

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

ORIGINAL

PRINTED: 01/31/2014
FORM APPROVED
OMB NO. 0938-0391

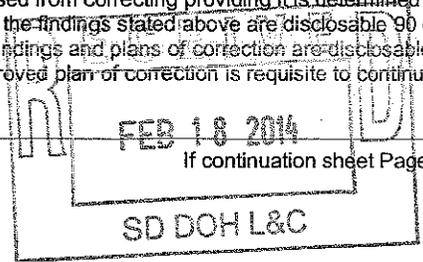
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/22/2014
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NAME OF PROVIDER OR SUPPLIER AVERA MARYHOUSE LONG TERM CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 717 EAST DAKOTA PIERRE, SD 57501
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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 000	INITIAL COMMENTS Surveyor: 26632 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/21/14 through 1/22/14. Areas surveyed included nursing services, injuries of unknown origin, resident abuse and neglect, and restraints/seclusion. Avera Maryhouse Long Term Care was found not in compliance with the following requirement: F221.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, record review, and interview, the provider failed to ensure: *A restraint assessment was completed, physician orders were obtained, and restraints had been care planned prior to initiation of using an electric recliner for one of one sampled resident (2) that could not operate that recliner. *Documentation was present that all nursing staff had been educated on what constituted a restraint . Findings include: 1. Observation on 1/22/14 from 1:00 p.m. through 1:30 p.m. in the third floor television area revealed resident 2 was seated in an electric	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE *Executive Director* (X6) DATE *2/14/14*

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 221	<p>Continued From page 1</p> <p>recliner with the foot rest up. The recliner was electrically controlled. It was plugged into an electrical socket, but the control for the recliner was out of reach and sight of resident 2. The control was in a pocket on the left lower side of the chair. The television was on during that time. There was a licensed nurse who would frequently come and go from that area. There were no other staff present during that time. Resident 2 would frequently readjust his position while in the recliner.</p> <p>Review of resident 2's medical record revealed: *He had diagnoses that included vascular dementia (decreased memory and problem solving skills) and macular degeneration (decreased central vision). *He did not have a physician's order for a restraint. *There was no restraint assessment.</p> <p>Review of his 12/26/13 care plan revealed no problems, goals, or interventions on the use of the electric recliner as a restraint.</p> <p>Review of an undated report from the provider given to the surveyor on 1/23/14 revealed: *On 1/9/14 resident 2 was found in an electric recliner by his family. The recliner was leaned back and unplugged. The family had been told by certified nursing assistant (CNA) A that he had been put in the recliner to keep him from leaving the facility. *CNA A told the family resident 2 had been restless. She was aware he was in the recliner, leaned back, and it had been unplugged. She did not remember who had unplugged the recliner. She was not aware it was a restraint. *CNA B had been aware resident 2 was seated in</p>	F 221	<p><i>Corrective actions includes resident 2 will have a control in sight and available to use within reach whenever he is in an electric recliner. That recliner will also remain plugged in. Resident 2 and other potentially affected residents will be identified by charge nurses and MDS nurses as residents who are at risk to fall or exhibit behavior problems that put themselves or others at risk.</i></p> <p><i>Compliance with residents remaining restraint free, and our policies and procedures regarding our residents who may be potentially affected will be monitored by RNs and LPNs delegated to complete a monitoring tool</i></p>	2/14/14

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F 221	<p>Continued From page 2</p> <p>the recliner, leaned back, and it was unplugged. She was aware that unplugging the recliner could be a restraint.</p> <p>*CNA C was aware resident 2 was in the recliner and leaned back but was not aware it was unplugged. She was aware that unplugging the recliner could be a restraint.</p> <p>*Registered nurse D was aware resident 2 was in the recliner and leaned back. He was not aware it was unplugged. He was aware that would be a restraint.</p> <p>*A restraint review had been sent by e-mail to all staff on Friday 1/10/14.</p> <p>*That restraint review had been read at daily line-up twice daily for the next three days.</p> <p>*There was no documentation of which staff had been presented that information, or if all staff had received that information about restraints.</p> <p>Review of care notes on 1/9/14 for resident 2 revealed:</p> <p>*At 10:02 p.m. "Evening meds (medications) held. Resident very restless throughout evening, family did come in to sit with until resident ready for bed."</p> <p>*At 11:26 p.m. "Resident awake in bed calm. melatonin (for sleep), Namenda (for dementia), Norco (narcotic pain medication), and mirtazepine (anti-depressant) given."</p> <p>*There was no documentation of what his behaviors had been earlier while in the recliner.</p> <p>Interview on 1/22/14 at 10:00 a.m. with the director of nursing revealed:</p> <p>*She was aware of the above incident with resident 2.</p> <p>*She did not have documentation to ensure all nursing personnel had received the above training on restraints.</p>	F 221	<p><i>designed to observe for compliance with Policy 6312.25</i></p> <p><i>Decreasing / Eliminating the use of Physical and Chemical Restraints. This policy was reviewed and revised in 02/2014.</i></p> <p><i>Education has been provided to the facility staff in regards to this policy by means of direct in services, in written form and one on one communication verbally, including but not limited to employees A, B, C, D, E and F, by February 15, 2014.</i></p> <p><i>12 monitoring tools will be completed and reported to the Quality Improvement Committee, per month, by the DON in February 2014. This will be continued quarterly until the QIC advises to discontinue.</i></p>		

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F 221	Continued From page 3 *She agreed the use of the recliner had been a restraint for resident 2.	F 221	<i>Education will continue to be provided as needed, at orientation of new employees and at least annually.</i>		