.m. with RN D regarding resident 1 revealed: *She was the house supervisor on 10/11/14 from 6:00 a.m. to 6:00 p.m. *RN B was the charge nurse that day and would have done the nursing assessment and notified the physician and family if it had been necessary. *She did not recall the RN telling her anything unusual about the resident nor had she heard anything in report from the night nurses. *She thought she had heard the resident slid out of her chair a couple of times during the night but nothing else alarming. *She was surprised when the resident coded (without pulse or respirations). *She was called to the resident's room about 8:30 a.m. When she entered the room the crash cart was not in the room. *RN B and medication aide (MA) F were putting the resident on the floor. *"We didn't think to use the AED. We do not typically bring the AED that is located on central by the nurse's station." *She was unsure how long the facility had the AED but did not think they had ever used it.</p> <p>Interview on 12/15/14 at 2:00 p.m. with medication aide F regarding resident 1 revealed: *On 10/11/14 was the first time she had worked with her. *She was unsure if she had gone into report from the night staff that morning, but no one had told</p>	F 224		
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F 224	<p>Continued From page 16</p> <p>her the resident was not feeling well.</p> <p>*The resident was restless when she went by her room between 6:30 a.m. and 6:45 a.m.</p> <p>*The CNAs had asked her to assist them with transferring the resident. They were using an EZ stand lift. The resident was able to stand okay but kept sliding in the chair.</p> <p>*They assisted her into a wheelchair, and they had taken her across the hallway to put her in bed in another room. She did not have a bed in her room per her request as she usually slept in the recliner.</p> <p>*She was unsure who made the decision to put the resident into bed. "She was a full lift into bed." When we put her O2 on she settled down.</p> <p>*Between 8:00 a.m. and 8:30 a.m. RN B told her to give the resident her nebulizer treatment and her a.m. medications. The resident was not anxious when she put the mask on her for the nebulizer treatment, so she left her and went to get another resident her medications. "The resident was talking and breathing when she left the room."</p> <p>*In about two to three minutes after she had left the resident's room the CNAs called her back and told her the resident was not breathing. She called RN B immediately.</p> <p>Interview on 12/15/14 at 4:00 p.m. with RN B regarding resident 1 revealed she:</p> <p>*Was the charge nurse on 10/11/14 at 6:00 a.m.</p> <p>*Knew the CNAs had called her down to the resident's room that morning between 6:00 a.m. and 6:30 a.m. *Said the night nurse had gone to the resident's room with her, and had said things were normal for the resident.</p> <p>*Said the CNAs had just gotten her up in her wheelchair for the day, and they thought the resident was acting differently.</p>	F 224			

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F 224	<p>Continued From page 17</p> <ul style="list-style-type: none"> *Put the resident's O2 back on, and her O2 saturations had improved. *Made several follow-up visits to the resident's room, and she was improving and doing better. *Said between 8:00 a.m. and 8:30 a.m. the resident said she needed her nebulizer. *Told medication aide F to go ahead and give her the nebulizer and her morning medications. *Got called back into the resident's room by the CNAs she was not breathing. *Helped the CNAs transfer her to the floor using a lift sheet from the low bed she was in. *Started chest compressions right away, and the crash cart arrived in the room shortly after. *Felt like it was five minutes before the crash cart arrived but was doubtful it was that long. *Said the staff member that grabbed the crash cart should have grabbed the Automatic External Defibrillator (AED) (delivers electric shock when the heart rhythm has stopped), and they had not. *Had not felt it necessary to contact the physician at 6:53 a.m. when she had done her assessment, as the resident's O2 saturations had improved when they put her O2 back on. *Contacted the family prior to her being transported to the ER. No one had felt it was necessary to contact the family prior to that. <p>Interview on 12/15/14 at 4:40 p.m. with RN I regarding resident 1 revealed:</p> <ul style="list-style-type: none"> *She had worked on 10/10/14 when the resident had two falls close together. She kept sliding out of the recliner chair. *The resident had a lot of respiratory issues. *She knew the facility had an AED and thought they usually used it. She had not had to use it since she started on 7/30/13. *All the nurses had been educated on the AED in the CPR certification done in August 2014. 	F 224		

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F 224	<p>Continued From page 18</p> <p>*During a code green no one was designated to bring the AED to the emergency. A code green did not necessarily mean a resident was without respirations or a pulse, it could mean any type of medical emergency (such as a fall with injury).</p> <p>Interview on 12/16/14 at 8:12 a.m. with the medical director regarding resident 1 revealed: *That was the first time he had heard about all the problems with the resident. *If it was the provider's policy to use the AED and they had one, the AED should have been used for her. *"A code team is important to know who is doing what." *The goal is to have all residents be "no codes [no CPR to be initiated]." *If AEDs are available, they should have been used. *He was not sure what her cause of death was or if the AED use would have made any difference, but they should have used it.</p> <p>Interview on 12/16/14 at 9:30 a.m. with RN C regarding resident 1 revealed she: *Confirmed she was working with orientee LPN A on 10/10/14 at 6:00 p.m. through 10/11/14 at 6:30 a.m. *Knew that LPN A had done the resident's assessment (vital signs, lung sounds, and pain monitoring) that night. *Knew LPN A had voiced no concerns to her regarding the resident's assessment. *Had stopped in a couple times during the night to see the resident, and she found nothing alarming with her condition. *Felt there was no need to contact a physician during the night or when she had gone into the room on 10/11/14 at 6:53 a.m. with RN B.</p>	F 224		

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F 224	<p>Continued From page 19</p> <p>*Was amazed the resident died on the morning of 10/11/14.</p> <p>Phone interview on 12/16/14 at 9:57 a.m. with resident 1's physician revealed:</p> <p>*To his knowledge he had not been informed on 10/10/14 or on the morning of 10/11/14 of her change in condition.</p> <p>*He had a note on his desk when he went to work on 10/13/14 that the resident had expired (died) on 10/11/14.</p> <p>*It was his expectation the facility should have used the AED.</p> <p>*He left it up to the nursing staff to inform him of changes in a resident's condition.</p> <p>*He would have expected to have been notified of the resident's change in lung sounds and increased SOB.</p> <p>Interview on 12/16/14 at 10:40 a.m. with the DON and the clinical services specialist regarding resident 1 revealed:</p> <p>**Hindsight the expectations should have been the physician had been notified of her change in condition on 10/11/14 at 6:53 a.m."</p> <p>*They were unable to state if the resident's needs were being met on the night of 10/10/14 and the morning of 10/11/14. "They would have to review the notes again."</p> <p>**"She should have been more comfortable and the physician should have been notified of her change in condition prior to coding [without respirations or pulse] at 8:30 a.m. on 10/11/14.</p> <p>*Their CPR policy was followed.</p> <p>*Their AED policy was not followed and their expectation was that it should have been.</p> <p>*They did not know why there was a discrepancy in the time the emergency services was contacted. RN B had documented they had been</p>	F 224		

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F 224	<p>Continued From page 20</p> <p>called at 8:38 a.m. and the emergency services had documented they had been called at 8:52 a.m.</p> <p>*They agreed they had 34 out of 132 residents who were also a full code status.</p> <p>Review of resident 1's 10/11/14 ER notes revealed:</p> <p>***Per report, resident was given a neb [nebulizer] treatment earlier this morning."</p> <p>***She was then found down and unresponsive and CPR was started."</p> <p>***It is unclear when the last time she was seen awake and normal."</p> <p>***Emergency services was called at 8:52 a.m. and upon responding to the call found the resident in asystole [no heartbeat]."</p> <p>***Patient is cyanotic [purple] with unresponsive pupils and has been coded for 30 minutes with no spontaneous return of pulses or blood pressure. The code was called [stopped] at 9:20 a.m. Family was notified and are present in the ER."</p> <p>Review of the 10/11/14 emergency services report revealed:</p> <p>***Time 911 called was 8:52 a.m., time dispatched 8:52 a.m., time arrived scene 8:56 a.m."</p> <p>***On scene we were directed to the patient's [resident's] room where we found numerous staff members performing CPR."</p> <p>***The staff member near me advised the patient [resident] had not been acting normal since they checked on her this morning and appeared to be having some breathing difficulty."</p> <p>***They administered a neb [nebulizer] treatment to the patient [resident] and when they returned to the patient [resident] they found her unresponsive with no breathing or pulse."</p> <p>***They started CPR immediately and called us."</p>	F 224			

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F 224	<p>Continued From page 21</p> <p>**Due to the panic and confusion in the room, no one was exactly sure the time frame from when she was last seen breathing and I did not waste time waiting for them to find out the information."</p> <p>**I applied the de-fib [defibrillator] patches and monitor showed her to be in asystole."</p> <p>*Departed scene at 9:10 a.m. to the hospital.</p> <p>Review of the provider's May 2008 CPR policy revealed: **CPR will be provided to residents/patients experiencing a respiratory or cardiac arrest, unless they have indicated their choice to DNR [do not resuscitate] with valid medical doctor [MD] order." **Staff members will respond with the modified crash cart. If facility has an AED it may also be used." **The charge nurse will designate a staff member to get the crash cart and AED as well as assign a recorder."</p> <p>Review of the provider's August 2006 Defibrillator-AED policy revealed: **The AED is indicated for use on victims of sudden cardiac arrest on whom an apparent lack of circulation is indicated by all of the following: -Unconsciousness. -Absence of breathing. -Absence of detectable pulse. -CPR has been initiated." **Defibrillator certification will be offered at least twice yearly at the facility." **The facility will ensure it will be staffed 24 hours per day with someone certified to use the AED." **When a code blue is called, a designated staff person will the bring the AED to the site of the code."</p>	F 224		

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F 309 F 309 SS=G	Continued From page 22 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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: Based on record review, interview, policy review, and job description review, the provider failed to ensure one of one sampled resident (4) with a new tracheostomy (breathing tube inserted into the neck) was monitored, assessed, treated, and documented the physician notification and involvement with a change in condition. Findings include: 1. Review of resident 4's medical record revealed a 9/3/14 admission date from a rehabilitation care hospital. Review of resident 4's 9/3/14 hospital discharge summary revealed: *Diagnoses included anoxic (no oxygen) brain damage, coma (unresponsive), tracheostomy, pneumonia (infection in lungs), trauma from drowning and nonfatal submersion into water, epilepsy (uncontrollable body movements), gastrostomy tube (tube inserted into the stomach for nutrition and medication), and clostridium difficile (bacterial infection causing loose stools). *At the time of discharge her temperature was 98.1 degrees Fahrenheit (F) (normal 98.6).	F 309 F 309	F309 1. Resident #4 has been discharged from this facility. 2. All residents are potentially at risk. 3. a. Education to all nursing staff completed by the DON or designee on or before 1/15/15 on ensuring residents with new tracheostomies are monitored, assessed, treated and document the physician notification and involvement with a change in condition. b. Director of Nursing or designee will complete written audits of proper tracheostomy care of residents weekly x 4, then monthly x 2. Audit selection is random with a maximum of four. The following areas will be audited 1. Appropriate assessment/monitoring is completed. 2. Proper physician notification of changes in condition. 3. Ensure all OTC medications are in facility. 4. DON or designee will report results of the audits to the facility	1/15/15

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F 309	<p>Continued From page 23.</p> <p>*Respiratory assessment "Has copious (large) amounts of tracheal and oral secretions, requiring frequent suctioning. Lungs are coarse at times, but usually clear with suctioning. Trach [tracheostomy] site without signs and symptoms of infection."</p> <p>Review of resident 4's 9/3/14 provider admission assessment revealed she:</p> <p>*Was unresponsive. *Had abnormal sounds in both lungs. *Had white and frothy secretions from her tracheostomy with suctioning. *Had a temperature of 99.8 degrees F at 2:45 p.m. *Was incontinent of both urine and bowel. *Had no documentation to support the condition of her skin.</p> <p>Review of resident 4's medical record revealed: *A physician's order for the following: -Acetaminophen (pain medication) 325 milligrams (mg) one or two tablets every fours as needed for elevated temperature. -Ibuprofen (pain medication and blood thinner) 600 mg every six hours as needed for elevated temperature. -Zarelto (blood thinner) 15 mg once a day to prevent blood clots. -Menthol-zinc oxide ointment was to have been applied to her bottom every shift for redness and irritation. That medication had been documented as unavailable from pharmacy for nine shifts form 9/3/14 through 9/11/14. *She had: -Required frequent use of the acetaminophen and ibuprofen for uncontrollable and elevated temperatures. -Increased oral and tracheostomy secretions that</p>	F 309	<p>QAPI committee for review and recommendations monthly x 3. Addendum: As of 1/12/2015, there is no current resident in the facility with a tracheostomy. Should the facility admit a resident in the future with a tracheostomy, nursing staff will receive documented re-education about the appropriate care and assessment of the individual with a tracheostomy, ensuring physician notification for change in condition and all necessary supplies and equipment are available for use.</p>	1/15/15	

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F 309	<p>Continued From page 24 had required frequent suctioning. *Her lung sounds had always been abnormal. *On 9/17/14 she had been admitted to an acute care hospital for worsening of pneumonia. *On 9/25/14: -She was readmitted to the facility. -The ibuprofen was changed to 600 mg three times a day for pain. -The Zarelto order remained unchanged. *On 9/29/14 she was emergency admitted to an acute care hospital for: -Uncontrollable and elevated temperatures. -Bloody secretions from the tracheostomy site. -Increased secretions from the tracheostomy. *On 9/29/14 she was discharged from the acute care hospital and admitted to another facility.</p> <p>10/9/14 Dw/3000H/22</p> <p>On 12/11/14 this surveyor had requested all of the provider's nurses' documentation for resident 4's entire stay in their facility. This surveyor had been provided the following documentation for review: *Nurse's progress notes from 9/3/14 through 10/2/14. *Assessment reports documented by the nurses from 9/3/14 through 9/17/14. No documentation had been provided for assessments from 9/25/14 through 9/29/14.</p> <p>Review of resident 4's nurse's progress notes from 9/4/14 through 10/2/14 revealed: *On 9/4/14: -At 8:38 a.m. acetaminophen had been given for an elevated temperature. The acetaminophen had been effective. There was no documentation on how elevated her temperature had been or the level of effectiveness. -At 2:10 p.m. the menthol-zinc oxide ointment had not been available. A "remedy" had been applied.</p>	F 309		
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F 309	<p>Continued From page 25</p> <p>No documentation on what that remedy was.</p> <p>-At 9:11 p.m. the menthol-zinc oxide continued to not be available and a "remedy" was used.</p> <p>*On 9/5/14:</p> <p>-At 9:42 a.m. acetaminophen had been given for an elevated temperature of "10020.3" The nurse had documented the medication had been effective with a temperature of 99.1 degrees F.</p> <p>-At 4:03 p.m. the resident had been administered acetaminophen for an elevated temperature. There was no documentation to support how elevated her temperature had been.</p> <p>*On 9/6/14 her temperature had been 99.9 F. "Administration had been ineffective." No documentation to support what was ineffective. The menthol-zinc oxide had remained unavailable, and a "remedy" was being used.</p> <p>*On 9/7/14 at 1:47 p.m. the menthol-zinc oxide continued to be unavailable. "Ordered from [pharmacy name] yesterday, will use remedy." That medication continued to be unavailable on 9/8/14 at 4:23 p.m.</p> <p>*No charge nurse documentation for 9/9/14 and 9/10/14.</p> <p>*On 9/11/14 at 4:25 p.m. the physician had been in the facility to assess the resident. No documentation to support:</p> <p>-The resident's elevated temperatures had been discussed and reviewed.</p> <p>-The unavailability of the menthol-oxide ointment from the pharmacy for the resident's red and irritated bottom.</p> <p>-Clarification and review for the two blood thinning medications.</p> <p>*On 9/12/14 the following charge nurse documentation had been provided:</p> <p>-At 11:11 a.m. "Resident noted to have increased yellow/green (yesterday was white frothy) sputum from the trach over the past 24 hours. She has</p>	F 309		
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F 309	<p>Continued From page 26</p> <p>had elevated temps in the 99's lung sounds are coarse throughout all lobes. The resident has had to be suctioned five times since 6:00 this a.m. With moderate amounts of sputum suctioned. Oxygen sat [%] is 90 % with the humidified oxygen via the trach, oxygen is at 4 liters."</p> <p>-At 3:25 p.m. orders had been received to give Rocephin (antibiotic) 2 grams intravenously (IV) everyday for one week.</p> <p>-No documentation to support the resident had been given any type of treatment for elevated temperatures.</p> <p>*From 9/13/14 through 9/17/14:</p> <p>-Her temperatures had remained elevated. Those temperatures ranged from 99.5 F to 102.0 degrees F.</p> <p>-She had been given acetaminophen and ibuprofen as directed for the elevated temperatures.</p> <p>-The medications had been ineffective for treatment of her elevated temperatures.</p> <p>-On 9/15/14 the physician had been contacted with orders for a chest Xray, lab (laboratory tests) work, physical therapy to do chest compressions, and Levaquin (antibiotic) 500 mg everyday for ten days.</p> <p>*On 9/17/14 her Rocephin had been discontinued and Zosyn (antibiotic) was ordered. Her temperatures had remained elevated, and she was admitted to an acute care hospital.</p> <p>Review of resident 4's nurse assessment reports from 9/3/14 through 9/17/14 revealed:</p> <p>*Those reports reflected a head-to-toe assessment of the resident documented by the charge nurse.</p> <p>*Those assessments had only been done once a shift.</p> <p>*There had been no assessment report provided</p>	F 309		

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F 309	<p>Continued From page 27 for 9/5/14.</p> <p>*The times of day for documentation had been random.</p> <p>*The resident had increased tracheostomy secretions that required frequent suctioning.</p> <p>*From 9/12/14 through 9/17/14 her secretions had been described as green, yellow, thick, and dry.</p> <p>*On 9/16/14 her tracheostomy secretions had been documented as "red."</p> <p>*No documentation to support:</p> <p>-Her lungs had been assessed for clearing after suctioning had been performed.</p> <p>-The staff had been monitoring for any bleeding episodes with the use of two blood thinning medications.</p> <p>-Clarification had been done with the physician to ensure the use of two blood thinning medications was appropriate.</p> <p>-When the Menthol-zinc oxide ointment had been available, what the remedy was, and if the physician had been aware of the unavailability of that medication and the "remedy" being used.</p> <p>*No further documentation by the staff had been provided after 9/17/14.</p> <p>Review of resident 4's 9/17/14 hospital report revealed "She is brought over from the nursing home because of difficulties with temperature control as well as bloody secretions from her tracheostomy site and increased sputum production today."</p> <p>On 9/25/14 she had been readmitted to the facility. From 9/27/14 through 9/29/14 her temperatures ranged from 99.4 to 101.5 F degrees. Acetaminophen had been given and ineffective.</p>	F 309		

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F 309	<p>Continued From page 28</p> <p>On 9/29/14 at an unknown time the charge nurse had documented the following: **In residents room at 7:30 p.m. to change feeding, as bottle was empty. Noted resident to be having difficulty with breathing, respirations were 38. Felt residents skin and was hot and sweaty. Checked residents temperature. Temperature equaled 105.2 degrees F." *At 7:50 p.m. the resident was emergency admitted to an acute care hospital for: -"Significant" pneumonia. -Bloody secretions. -Elevated and uncontrollable temperatures. -Increased secretions from her tracheostomy.</p> <p>Review of resident 4's 9/3/14 and 9/25/14 pharmacy side effect record (SER) revealed: *On 9/3/14: -Drug dispensed "Ibuprofen 600 mg tablet." That medication interacts with "Zarelto 15 mg tablet." -Patient management "Monitor patients receiving concurrent (duplicate) therapy for signs of blood loss." *On 9/25/14: -"Ibuprofen can interact with her Zarelto." -Concurrent use might result in unwanted blood loss. *The provider had the 9/25/14 notification from the pharmacy but not the 9/3/14. *No documentation on those two forms by the physician or nurse to support acknowledgement and clarification for continued use.</p> <p>Interview on 12/15/14 at 11:50 a.m. with the pharmacist revealed: *She had confirmed the pharmacy had informed the provider of the potential risks of giving two blood thinning medications together on both of the resident's admissions to the facility.</p>	F 309		

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F 309	<p>Continued From page 29</p> <ul style="list-style-type: none"> *She had emailed the 9/3/14 notification they had given the provider to this surveyor. *The medication notifications would have been sent to both the provider and physician. *Menthol-zinc oxide ointment had been an over-the-counter medication. They would not have supplied this medication to the provider. It was the provider's policy to supply their own over-the-counter medications. *Calmoseptine had been the "remedy" medication the provider should have been using. *She would not have been aware if the provider was using the correct supplemental medication for the menthol-zinc ointment. *It was the provider's responsibility to ensure the correct over-the-counter medications were used and available. <p>Interview on 12/15/14 at 1:03 p.m. with registered nurse (RN) D revealed:</p> <ul style="list-style-type: none"> *She had worked with resident 4 on 9/12/14. *She had remembered the resident having trouble with elevated temperatures, and the physician recommending alternating acetaminophen and ibuprofen. There should have been documentation to support that recommendation or clarification from the physician. *She had helped with suctioning the resident in the past. One of the days there had been "some bloody sputum" with suctioning. *It was the expectation that all the charge nurses were responsible to notify the physician with any acute change in condition of a resident. *All nurses were responsible for monitoring the side effects of medications. *The pharmacist would have notified the provider of any potential medication interactions. It would have been the nurses responsibility to further 	F 309		
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F 309	<p>Continued From page 30</p> <p>clarify with the physician. There should have been documentation to support the physician involvement and clarification of orders.</p> <p>*The provider supplied the over-the-counter medications.</p> <p>*She had not been aware Calmoseptine had been a supplemental medication for menthol-zinc oxide ointment and an over-the-counter medication.</p> <p>*When a medication was not available the nurse should have contacted the pharmacy first to clarify why the medication had not been delivered. If there were continuing issues with the unavailability of the medication then the physician should have been notified.</p> <p>On 12/15/14 at the time of the above interview this surveyor requested from RN D any documentation to support the physician had been aware:</p> <p>*Of the uncontrollable temperatures and recommendations to alternate the acetaminophen and ibuprofen.</p> <p>*The resident had been taking two blood thinning medications.</p> <p>*The prescribed medication to treat her reddened and irritated bottom had not been available and clarification the "remedy" being used was acceptable.</p> <p>On 12/15/14 at 1:30 p.m. RN D had provided this surveyor with:</p> <p>*A patient instructions signature page upon resident 4's discharge from the acute care hospital on 9/25/14.</p> <p>*The hospital discharging RN had signed and dated the form on 9/25/14.</p> <p>*Attached to the patient instructions signature page had been a list of discharging medications</p>	F 309		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/16/2014
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NAME OF PROVIDER OR SUPPLIER FIRESTEEL HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 EAST 7TH AVENUE MITCHELL, SD 57301
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F 309	<p>Continued From page 31 for resident 4.</p> <p>*The physician had electronically signed the discharging medications list on 10/3/14.</p> <p>Interview on 12/15/14 at 8:30 a.m. with the medical director revealed: *He had not liked the medication Zarelto. The side effects of that medication were not good, and he had three patients die from the use of that medication. *The pharmacy notified the physician regarding any potential for medication interactions, side effects, and concerns. *He would have expected the primary physician would have been aware of the above concerns regarding resident 4. *He stated "If the provider would have contacted me I would have said getting over your head."</p> <p>Interview on 12/16/14 at 9:45 a.m. with RN C revealed: *She primarily worked the night shift. *She had worked with the above resident on several occasions. *Resident 4 had been a complicated resident who had required a lot of "attention." *When the resident had first been admitted her lungs cleared with suctioning. As time progressed her lungs became more course with increase in suctioning needed, and clearing of the lungs had not occurred. There should have been documentation to support those assessments. *She had been provided information to alternate the acetaminophen and ibuprofen for elevated temperatures. She had assumed the reporting nurse had reported the uncontrollable temperatures to the physician and was following his recommendations. There should have been documentation to support that recommendation in</p>	F 309		
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F 309	<p>Continued From page 32 the resident's chart. *All nurses were responsible for monitoring the side effects of medications. The nurse who had received the notifications from the pharmacy was responsible to follow-up and clarify any concerns with the primary physician. There should have been documentation in the resident's chart to support this clarification with the physician. *To her knowledge the resident assessment reports were done once per shift. All other concerns and assessments throughout the shift were to have been charted in the resident's progress notes.</p> <p>Interview on 12/16/14 at 10:40 a.m. with the DON and clinical care nurse regarding resident 4 revealed: *There had been no comment offered on what the expectation would have been from the provider for nurses monitoring side effects of medications. *The DON would not have expected the nurses to clarify with the physician regarding any potential medication interactions. She had assumed the physician would have been aware of any medication interactions upon prescribing them for the residents. *Confirmed the pharmacy would have sent or faxed any medication notifications to the provider and the physician. *They confirmed the provider supplied their own over-the-counter medications for the residents. *They would have expected the pharmacy to notify them with any concerns regarding over-the-counter medications. *The provider had no over-the-counter medication policy. *They offered no comment regarding the expectations from the licensed nursing staff</p>	F 309		
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F 309	<p>Continued From page 33 regarding the accuracy and timeliness for:</p> <ul style="list-style-type: none"> -Assessments. -Documentation. -Providing prescribed treatments. -Notification to the physician regarding any acute change in conditions. <p>Review of the provider's June 2013 Resident, Physician, and Family Notification policy revealed: *"To assure all necessary parties are notified promptly when a resident has had a change in condition which may necessitate orders from the physician and maintain accuracy with the resident's overall plan of care." *Procedure: "The facility will inform the resident, physician, and family or legal representative when there is a change in condition such as but not limited to:" -"A significant change in the resident's physical, mental, or psychosocial status." -"A need to alter treatment significantly, such as discontinuing an existing treatment or commence a new treatment."</p> <p>Review of the provider's April 2013 Change of Condition policy revealed: *Policy: "To notify the physician in the event of a status change." *"The resident's condition is assessed and reported to the medical doctor (MD) immediately if the resident experiences:" -"Vital signs that vary significantly from the resident's normal limits, and have been monitored for an 8-24 hour period and have not improved with basic nursing intervention such as treatment for fever." -"Any other significant change in condition as determined by a licensed nurse."</p>	F 309			

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F 309	<p>Continued From page 34</p> <p>Review of the provider's 5/1/10 Pharmacy Services and Procedures Manual regarding Side Effect Record (SER) policy revealed:</p> <p>**Pharmacy may, at its option or as required in a pharmacy services agreement, provide a SER that lists all current medications, their most common side effects, medication class, and special messages/instructions."</p> <p>**If pharmacy provides a SER, the side effects listed may not be all-inclusive. Facility should consult the manufacturer package insert, and/or the Omnicare Geriatric Pharmaceutical Care Guidelines, and/or other current literature for additional details."</p> <p>**Facility should file and maintain the resident's most recent SER with the most recent medication administration record or store the SER in a place where the SER is readily accessible to the facility staff."</p> <p>*Nothing to ensure physician involvement with medication side-effect monitoring.</p> <p>Review of the provider's undated Nurse Staff (RN) Job description revealed:</p> <p>*General purpose: "Assess resident needs, develop individual care plans, administer nursing care, and evaluate nursing care."</p> <p>**Adhere to state rules and regulations concerning delivery of care and assure that effective quality nursing care is delivered which is outcome focused through utilization of the nursing process."</p> <p>**Identify rationale and anticipated outcomes for each nursing intervention."</p> <p>**Keep physician and/or other health care professionals informed of resident's condition; and notify physician and/or other health care professionals immediately of significant changes of condition."</p>	F 309		
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F 309	Continued From page 35 **Critique and take responsibility for evaluating nursing care delivered." **Ensure accurate documentation of all medical records and reporting forms." **Demonstrate knowledge of drug reactions and sensitivities and nursing interventions." Review of the provider's undated Director of Nursing Job description revealed: **Manage the overall operation of the department in accordance with company policies, and standards of nursing practices and government regulations, so as to maintain quality care." **Carry out, coordinate and manage administrative functions and areas of programs related to nursing services which may include departmental documentation or medical records." **Monitor quality of care and resident activity, assessment of resident's status, administration of medication and treatments, admissions and discharges; and consult with family members, physicians, and other health care professionals."	F 309		
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: 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	F 490	F490 The Administrator has collaborated with the DON and interdisciplinary team regarding the review and revision of affected policies and procedures as well as the necessary staff education. 1. Resident #1 has expired and Resident #4 has discharged from this facility. 2. All residents are potentially at risk.	1/15/15

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F 490	<p>Continued From page 36</p> <p>safety and overall well-being for all of its 132 residents by ensuring:</p> <p>*The policy and procedure was followed for the use of an AED (automated external defibrillator) (delivers electric shock when the heart rhythm has stopped) for one of one sampled resident (1) who required cardiopulmonary resuscitation (CPR).</p> <p>*A process was in place to identify each staff members responsibility and/or task during a CPR occurrence.</p> <p>*The family and physician were updated of an acute change in one of one sampled resident's (1) condition.</p> <p>*One of one sampled resident (4) with a new tracheostomy (breathing tube inserted into the neck) was monitored, assessed, treated, and documented on for physician notification and involvement.</p> <p>Findings include:</p> <p>1. Interview on 12/16/14 at 10:40 a.m. with the director of nursing (DON) and clinical nurse specialist revealed:</p> <p>*They had an AED policy but confirmed they had not been following it.</p> <p>*Confirmed their process for each staff members responsibility and/or task during a CPR occurrence required reviewing and changing.</p> <p>*The DON stated "In hind sight I would have expected the nursing staff to notify the physician with any acute change in condition."</p> <p>Review of the provider's undated Director of Nursing Job description revealed:</p> <p>**"Manage the overall operation of the department in accordance with company policies, and standards of nursing practices and government regulations, so as to maintain quality care."</p>	F 490	<p>3.</p> <p>a. Education to all licensed nursing staff by the Director of Nursing or designee on or before 1/15/15 on utilization of resources to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>b. Director of Nursing or designee will complete written audits of utilization of resources to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident weekly x 4, then monthly x 2. Audit selection is random with a maximum of four. The following areas will be audited 1. Follow proper AED procedures 2. Follow proper CPR procedures. 3. Ensure proper notification of changes in condition. 4. Ensure residents with new tracheostomies are monitored, assessed, treated and document the physician notification and involvement with a change in condition.</p>	

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F 490	<p>Continued From page 37</p> <p>**Carry out, coordinate and manage administrative functions and areas of programs related to nursing services which may include departmental documentation or medical records."</p> <p>**Monitor quality of care and resident activity, assessment of resident's status, administration of medication and treatments, admissions and discharges; and consult with family members, physicians, and other health care professionals."</p> <p>Review of the provider's 5/5/14 Director of Clinical Services Job description revealed:</p> <p>**Provides consulting services, direction and support in the identification, development and implementation of programs, systems, processes and procedures that support clinical services of the health care facilities in the efficient and effective delivery of quality care and services to the residents."</p> <p>**Observes, identifies, evaluates, and recommends, in concert with facility staff, performance and process management standards to effectively manage the delivery of quality care and services to residents to meet or exceed all federal, state and company regulations, policies, and procedures."</p> <p>**Implements policies and procedure governing nursing and other resident care services."</p> <p>**Assists with the implementation of corporate policies affecting the nursing department."</p> <p>Review of the provider's undated Administrator Job description revealed:</p> <p>*General purpose: "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 operational and business</p>	F 490	4. The Administrator will receive and review all audits (Refer to F157, finding 1, F224, finding 1, F309 finding 1) completed with the DON prior to monthly QAPI committee meeting. This will be an ongoing practice throughout the auditing process. Director of Nursing or designee will then report results of the audits to the facility QAPI committee for review and recommendations monthly x 3.	

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F 490	Continued From page 38 objectives." *Essential job functions: -"Monitors each department's activities, communicates policies, evaluates performance, provides feedback, and assists, observes, coaches, and disciplines as needed." -Oversees regular rounds to monitor the delivery of nursing care to ensure resident needs are being addressed. Refer to F157, finding 1; F224, finding 1; and F309, finding 1.	F 490			

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