

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

ORIGINAL

PRINTED: 09/03/2014
FORM APPROVED
OMB NO. 0938-0391

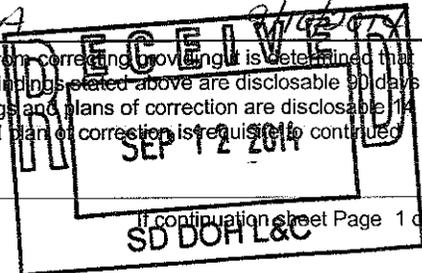
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/21/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469	
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F 000	INITIAL COMMENTS <i>Addendums noted with an asterisk per 9/11/14 telephone to facility interim administrator.</i> Surveyor: 32333 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/19/14 through 8/21/14. Areas surveyed included quality of care and treatment, nursing services, and resident assessment. Golden LivingCenter - Redfield was found not in compliance with the following requirement: F323.	F 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on record review, interview, policy review, and manufacturer's product information and instruction review, the provider failed to maintain a safe environment with appropriate supervision and monitoring for two of five sampled residents (1 and 2) that had fallen resulting in major injuries. Findings include: 1. Review of resident 1's complete medical record revealed: *A diagnosis of Alzheimer's disease (confused mental thinking). *He had been a resident in the advanced	F 323	* Resident 1 no longer resides in the facility and unable to change past events. As of 5/17/14 at 1530, AACU exit door to courtyard was not propped open; exit door was securely locked. AACU staff on duty 5/17/2014 and 5/18/14 were instructed that AACU exit door was not to be propped open, but remain securely locked. All residents at risk for falls due to physical, behavioral or cognitive deficits, have the potential to be affected. On 5/20/14, all facility staff were educated that no outside exit doors are to be propped open, but remain securely locked. May 2014, prevention of falls education was provided to all staff through written materials via IDNS. On June 5, 2014 falls prevention education was presented to ACU/AACU staff via in-	

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

Debra McNaugh

Interim NHA

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided 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 323	<p>Continued From page 1 Alzheimer's care unit (AACU). *A history of wandering and falls. *He had been assessed to be at risk for falls. *He had been assessed to be at risk for elopement (leaving the facility).</p> <p>Review of resident 1's nursing progress notes revealed: *On 5/17/14 at 3:06 p.m. "Was found outside without any other people. Found on ground." Vital signs taken. "Neuro check completed & [and] will not bear weight or stand. States his left hip hurts." *On 5/17/14 at 3:30 p.m. "Wife was in AACU when resident was found outside on ground. Contacted Dr. ____ at CMH [Community Memorial Hospital] & received order to transport to ER [emergency room] via ambulance." *On 5/17/14 at 6:23 p.m. "Talked to Dr. ____ from CMH ER, resident has a minimally displace fracture of the left hip neck. Family does not want surgery. Will be admitted to hospital for pain control. Family with resident."</p> <p>Review of resident 1's 5/17/14, 5-Working Day Investigation report revealed "Through observation, (independently ambulatory) resident had been ambulating in outside courtyard with wife and another facility resident. This resident, along with wife and other facility resident came back into facility through an opened door from AACU to courtyard. (CNA [certified nursing assistant] reported that she opened AACU door to courtyard to allow those using courtyard free access from facility into courtyard and back into facility.) Wife and other resident sat down at an AACU dining room table to visit. Within moments, CNA staff near dining room observed this resident to not be in accompaniment of wife and other resident. At this time, CNA who was in another</p>	F 323	<p>service by IDNS. On July 17, 2014 a falls prevention education was presented to all staff by Golden Living Clinical Consultant.</p> <p>A directed all staff in-service training regarding the provision of care that meets the residents' physical, mental and psychosocial well being, including the necessity to maintain an environment that promotes resident safety will be provided by 9/19/14.</p> <p>Maintenance personnel or designee will audit exits to ensure they are properly secured weekly x 4 then monthly x 11. Results of these audits will be presented by the Maintenance personnel to the monthly QAPI committee for review and recommendation. Executive Director (ED) or designee will perform random audits of the AACU exit door to ensure that it is properly secured. Audits will be completed weekly x 4, then monthly x 11. Results of these audits will be presented by the ED to the monthly QAPI committee for review and recommendation</p>	

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F 323	<p>Continued From page 2</p> <p>resident's room observed this resident through window to be ambulating in courtyard and began her way to the courtyard; at this time, RN [registered nurse] in ACU [Alzheimer's Care Unit] received a report from a resident's family member visiting in the facility, who had been looking out of another window, that there was a gentleman on the ground in the courtyard. This family member reported to the RN that it appeared that this gentleman attempted to sit in the swing (located in the courtyard) and missed the swing, falling to the ground. RN responded immediately to courtyard finding the CNA (who had seen resident ambulating in courtyard through a resident room window) had reached the courtyard and the resident who was laying on ground."</p> <p>Review of resident 1's 3/24/14 Minimum Data Set assessment revealed: *For transfers he had been assessed to require extensive physical assistance, staff to provide weight bearing support with two plus person assistance. *For ambulation he had been assessed to require supervision with one person for physical assistance.</p> <p>Review of the South Dakota Department of Health 11/7/13 recertification survey revealed the provider had been cited under F323 for the unsupervised access to the courtyard with access doors from the ACU and AACU. It also addressed the ACU door was being propped open. Refer to tag F323, finding 1, from the 11/7/13 survey.</p> <p>Review of the providers 12/27/13 plan of correction from that 11/7/13 survey revealed: *A directed in-service training would be provided to staff by 12/5/13 regarding provision of care that</p>	F 323	<p>On 7/22/14, seat belt alarm battery for resident #2 was changed. Beginning 7/30/14, monitoring of seat belt alarm for resident #2 for proper functioning was done by nursing staff every 2 hours while resident in wheelchair and logged in electronic medical record; as of 8/7/14, the monitoring of the change of alarm battery every month per manufacturer's recommendation is logged by nursing per resident's medical record. On 7/22/14, all staff were educated regarding the proper monitoring of resident #2's seat belt alarm to assure alarm is on and functioning. In early August, 2014, monitoring of resident's alarm added to CNA daily assignment sheet.</p> <p>All residents who have positioning alarms in place have the potential to be affected. All positioning alarms in use in building were assessed for proper functioning by 9/4/14. All positioning alarms in use in building are assessed and logged by nursing via the electronic medical record for proper functioning on daily basis with the changing of alarm batteries done and logged by nursing per the manufacturer's recommendations on 9/4/14.</p>		

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F 323	<p>Continued From page 3</p> <p>meets the resident's physical, mental, and psychosocial well being including the necessity to maintain an environment that promoted resident safety.</p> <p>*Maintenance personnel or designee would audit exits to ensure they alarmed, locked and unlocked properly weekly for four weeks, then monthly for three months.</p> <p>Interview on 8/20/14 at 10:50 a.m. with the ACU and AACU director revealed:</p> <p>*On the ACU residents were allowed to go outside with family.</p> <p>*On the AACU staff were supposed to go outside with residents.</p> <p>*Doors were never supposed to have been propped open.</p> <p>Interview on 8/20/14 at 1:15 p.m. with the maintenance director revealed the door to the AACU should never have been propped open. That door was supposed to have been locked at all times.</p> <p>Interview on 8/20/14 at 1:50 p.m. with the administrator revealed there had been no policy relative to the door in the AACU leading out to the courtyard. That door was supposed to have been locked at all times. If residents had been assessed to be ambulatory they could be unsupervised in the courtyard. They had not done any specific assessment for safety for residents to go outside. That door should have never been propped open.</p> <p>Interview on 8/20/14 at 2:25 p.m. with the director of nursing revealed the above door should not have been propped open. The best practice would have been for residents to have been</p>	F 323	<p>Education to all staff regarding proper use and functioning of patient body alarms will be completed by 9/19/14.</p> <p>Director of Nursing Service (DNS) or designee will audit documentation of alarm function weekly x 4 and monthly x2. Results of these audits will be presented by the DNS to the monthly QAPI committee for review and recommendation.</p> <p>Lift assessment for resident #3 was updated on 9/8/14 to include resident's preference for intermittent use of Sara. Lift leg straps omit dem</p> <p>All residents who are transferred with the use of sit to stand lifts are at risk.</p> <p>Proper use of lifts audits and re-education as needed beginning early May 2014, remain in progress. omit dem</p> <p>DNS or designee will randomly audit 3 transfers with sit to stand lifts weekly x 4 weeks; monthly x 2 and report findings to QAPI for further review and recommendations. omit dem</p> <p>A directed all staff in-service training regarding the provision of care that meets the residents' physical, mental and psychosocial well being, including the necessity to maintain an environment that promotes resident safety will be provided on 9/19/14 to include</p>	

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F 323	<p>Continued From page 4</p> <p>supervised. All residents in the AACU should have been supervised when outdoors. There had been no policy regarding the supervision of a residents in the courtyard or propping doors open. If a door was locked the resident should have been accompanied outside.</p> <p>Surveyor: 32331</p> <p>2. Review of resident 2's medical record revealed she:</p> <ul style="list-style-type: none"> *Had been admitted on 3/13/07. *Had diagnoses that included Parkinson's disease (a progressive disorder of the nervous system) and a lack of coordination. *Was at risk for falls with a score of 12 (a total score of 10 or above made the resident at risk). *Had fallen on 7/22/14 on the floor in front of her sink in her room. -She was found on the floor at 2:03 p.m. -That fall had been unwitnessed by staff. -Had been unresponsive for ten minutes after she had been found on the floor. -Had a laceration (break in the skin) to the back of her head, a bruise to her right elbow, and a skin tear to her left forearm. -Had discomfort to left shoulder reported. -Was taken to the emergency room by an ambulance at 2:15 p.m. <p>Review of resident 2's 8/14/14 care plan revealed she:</p> <ul style="list-style-type: none"> *Was at risk for falls related to impaired mobility/balance. *Had a history of falls. *Had impaired safety awareness. *Was to have been checked for wheelchair positioning frequently throughout each shift. *Was encouraged to always call for help when 	F 323	<ul style="list-style-type: none"> • accident prevention by not propping exit doors open • monitoring the alarming seat belts for being turned on and properly functioning batteries • providing residents with adequate supervision <p><i>JT/SDDOH/MF</i></p>	9/19/2014

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F 323	<p>Continued From page 5 needed.</p> <p>*Was to have left her seat belt on as a reminder that it was for her own safety.</p> <p>Review of resident 2's 7/22/14 initial nursing facility event report required by and reported to the South Dakota Department of Health revealed:</p> <p>*She been been found on the floor in the room by the sink.</p> <p>*She had sustained an approximate two centimeter laceration to the back of head that had been bleeding profusely (excessively).</p> <p>*She went to the emergency room by ambulance where she had been evaluated for injuries.</p> <p>*She returned to the facility with no sutures (stiches) or report of further injuries.</p> <p>*She had an alarming seat belt on when up in her wheelchair that she could remove independently.</p> <p>*The alarm had not sounded when she had fallen.</p> <p>*Staff had stated awareness of the need to have punched the alarm 'on' when she had been transferred into the wheelchair.</p> <p>*The alarm light remained a constant blue on the personal alarm when the alarm was on.</p> <p>*Staff had found the blue alarm light had been blinking.</p> <p>*The battery changed the alarm light to a constant blue.</p> <p>*Staff had been educated on the need to have observed the alarm light to ensure the alarm was on when she was in the wheelchair.</p> <p>*Staff were to have reported if the light was blinking as that meant the battery needed to have been changed.</p> <p>Review of resident 2's physician's orders revealed: On 9/20/12 "TABS [a type of personal alarm system] Alarm for safety."</p>	F 323			

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F 323	<p>Continued From page 6</p> <p>*On 1/21/14 "Patient may continue to utilize Velcro seatbelt to improve positioning and safety. (Note patient is able to remove independently and on command)."</p> <p>*On 8/7/14 "Change battery to seat belt alarm q [every] 30 days every day shift every 30 day(s) for Prevention."</p> <p>*The above order on 8/7/14 was written after the resident had fallen on 7/22/14 and had sustained a major injury.</p> <p>Review of resident 2's treatment administration record revealed:</p> <p>*On 7/30/14 "Check seat belt alarm to ensure it is working properly Q [every] 2 hours while in wheelchair."</p> <p>*The above order on 7/30/14 was written after the resident had fallen on 7/22/14 and had sustained a major injury.</p> <p>Interview on 8/19/14 at 4:00 p.m. and on 8/21/14 at 10:30 a.m. with the director of nursing (DON) regarding resident 2's fall on 7/22/14 revealed:</p> <p>*She had been toileted at 11:00 a.m.</p> <p>*She had fallen at 2:00 p.m.</p> <p>*She had been taken to the emergency room after she had fallen.</p> <p>*Upon her return from the emergency room her personal alarm light had been blinking.</p> <p>*The battery had been changed at that time, it was no longer blinking, and it was a constant blue.</p> <p>*There was a nursing assignment care sheet used for communication to direct care staff regarding each resident's observation and condition changes.</p> <p>-She was currently listed on the care sheet with "Seatbelt alarms at ALL times (blue light must be on, not flashing)."</p>	F 323		

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F 323	<p>Continued From page 7</p> <p>-The DON reported the above had not been on the care sheet prior to her fall; it had been added after her fall on 7/22/14.</p> <p>*The DON agreed the seatbelt's blue light needed to have been more closely monitored and the battery changed on a regular schedule.</p> <p>-She confirmed the resident's personal alarm light had not been properly working.</p> <p>-She confirmed the alarm had not sounded prior to the resident's fall on 7/22/14 resulting in a major injury.</p> <p>-She confirmed the manufacturer's production information for the seatbelt alarm had not been followed.</p> <p>Review of the undated manufacturer's product sheet information for resident 2's Safe-mate Alarmed Velcro Seatbelt revealed:</p> <p>*"Test the belt for proper operation.</p> <p>*Firmly press the switch to the ON position (blue LED light remains lit).</p> <p>*The alarm should sound as soon as the belt is separated."</p> <p>*The device was not a substitute for proper supervision.</p> <p>*Check fall risk patients frequently.</p> <p>*Change battery monthly.</p> <p>Interview on 8/21/14 at 11:00 a.m. with the administrator revealed the provider had no policy on personal resident alarms.</p> <p>Review of the provider's revised 2013 Falls Management Clinical Guidelines policy revealed at risk residents were identified through a "fall alert" communication system to caregivers.</p>	F 323			