

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/12/2015
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NAME OF PROVIDER OR SUPPLIER CENTERVILLE CARE AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 500 VERMILLION ST CENTERVILLE, SD 57014
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F 000	<p><i>Addendums noted with an asterisk per 4/13/15 telephone to facility administrator. KRISDDOCHMF</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 22452 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/11/15 through 3/12/15. Areas surveyed included resident care and treatment. Centerville Care and Rehab Center was found not in compliance with the following requirements: F164, F224, F225, F250, F280, F281, F309, F323, and F490.</p>	F 000	F000	
F 164 SS=F	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another</p>	F 164	F164	5/1/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE ADMINISTRATOR	(X6) DATE 4/2/2015
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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 164	<p>Continued From page 1 healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 18387 Based on observation, record review, policy review, and interview, the provider failed to maintain all residents' personal information in a private and confidential manner. Findings include:</p> <p>1. Observation throughout the survey from 3/11/15 to 3/12/15 revealed: *The door to the office of health information remained open. *The room was left unattended. *Confidential residents' records were located in that room on a table. *Residents, visitors, and staff members were present in the hallway at all times.</p> <p>2. Observation and record review on 3/12/15 from 8:10 a.m. to 8:40 a.m. revealed at the nurses station: *Three sheets of resident's information was on the end of the desk. *Residents' room numbers and their names were listed. *Information was specific for residents' on the sheets. Some of the information included: -Sleeps in the recliner. -Pericare (to wash the resident's private area) every shift. -CHART BEHAVIORS. -Chart wandering and verbal hallucinations. -Do not let him cuss, tell to stop, and be respectful. -Staff do not purchase anything for him.</p>	F 164	<p>*Education to all staff regarding resident confidentiality was provided by the DON. All medical records that were in the health information room have been moved to another room that can be locked. KR/SDO/MLM</p>		

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F 164	Continued From page 2 -Diabetic. -Wash abdominal folds and breast area twice daily. *No staff members were present at the nurses station. *Residents and housekeeping staff were in that area. During the above time an individual placed a tray on the nurses station next to the above sheets. The individual identified herself as a laboratory technician from the local clinic, and she was not employed by the facility. 3. Interview on 3/12/15 at 9:05 a.m. with the administrator confirmed: *The office to health information contained confidential resident information. *The residents' information was not secured. *The residents' sheets at the nurses station should have been kept confidential. Review of the provider's undated Personal Privacy and Confidentiality policy revealed the residents had the right to personal privacy for medical treatment and personal care.	F 164			
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 224	F224 Resident 2 has discharged. All other residents with a history of falls were investigated to determine that no abuse or neglect had occurred.	5/1/2015	

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F 224	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452</p> <p>Based on record review, interview, and policy review, the provider failed to investigate to determine if abuse or neglect had occurred for one of one sampled resident (2) with a history of falls. Findings include:</p> <p>1. Review of resident 2's medical record revealed he had been admitted to hospice services at the request of his daughter on 2/6/15 for end stage dementia (memory loss).</p> <p>Review of resident 2's 11/2/14 through 2/22/15 nurses notes and incident reports revealed: *11/2/14 at 4:25 p.m.- "Resident's knees buckled when being transferred from recliner to wheelchair by certified nursing assistant [CNA]. Lowered to floor." *11/13/14 at 11:15 a.m.- "Attempted to get up on own and fell forward out of chair. Cut on forehead and on 2nd to last finger on right hand." *2/1/15 at 9:32 p.m.- "Staff was assisting resident to bed using the stand aide [lift that requires the resident to be able to bear some weight on their legs]. Resident decided not to stand up and lifted his legs leaving him hanging from the stand aide by his arms. Staff assisted to remove him from the stand aide and lowered him to the floor. A total lift [mechanical lift that requires no weight bearing from the resident] was used to help lift him from the floor to his bed." *2/3/15 (no time)- "Resident found lying on the floor on his right side. Skin tear to right elbow." *2/5/15 at 2:25 p.m.- "Resident had his Tabs on [monitor that alarms]. In bed in low position. Resident rolled out of bed. Found lying on his comforter."</p>	F 224	<p>Administrator, DON, and interdisciplinary team reviewed and revised as necessary the policy and procedures about appropriate incident investigation and reporting. Education will be provided to all staff.</p> <p>DON or designee will audit all residents with new falls to ensure an investigation was conducted to determine that no abuse or neglect had occurred one time per week for four weeks and monthly for two more months. ^</p> <p>DON or designee will present findings from these audits at the monthly QAPI meetings for review.</p> <p><i>*The DON is responsible for all investigations. KZ/SDDOH/MF</i></p>		

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F 224	<p>Continued From page 4</p> <p>*2/9/15 at 10:15 a.m.- "Found resident laying on pillow between wall and the bed."</p> <p>*2/10/15 at 9:30 a.m.- "Found on floor mat beside low bed. Body pillow with him."</p> <p>*2/19/15 at 12:30 a.m.- "Found laying on left side on floor mat next to bed. Tabs monitor on. No injuries."</p> <p>*2/22/15 at 5:50 a.m.- "CNA came to get resident ready for the day, bed in up position for her to work with the resident. She went to get washcloth and resident rolled out of bed. She had placed body pillow prior to leaving bedside. Skin tear front of forehead, bridge of nose, reopened one on left elbow, pinpoint one 2nd finger right hand, and 3rd finger left hand."</p> <p>Interview on 3/12/15 at 8:30 a.m. with the director of nursing regarding resident 2's 2/22/15 fall with injuries revealed she:</p> <p>*Had not investigated the incident other than reading the documentation from the nurse and talking to CNA A. It was not an unwitnessed incident as CNA saw him rolling off the bed.</p> <p>*Stated CNA A felt very bad regarding the incident.</p> <p>*Felt it was not necessary for any disciplinary action to be done.</p> <p>*Confirmed CNA A left his bed not in the low position and went into the bathroom to get a washcloth. The CNA had her back turned away from him when she was in the bathroom.</p> <p>*Agreed he had a lot of falls, but the facility had related it to the family having the physician discontinue his psychotropic medication (mood and behavior altering) the end of January 2015. Since that time he had become more restless and resistant with care.</p> <p>*Stated the CNA had put the body pillow around him before she went into the bathroom. They had</p>	F 224			

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F 224	Continued From page 5 started the body pillow the past month. He had rolled out of bed before, and the body pillow had protected him from serious injury. *Confirmed he got injured during the incident, but he did not need to be sent to the emergency room. Review of resident 2's undated care plan revealed "Resident has high/low bed. Staff will make sure it is in low position when in bed to eliminate risk for falls." Review of the provider's undated Abuse policy revealed: *Mistreatment, neglect, or abuse of residents is prohibited by any individual. *Neglect is failure to provide goods, materials, and services necessary to avoid physical harm, mental anguish, or mental illness. *The investigative team shall generate a written summary based on all discussions, observations, documentation, findings, and conclusions of their investigation of alleged violation. That report shall be maintained in the administrator's office for a minimum of five years.	F 224			
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or	F 225	F225 Resident 4 was reviewed to ensure the elopements and inappropriate resident-to-resident behavior was reported and investigated. All other residents with elopements or inappropriate resident-to-resident behavior were reviewed to ensure the events were reported and investigated.	5/1/2015	

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F 225	<p>Continued From page 6 other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 18387 Based on record review, policy review, and interview, the provider failed to: *Report and investigate two elopements throughly to prevent elopements for one of one sampled resident (4) who had a history of elopements. *Report and investigate one of one sampled resident (4) for resident-to-resident inappropriate behavior. Findings include:</p>	F 225	<p>Administrator, DON, and interdisciplinary team reviewed and revised as necessary the policy and procedures about appropriate incident investigation and reporting. Education will be provided to all staff.</p> <p>DON or designee will audit all residents with new elopements or inappropriate resident-to-resident behavior to determine if they were reported and investigated one time per week for four weeks and monthly for two more months.</p> <p>DON or designee will present findings from these audits at the monthly QAPI meetings for review.</p>		

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F 225	<p>Continued From page 7</p> <p>1. Review of resident 4's initial elopement report sent to the South Dakota Department of Health (SD DOH) revealed on 2/8/15 the resident had been identified by a town resident at a street address. The resident had been found on the laying on the sidewalk. Review of the five day investigation report completed by the provider revealed the door alarms had not been working properly and were repaired. the staff was educated on the importance of reporting issues with the alarm system.</p> <p>Review of resident 4's elopement report sent to the SD DOH revealed on 3/6/15 the resident was found walking outside. The report did not address what door the resident eloped from, the resident's cognition, or if the resident was able to say what happened. No interventions had been included to prevent further elopements.</p> <p>2. Review of 1/6/15 social service designee (SSD) progress notes revealed resident 4 "was found setting on his roommates lap and had pulled back his roommates covers and was touching him."</p> <p>Interview on 3/12/15 at 1:00 p.m. with the director of nursing (DON) revealed she was not aware resident-to-resident inappropriate behavior was to be reported to the state. No investigation or interventions had been implemented to prevent further occurrences.</p> <p>3. Review of resident 4's 1/6/15 progress notes by the SSD revealed: *The resident had unpredictable behaviors, elopement, and reported sexual behaviors. *The staff were not always able to redirect him.</p>	F 225			

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F 225	<p>Continued From page 8</p> <p>*He had eloped from the facility several times since his admission. He was running during one attempt and was followed by staff.</p> <p>*He was found pacing in the parking lot without a coat on in the cold.</p> <p>*He had a Wanderguard alarm on and the doors had alarmed..</p> <p>Review of resident 4's current care plan revealed:</p> <p>*The resident would wear a Wanderguard alarm to alert staff he had exited the building.</p> <p>*For the focus area that the resident was physically aggressive the interventions were:</p> <ul style="list-style-type: none"> -To analyze the time of day, places, circumstances, triggers. -What de-escalates behavior and document. -Monitor behaviors and document observed behavior and attempted interventions in behavior log. <p>*For the focus area that the resident is an elopement/wanderer risk the interventions were:</p> <ul style="list-style-type: none"> -Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers: No resident preferences were provided. -Document wandering behavior. -Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the needs for more exercise? Intervene as appropriate. -Provide structured activities: toileting, walking inside or outside, reorientation strategies including signs, pictures, and memory boxes. <p>Interview on 3/12/15 at 1:00 p.m. with the director of nursing regarding resident 4 revealed:</p> <p>*She was not aware the resident had other elopements as documented by the SSD.</p> <p>*She was not aware if an investigation had been</p>	F 225			

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F 225	Continued From page 9 completed for those elopements. *The care plan was not specific for the interventions for the elopements or inappropriate behaviors. *She was not aware inappropriate resident-to-resident care was to be reported to the SD DOH. Review of the provider's 7/10/13 Resident Incident policy revealed: *All incident reports would be given to the DON to assess and given to the administrator for review. *The DON would complete a log of all incidents and reports sent to SD DOH. *Reports would be sent to SD DOH even if it was determined the incident/accident resulted from abuse or neglect. The two hour event report and the 24 hours event report would be completed by the charge nurse, DON, or social worker. *Incidents that required an event report included: abuse, neglect, serious bodily injury, falls resulting in serious injury or hospitalization, injuries of unknown origin, theft of a resident's items, misappropriation of resident's funds, death (other than natural causes), and missing resident/elopements. Review of the provider's 7/17/14 Falls policy revealed to fill out the "24-Hour Event Reporting" sheet if suspicion of abuse and neglect or if the the fall resulted in a major injury or hospitalization; fax into the indicated number on the form."	F 225			
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest	F 250	F250 Resident 2 has discharged.	5/1/2015	

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F 250	<p>Continued From page 10</p> <p>practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, interview, and job description review, the provider failed to ensure family concerns were resolved regarding resident care issues for one of one sampled resident (2). Findings include:</p> <p>1. Review of resident 2's medical record revealed he had been admitted to hospice services at the request of his daughter on 2/6/15 for end stage dementia (memory loss).</p> <p>Review of resident 2's 1/27/15 through 3/9/15 progress notes by the director of nursing (DON), dietary manager, dietitian, activity director, and social services designee (SSD) revealed: *1/27/15 at 2:01 p.m.- "Care team met today per family request to have one week early. We spoke about his choking episodes that he has had over a 2 month period. He was seen by speech therapist [ST] with recommendations. Family would like all his food cut up prior to leaving kitchen window. They want him to stay up until 7:30 p.m. if able to help with digestion. They stated if he is leaning then put him down. They would like his Risperdal [antipsychotic medication for mood/behavior] and Donzepil [medication for treatment of severe dementia] stopped. They feel at this point they are no longer helping him. They stated his quality of life is no longer there. We told family that we will send facsimile [fax] requesting your wishes."</p>	F 250	<p>All other residents were reviewed to ensure family concerns were resolved regarding resident care issues.</p> <p>Social service designee will audit all new family concerns regarding resident care issues one time per week for four weeks and monthly for two more months to ensure the concerns were resolved.</p> <p>Social service designee will present findings from these audits at the monthly QAPI meetings for review.</p> <p><i>* Education was provided to the SSD regarding ensuring family concerns were addressed and reviewed with the consultant social worker. KR/SSD/DH/MF</i></p>		

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F 250	<p>Continued From page 11</p> <p>*2/4/15 at 2:38 p.m.- "Call placed to daughter after granddaughter informed this recorder that family was upset related to his care. Daughter relayed that communication was very poor, nobody knows anything, and they sat in care team and everyone passed the buck and no one knew anything. I informed daughter that we talked extensively related to his medication, eating, mobility, and what we were doing and what family wants done. Family requested to have medication stopped. They felt he no longer needed his zoloft (antidepressant) or Risperdal. On 1/16/15 order received to decrease zoloft to 25 milligrams [mg] daily for one week and then discontinue. On 1/28/15 order received to discontinue Donzepam and Risperdal. Since this time we are seeing more anxiety, restlessness that possibly contributed to his falls. Granddaughter made the comment that staff said they told daughter they pushed him out of bed. When confronted daughter about what supposedly the staff said we pushed him out of bed. The daughter stated she never said he was pushed out of bed. I educated daughter that with family working at the facility in different departments word of mouth is getting out of control and rumors are being said that isn't true. Informed daughter if having problems within family all saying different things needs to be stopped. We are here to care for the resident and not get involved in family matters. Daughter would like him returned to hospice care if qualifies. Informed daughter that if she isn't happy with his care, it's her decision to find another placement. Daughter said that she has tried and no one wants him. Daughter will make phone calls related to this matter."</p> <p>*2/5/15 at 4:05 p.m.- "Resident was admitted to hospice at the request of his daughter. Resident has not had any changes but daughter felt he</p>	F 250			

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F 250	<p>Continued From page 12 needed extra care." *2/6/15 (no time)- "Resident was admitted to hospice care today. Daughters do not agree on their dad's care. ST recommended no bread products. One daughter agrees with ST and one daughter disagrees. Spoke with ST and she stated that this is what is safe for the resident and daughter who agrees is power of attorney [POA]. Other daughter who disagrees works at facility and has been educated that we need to follow diet as it says. She feels he needs to have cookies and breads because he loves them. This daughter educated to soak his cookies in coffee and to avoid bread products. Daughter that agrees called and was very upset. She stated cook did not follow diet as ordered. Visited with cook and he stated he must have overlooked diet card and gave him bread as a mistake. Cook was educated and this has not happened again. Daughter was calmed down by end of conversation, but upset this writer [dietary manager] was not at his care plan last week. This writer was on vacation for a week, and ST and daughter who works in dietary were both at care plan." *2/17/15 at 12:00 noon- "Per report from dietary manager the resident has had more falls recently. Only injury reported in notes was bruising. Family disagrees about current diet order. This is a diet the daughter who is POA wants followed." *2/22/15 at 8:30 a.m.- "Registered nurse [RN] informed by certified nursing assistant [CNA] that resident rolled out of bed while she went to warm up a washcloth for morning cares. Had placed a body pillow between him and the edge of the bed. He received about a half dime sized skin tear on his forehead, a skin tear on the bridge of his nose, reagravated old skin tear left elbow, two small skin tears on left hand 2nd finger, and skin</p>	F 250			

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F 250	Continued From page 13 tear right hand 3rd finger. Daughter here and took several pictures of resident's face with her cell phone." *2/23/15 at 1:31 p.m.- "Daughter called wanting to have care team with her family." *2/24/15 at 1:45 p.m.- "CNA came to dietary manager after lunch and was upset. Resident's son sat down at dinner table and told CNA she didn't have to sit down and pretend to feed him just because she was told to since family was here in facility. He then told his dad that his meal looked like what they had served him last Tuesday night when he was here. CNA told him this was not true and the kitchen gave him food that was just made today. He then asked his dad why they didn't put stitches in his head. CNA stated she tried giving resident a drink and he couldn't take a drink so she tried a straw and son said to dad why do they make you drink from a straw. CNA said she had to get up and move away because she was getting upset." *2/25/15 at 4:51 p.m.- "Doctor her for rounds. Family wanted lorazepam [antianxiety medication] scheduled and the doctor would still only approve it for every 6 hours. I encouraged daughter to call doctor if she has issues that she wishes to discuss with him or to call me back and I would help facilitate that conversation between her and the doctor." *2/25/15 at 5:09 p.m.- "Spoke with daughter regarding the lorazepam order. She does understand why the doctor would not schedule it but did question her if he could be having pain. I did tell her that I would send an order from the doctor through hospice for roxanol [narcotic pain medication] to see if this will help his restlessness as well. We cannot determine if he is having pain or anxiety but with several falls in the past few days the daughter felt that it could be pain	F 250			

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F 250	<p>Continued From page 14 related."</p> <p>2/26/15 at 11:18 a.m.- "Returned a call to daughter regarding our conversation from yesterday. Doctor did order scheduled pain medication but would not schedule the lorazepam any more than it already is. I answered her questions and will follow-up as necessary."</p> <p>*3/9/15 at 4:40 p.m.- "Respirations have ceased with no heartbeat. No blood pressure."</p> <p>*There was no documentation of any family concerns from 2/26/15 through 3/9/15.</p> <p>Interview on 3/11/15 at 4:00 p.m. with the SSD regarding resident 2 revealed: *She had never involved the ombudsman (resident advocate from the Department of Social Services) regarding any of the family issues. *The ombudsman was at the last 2/25/15 care team meeting. *She thought she had involved the consultant social worker by email, but she was unable to locate the email. *She stated the social worker had no advice for her regarding the family issues. *She confirmed it was difficult having family members work at the facility especially if the family could not agree on issues. *She felt the significant family issues interfered in their care of the resident.</p> <p>Review of the social worker's 11/26/14 and 2/16/15 consultation notes revealed no documentation regarding resident 2 and the significant family concerns related to his care.</p> <p>Review of the 8/5/13 SSD job description revealed: *"Under the direction of the administrator and social work consultant this person plans, directs,</p>	F 250			

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F 250	Continued From page 15 and organizes social program to meet the objectives of the facility as part of total patient care." **"Work with interdisciplinary team to provide psychosocial support to residents, families, or vulnerable populations so they can cope with chronic, acute, or terminal illnesses." **"Assess resident's needs throughout his/her stay to maintain a care plan that addresses social, emotional, and psychosocial needs. Continue to assess resident needs while he/she is adjusting to their new environment and utilize outside resources as needed such as pastoral care, social work consultant, and working with the resident and/or his/her family or friends."	F 250			
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F280 Residents 2, 4, 5, 6, 7, and 8's interdisciplinary care plans were reviewed to ensure they were individualized and contained measurable goals for their history of falls. All other resident's interdisciplinary care plans were reviewed to ensure they were individualize and contained measurable goals. DON and interdisciplinary team reviewed and revised as necessary the policy and procedure about a complete and accurate care plan. Education will be provided for all staff responsible for use of care plans.	5/1/2015	

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F 280	<p>Continued From page 16</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, interview, and policy review, the provider failed to: *Have individualized care plans for six of six sampled residents (2, 4, 5, 6, 7, and 8) who had a history of falls. *Individual the care plans for with measurable goals for three of six of sampled residents (2, 4 and 5). Findings include:</p> <p>1. Review of residents 2, 4, 5, 6, 7, and 8's care plans fall prevention revealed no individualized interventions to minimize or prevent falls.</p> <p>Refer to F323, findings 2, 3, 4, 5, and 6.</p> <p>2. Review of resident 2's undated care plan revealed: **Resident is totally dependent on one to two staff for transferring. Date initiated [started] was 7/23/13." **"High fall risk." **Resident has high/low bed. Staff will make sure bed in low position when in bed to eliminate risk for falls."</p> <p>Review of resident 2's 11/2/14 incident report revealed: *Resident's knees buckled when transferring from recliner to wheelchair by certified nursing assistant (CNA). *He was lowered to the floor. *There was no documentation if any equipment was used during the transfer.</p>	F 280	<p>DON or designee will audit resident interdisciplinary care plans to ensure they are individualized and contain measurable goals one time per week for four weeks and monthly for two more months. ^</p> <p>DON or designee will present findings from these audits at the monthly QAPI meetings for review.</p> <p><i>* Each careplan will be reviewed at least quarterly. KRK/DDDH/MF</i></p>		

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F 280	<p>Continued From page 17</p> <p>Review of resident 2's 2/1/15 incident report revealed: *Staff were using the standaide (lift that requires resident to bear weight on their legs) and resident decided not to stand. *He lifted his legs up. *Staff were able to lower him to the floor and unhook the standaide. *Hoyer lift (mechanical lift that requires resident to have no weight bearing on legs) used to pick him up from the floor. *There was documentation under additional comments and/or steps taken to prevent reoccurrence "May need to be Hoyer lift."</p> <p>Interview on 3/12/15 at 10:00 a.m. with the director of nursing (DON) regarding resident 2 revealed: *She was unsure what total assistance for transfers on the care plan meant. *They were not specific about putting to use the standaide or Hoyer lift on the care plan. *It was up to each individual certified nursing assistant (CNA) to decide with each transfer how much assistance they needed for the transfer and what type of lift should be used. *His cooperation and alertness varied from day-to-day and shift-to-shift. *The CNAs usually did not ask the charge nurses what lift should be used. *The charge nurses really did not get involved in how to transfer residents, they relied upon the CNAs to use their judgement.</p> <p>Review of the provider's undated Lifting and Transferring policy revealed "Two or more people are needed to move a resident who is completely helpless or who is not allowed to move by</p>	F 280		

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F 280	<p>Continued From page 18 him/herself."</p> <p>Review of the provider's 2/18/14 Mechanical Lift policy revealed: **"The DON will ensure that all staff utilizes proper body mechanics and lifting techniques." **"The DON will ensure the availability of appropriate lifting and safety equipment for the staff and educate them on the use of those items." **"The DON will ensure that each resident lifting protocol is care planned and education provided to the staff." **"Staff members will utilize the proper transfer/lift procedure for each resident. This includes the use of the resident transfer devices (Total [Hoyer] lift and Stand lift [standaide] and applying proper body mechanics." **"The DON or licensed nurse will work together with the residents' physician and/or physical therapy to adjust lifting protocols for each resident when a change is warranted." **"The DON or licensed nurse and each resident's primary physician will be responsible for assuring appropriate lift designation for each resident. This will be placed on the care plan."</p> <p>Surveyor: 18387 3. Review of resident 4's care plan revealed the resident was sixty-nine years old. The care plan had the following focus area "The resident has little or no activity involvement r/t (related to) his Parkinson's disease and his mental status. Resident has always been a loner most of is life according to his sister. Resident was very secluded all of his life by his Mother whom he lived with. Resident has no interest except</p>	F 280			

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F 280	<p>Continued From page 19 watching TV and when asked what he might like to do he will not answer."</p> <p>The goal for resident 4 was that he will respond to one-to-one visits and attend one activity each day.</p> <p>Interventions for resident 4 included: *Explain to the resident the importance of social interaction, leisure activity time. Encourage the resident's participation by (SPECIFY). No other information was listed for the specifics. *Invite/encourage the resident's family members to attend activities with resident in order to support participation. *The resident needs assistance/escort to activity functions.</p> <p>4. Review of resident 5's care plan revealed the the following focus area "The resident has little or no activity involvement r/t resident wishes not to participate. Resident has schizophrenia and talks to someone above her."</p> <p>The goal for resident 5 was the resident will express satisfaction with type of activities and level of activity involvement when asked through the review date.</p> <p>Interventions for resident 5 included: *Invite/encourage the resident's family members to attend activities with resident in order to support participation. *The resident is able to choose what activities she wants to participate in. She likes to do thing in her "own world."</p> <p>5. Review of the provider's 7/17/14 Falls policy revealed the resident's care plan was to be</p>	F 280			

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F 280	Continued From page 20	F 280			
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review and interview, the provider failed to ensure physician's orders were followed for pain and anti-anxiety medications for one of one sampled resident (2). Findings include:</p> <p>1. Review of resident 2's medical record revealed he had been admitted to hospice services at the request of his daughter on 2/6/15 for end stage dementia (memory loss). He expired (died) on 3/9/15.</p> <p>Review of resident 2's 2/12/15 physician's orders revealed: *Lorazepam (anti-anxiety medication) 0.25 milliliter (ml) every bedtime (hs). *Lorazepam 0.25 ml every 4 hours as needed (PRN) agitation/restlessness. *There was documentation the orders had been noted (transcribed) on 2/18/15.</p> <p>Review of resident 2's 2/25/15 physician's orders revealed "Ultracet [controlled pain medication] tablet 37.5-325 milligrams [mg] one tablet by mouth four times a day for pain."</p> <p>Review of resident 2's 2/25/15 facsimile (fax)</p>	F 281	<p>F281</p> <p>Resident 2 has discharged.</p> <p>All other residents' medication administration records were reviewed to ensure physician's orders were followed for pain and anti-anxiety medications.</p> <p>DON or designee will audit all new physician orders once per week for four weeks and monthly for two more months to ensure pain and anti-anxiety medications are being followed.</p> <p>DON or designee will present findings from these audits at the monthly QAPI meetings for review.</p> <p><i>* Education was provided to all nursing staff by the DON regarding compliance with physician's orders. KPK/DDO/HMF</i></p>	5/1/2015	

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F 281	<p>Continued From page 21</p> <p>communication to the physician revealed: *Family would like to have his lorazepam 0.25 ml scheduled around the clock." *The physician responded "Change lorazepam to 0.25 ml every 6 hours PRN."</p> <p>Review of resident 2's 2/27/15 physician's orders revealed: *Lorazepam 0.5 ml sublingual (under tongue) PRN after 0.25 ml utilized and ineffective. *Morphine (narcotic pain medication) give 1.0 ml sublingual every 30 minutes PRN after 0.5 ml dose given and ineffective at end of life for comfort. *Morphine 0.5 ml sublingual every 30 minutes PRN for pain, shortness of breath (SOB), or restlessness at end of life.</p> <p>Review of resident 2's 3/8/15 physician's orders revealed "Discontinue all medications except hospice PRN comfort medications (morphine and lorazepam).</p> <p>Review of resident 2's February 2015 medication administration record (MAR) and as needed (PRN) record revealed: *Lorazepam 0.25 ml at HS was not documented until started on 2/18/15 (the physician order had been dated 2/12/15). *Lorazepam 0.25 ml every 4 hours PRN ordered 2/12/15 was not on the MAR. *Lorazepam was documented as administered on 2/25/15 and on 2/28/15 for restlessness with no documentation for the effectiveness of the lorazepam. *There was no documentation the Ultracet had been administered on 2/26/15 at 8:00 a.m., 12:00 noon, or 8:00 p.m. The spaces to document his pain level for each of the four doses was left</p>	F 281			

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F 281	<p>Continued From page 22</p> <p>blank.</p> <p>*On 2/27/15 the spaces to document his pain level for all four doses of the Ultracet were left blank.</p> <p>*On 2/28/15 the spaces to document his pain level were left blank for the 4:00 p.m. and 8:00 p.m. doses of Ultracet.</p> <p>Review of resident 2's February 2015 daily behavior/mood log completed by the certified nursing assistants (CNA) revealed:</p> <p>*There was documentation he had displayed "fidgety or restless" behavior every day from 2/10/15 through 2/28/15.</p> <p>*In addition to the scheduled HS dose of lorazepam started on 2/18/15 he had received PRN lorazepam for restlessness/comfort only on 2/24/15, 2/25/15 (two doses), 2/26/15, and 2/28/15.</p> <p>Review of resident 2's 3/1/15 through 3/8/15 MAR revealed:</p> <p>*There were five doses of Ultracet at 12:00 noon left blank.</p> <p>*There were three doses of Ultracet at 4:00 p.m. left blank.</p> <p>*There were two doses of Ultracet at 8:00 p.m. left blank.</p> <p>*For all the scheduled doses of Ultracet the space for pain level was either left blank or "not applicable."</p> <p>*There was no documentation PRN lorazepam had been given for restlessness/comfort on 3/4/15, 3/6/15, or 3/7/15.</p> <p>*Morphine (roxanol) was documented as administered on 3/9/15 at 12:45 a.m. for restlessness with no documentation of follow-up for the effectiveness of the morphine.</p>	F 281			

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F 281	<p>Continued From page 23</p> <p>Review of resident 2's 3/1/15 through 3/9/15 daily behavior/mood log revealed:</p> <ul style="list-style-type: none"> *There was documentation he had displayed "fidgety or restless" behavior all nine days. *In addition to the scheduled HS dose of lorazepam he had received PRN lorazepam for restlessness/comfort only on six of those days. <p>Interview on 3/12/15 at 10:15 a.m. with the director of nursing regarding resident 2 revealed:</p> <ul style="list-style-type: none"> *They had been having delays in getting physician's orders from hospice with him. *She thought the 2/12/15 physician's orders had been faxed to hospice on that date, but they had not received the orders until 2/18/15. *She had not spoken to hospice regarding the issue with physician's orders. *She was not sure why there were so many Ultracet were not documented as administered. She did not know if the Ultracet had or had not been given. *They were unable to fill in the pain level "He couldn't respond" on their system. *She was not aware the behavior log showed daily episodes of restlessness, and the nurses had not utilized the PRN lorazepam ordered by the physician. *She was not sure the CNAs were reporting his restless behavior to the nurses or if the nurses were checking with the CNAs or reviewing the behavior log. *She had not informed the family or the physician the nurses had not been following the PRN lorazepam orders for restlessness/comfort. *It was hard to tell when he could not respond to them if he was having pain or if the restlessness was due to his mood/behavior medications being discontinued the end of January 2015. *They had not documented any 	F 281		

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F 281	Continued From page 24 non-pharmalogical approaches to pain control, and she was unsure what if any approaches had been attempted.	F 281			
F 309 SS=G	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: Surveyor: 22452 Based on record review and interview, the provider failed to ensure quality of care during end of life for one of one sampled resident (2). Findings include: 1a. Review of resident 2's 11/2/14 through 2/22/15 nurses notes and incident reports revealed: *Multiple falls and injuries (11/2/14, 11/13/14, 2/1/15, 2/3/15, 2/5/15, 2/9/15, 2/10/15, 2/19/15, and 2/22/15). *None of the above falls had been investigated. Refer to F224, finding 1, and F323, finding 2. b. Review of resident 2's 1/27/15 through 3/9/15 progress notes by the director of nursing (DON), dietary manager, dietitian, activity director, and social services designee (SSD) revealed: *Multiple documentation regarding the family's concern related to his care and medication.	F 309	F309 Resident 2 has discharged. All other residents were reviewed to ensure quality of care was present during end of life. Administrator, DON, and interdisciplinary team reviewed and revised as necessary the policy and procedures about end of life care. Education will be provided for all staff responsible for the provision of care. DON or designee will audit all new residents receiving end of life care to ensure quality care is being provided one time per week for four weeks and monthly for two more months. DON or designee will present findings from these audits at the monthly QAPI meetings for review. <i>*DON and ombudsman provided education to all staff regarding resident end of life care. KRISDORH/MF</i>	5/1/2015	

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F 309	Continued From page 25 *There was no documentation the provider had made any referrals or resolved their concerns. Refer to F250, finding 1. c. Review of resident 2's undated careplan revealed: *There were no specific guidelines for transfers documented for the certified nursing assistants. *There was documentation the high/low bed should be in the low position when he was in bed as he was a high fall risk. On 2/22/15 he rolled out of bed when it was in a high position when the caregiver had left him unattended to get a washcloth in the bathroom. Refer to F280, finding 2. d. Review of resident 2's 2/12/15 through 3/8/15 physician's orders and February 2015 and March 2015 medication administration records revealed medications were not administered according to the physician's orders. Refer to F281, finding 1.	F 309			
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: 22452 Based on observation, record review, policy	F 323	F323 Residents 2, 4, 5, 6, 7, 8, 9, and 10 were reviewed to ensure fall prevention interventions were reported, investigated, and implemented to minimize falls. All other residents with history of falls were reviewed to ensure fall prevention interventions were	5/1/2015	

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F 323	<p>Continued From page 26</p> <p>review, and interview, the provider failed to: *Implement interventions throughout the facility for all residents to minimize resident's falls. *Report, investigate, and implement fall prevention interventions for eight of eight sampled residents (2, 4, 5, 6, 7, 8, 9, and 10) who had fallen. Findings include:</p> <p>1. Review of the provider's fall tracking log for the residents revealed: *November 2014 there were nineteen falls. -Resident 2 was listed twice. -Resident 5 was listed four times. -Resident 7 was listed twice. *December 2014 there were twenty-one falls recorded. -Resident 2 was listed twice. -Resident 4 was listed twice. -Resident 5 was listed four times. -Resident 7 was listed twice. *January 2015 there were ten falls recorded. -Resident 4 had one fall. -Resident 5 was listed twice. *February 2015 there were twenty falls or rolled off the bed. -Resident 2 was listed six times for falls or rolling off the bed. -Resident 4 had fallen outside of the facility once and had one fall within the facility. -Resident 5 had one fall.</p> <p>Review of the provider's manager meeting weekly notes from January 5, 2015 to March 6, 2015 revealed they had discussed residents falls. Residents names were listed. No intervention was listed to minimize falls. On 2/13/16 there was the comment "Do we need to assemble a fall prevention committee?"</p>	F 323	<p>reported, investigated, and implemented to minimize falls.</p> <p>Administrator, DON, and interdisciplinary team reviewed and revised as necessary the policy and procedures about individuals identified as a fall risk. Education will be provided that not all falls are reportable to the DOH, but there must be adequate investigation into falls and appropriate care planning for safety. An accurate initial assessment for risk is key and planning for safety follows. Education will be provided for all staff.</p> <p>DON or designee will audit all new residents with falls to ensure fall prevention interventions were reported, investigated, and implemented to minimize falls one time per week for four weeks and monthly for two more months.</p> <p>DON or designee will present findings from these audits at the monthly QAPI meetings for review.</p> <p><i>* The DON is responsible for reporting, investigating, and evaluating residents' falls. The DON or nursing staff is responsible to update the residents' care plans.</i> KR/SDOH/ME</p>	

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F 323	Continued From page 27 Interview on 3/11/15 at 3:20 p.m. with the director of nursing (DON) revealed: *The incident report was completed for all falls. *No initial or five day report or investigation would be completed for any falls. *Her understanding was falls were not reportable unless the resident had been hospitalized or it was unwitnessed falls. *Review of the SD DOH investigation form indicated the provider had highlighted in the instructions the words "Required nursing facility event reporting." Interview on 3/12/15 at 8:45 a.m. with the administrator revealed: *He was aware of all of the resident falls. *They had a weekly management meeting where they discussed the falls. *They had quality assurance performance improvement (QAPI) meetings where the falls were discussed. *The QAPI committee consisted of the administrator, DON, activity director, and social services designee (SSD). Also included were the following department managers: dietary, housekeeping, business, laundry, and maintenance. *The incident reports were reviewed by the DON, the administrator, and the medical director. *They reviewed how many falls each resident had and discussed what they should do to minimize the falls. *The did not document interventions for the residents during either meetings. *The investigation should have included the who, what, where, when, and why. *They had discussed a fall prevention committee, but that had not been developed.	F 323			

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F 323	<p>Continued From page 28</p> <p>2. Review of resident 2's 11/2/14 through 2/22/15 nurses notes and incident reports revealed: *11/2/14 at 4:25 p.m.- "Resident's knees buckled when being transferred from recliner to wheelchair by certified nursing assistant [CNA]. Lowered to floor." *11/13/14 at 11:15 a.m.- "Attempted to get up on own and fell forward out of chair. Cut on forehead and on 2nd to last finger on right hand." *2/1/15 at 9:32 p.m.- "Staff was assisting resident to bed using the stand aide [lift that requires the resident to be able to bear some weight on their legs]. Resident decided not to stand up and lifted his legs leaving him hanging from the stand aide by his arms. Staff assisted to remove him from the stand aide and lowered him to the floor. A total lift [mechanical lift that requires no weight bearing from the resident] was used to help lift him from the floor to his bed." *2/3/15 (no time)- "Resident found lying on the floor on his right side. Skin tear to right elbow." *2/5/15 at 2:25 p.m.- "Resident had his Tabs on [monitor that alarms]. In bed in low position. Resident rolled out of bed. Found lying on his comforter." *2/9/15 at 10:15 a.m.- "Found resident laying on pillow between wall and the bed." *2/10/15 at 9:30 a.m.- "Found on floor mat beside low bed. Body pillow with him." *2/19/15 at 12:30 a.m.- "Found laying on left side on floor mat next to bed. Tabs monitor on. No injuries." *2/22/15 at 5:50 a.m.- "CNA came to get resident ready for the day. bed in up position for her to work with the resident. She went to get washcloth and resident rolled out of bed. She had placed body pillow prior to leaving bedside. Skin tear front of forehead, bridge of nose, reopened one</p>	F 323		
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F 323	<p>Continued From page 29 on left elbow, pinpoint one 2nd finger right hand, and 3rd finger left hand."</p> <p>Review of resident 2's 2/24/15 fascimile (fax) communication to the physician revealed: **On 1/28/15 order received to discontinue Aricept [medication for severe dementia (memory loss) and zoloft [antidepressant] per family request." **On 1/16/15 they requested to have risperdal [antipsychotic medication for mood/behavior]." **Since that time resident has fallen numerous times." **In your opinion do you feel the stop of his medications could contribute to his falls?" *The physician responded "No. I think it is his disease process."</p> <p>Interview on 3/12/15 at 10:00 a.m. with the director of nursing (DON) regarding resident 2 revealed: *She had really not investigated any of his falls. *The staff usually had observed him fall or roll out of bed when they entered the room. *They knew he was a high fall risk and had implemented the high/low bed, mat on the floor, and the Tabs monitor (alarm goes off when the resident attempts to get up unassisted). *They had removed the air mattress hospice had put on his bed with the 2/19/15 fall. They had determined that was causing him to roll off the bed. *They attributed his restlessness and increased falls in February 2015 related to the family's request he be taken off all his psychotropic (mood and behavior altering medication) at the end of January 2015. Surveyor: 18387</p>	F 323			

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F 323	<p>Continued From page 30</p> <p>3. Review of resident 5's incident reports revealed:</p> <p>*On 11/8/14 the resident had tripped carrying a tote. The resident had been taken by an ambulance to the local hospital.</p> <p>*On 11/12/14 at 4:20 a.m. the resident was found on the floor in the bathroom. She had only one gripper sock on. In the section list diagnosis if contributed to the incident/accident was written fractured left hip.</p> <p>*On 11/12/14 at 9:00 a.m. the resident had attempted to get up on her own and fell to the floor. She had been found sitting on the floor.</p> <p>*On 11/18/14 the resident was found sitting on the floor next to the bed and the wheelchair. Appears resident went to the bathroom without asking for assistance.</p> <p>*On 11/27/14 the resident was found sitting on the floor in front of the toilet and was hanging on the rail.</p> <p>*On 1/21/15 the resident was heard yelling. She was found on her knees in the bathroom next to the toilet. The resident had removed the safety alarm monitor and transferred herself.</p> <p>Review of resident 5's nurse's notes revealed on 11/8/14 the resident had fallen and complained of left leg pain. The physician had been notified and orders were received to transfer her to the hospital. She had been transferred to the hospital for a hip fracture. No information had been documented regarding to the events as to why the fall had occurred.</p> <p>Review of the nurse's notes on the above dates for the falls revealed no documentation for an investigation as to why the falls had occurred.</p> <p>Review of resident 5's current care plan revealed:</p>	F 323			

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F 323	<p>Continued From page 31</p> <p>*To encourage the resident to use bell to call for assistance.</p> <p>*For the focus regarding an actual fall with injury the interventions were to continue to use the interventions on the at-risk plan. For no apparent acute injury determine and address causative factors of the fall.</p> <p>*For the focus regarding use of the seat belt was to be used daily. The intervention was to position the resident correctly in the wheelchair. Another intervention listed was the resident was able to release the belt that sounded an alarm to alert the staff of the self-transfer.</p> <p>*There were no interventions on the care plan to direct staff on how to minimize falls for the resident.</p> <p>4. Review of resident 4's incident reports revealed: *On 12/22/14 the resident reportedly fell to his knees. The resident had stated he had lost his balance. *On 12/23/14 the resident was found sitting on the floor in his room. Resident was confused. *On 1/20/15 the resident was found on his hands and knees on the floor in front of the bed with the wheelchair over him. *On 2/14/15 the resident was found laying on the floor.</p> <p>Review of the nurses notes on the above dates for the fall revealed no documentation for an investigation as to why the falls had occurred.</p> <p>Review of resident 4's progress notes revealed: *On 1/6/15 the SSD documented: -The resident could be found sitting in other resident's wheelchairs in a slumped over position. -"He might go from a sitting to a standing position</p>	F 323			

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F 323	<p>Continued From page 32</p> <p>over a 5 minute period." It will take two to three staff to get him off the floor and dressed or in bed.</p> <p>*On 1/9/15 the DON documented:</p> <ul style="list-style-type: none"> -The resident required extensive assistance with the majority of his activities of daily living. -He had poor posture and inability to stand straight or ambulate without freezing in position. -He had altered mental status and unsteady gait with huge risk for falls. He had falls prior to admission and since his arrival into the facility. <p>Review of resident 5's current care plan revealed the following interventions:</p> <ul style="list-style-type: none"> *To encourage the resident to use the bell to call for assistance. *Provide a safe environment: call light in reach, adequate low glare light, bed in lowest position and wheels locked. *For the focus area regarding the resident was high risk for falls related to unawareness of safety needs, poor communication, and Parkinson's Disease with a shuffling gait the interventions were: <ul style="list-style-type: none"> -Anticipate and meet the resident's needs. -Ensure the call light was in reach and encourage him to use it. -Educate the resident/family/caregivers about safety reminders and what to do if a fall occurred. -Ensure the resident was wearing appropriate footwear when walking or propelling in wheelchair. -Follow facility fall protocol. -The resident needed a safe environment with even floors free from spills and/or clutter: adequate, glare-free light; a working and reachable call light; handrails on walls, and personal items within reach. *There were no interventions on the care plan to 	F 323			

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F 323	<p>Continued From page 33</p> <p>direct staff on how to minimize falls for him.</p> <p>5. Review of resident 6's incident reports revealed: *On 2/2/15 the resident was found lying on the floor in the middle of the room. An approximate twelve inch laceration was on his right forearm. The area was cleaned, and the resident was sent to the emergency room. Review of the nurse's notes indicated the resident had attempted to walk to the bathroom. *On 2/10/15 the resident had been in the bathroom and got up on his own. He was found on his knees with his head over the toilet. He had a laceration on the top of his head. *On 2/23/15 the resident was in bed and had rolled out onto the fall mat located next to the bed. The mobility monitor had sounded to alert the staff.</p> <p>Review of resident 6's current care plan revealed the following interventions: *To encourage the resident to use the bell to call for assistance. *For the focus area the resident was at moderate risk for falls due to unawareness of safety needs, and gait and balance problems. An intervention listed was to review information on past falls and attempt to determine cause of falls. Record possible root causes (why did it happen). Remove any potential causes if possible. Educate resident/family/caregivers as to causes. *There were no interventions on the care plan to direct staff on how to minimize falls for him.</p> <p>6. Review of resident 7's incident reports revealed: *On 12/7/14 he was found lying next to his bed wrapped in blankets. The resident indicated he</p>	F 323			

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F 323	<p>Continued From page 34</p> <p>had been trying to get to his wheelchair. *On 12/16/14 the resident fell out of bed while leaning over to get to the overbed table. "Because of physical condition, unable to stop/protect self once falling. Hit head against edge of bookcase."</p> <p>Review of resident 7's current care plan revealed no safety interventions or information he had a history of falls.</p> <p>7. Review of resident 8's incident report revealed no date, the fall occurred at 1:30 a.m., the resident was confused, and had been found sitting on the floor at the end of her bed. The overbed table was tipped over. Review of the progress notes for that incident indicated the same information, and they would continue to monitor.</p> <p>Review of resident 8's current care plan revealed she was at moderate risk for falls related to wandering and dementia (impaired memory). Interventions were: *Follow facility fall protocol. *Be sure the call light was within reach and encourage the resident to use it for assistance as needed. *Ensure the resident was wearing appropriate footwear when walking. *There were no interventions on the care plan to direct staff on how to minimize falls for her. *There was no information regarding the fall noted above.</p> <p>8. Review of resident 9's incident report on 2/16/15 revealed the resident was walking in the hall and attempted to sit in a wheelchair that was in the hall. The resident missed the chair and sat</p>	F 323		

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F 323	<p>Continued From page 35</p> <p>on the floor. There was no information on the incident report if the wheelchair had been locked or unlocked when the resident attempted to sit down.</p> <p>9. Review of resident 10's incident report dated 1/22/15 revealed when the resident was having physical therapy she had stepped on a bar causing her to fall on her left side hitting her hip and the back of her head.</p> <p>Review of resident 10's nurse's notes revealed documentation on 1/26/15 the resident had a fall in therapy on 1/22/15. No documentation was in the nurses notes regarding the fall until 1/26/15 when the resident complained of a left shoulder, left knee, and left jaw pain. The resident complained of pain level at a six on the pain scale from one to ten with ten being the worst pain.</p> <p>10. Review of the provider's 7/10/13 Resident Incident policy revealed: *All incident reports would be given to the DON to assess and given to the administrator for review. *The DON would complete a log of all incidents and send reports to SD DOH. *Even reports would be sent to SD DOH if it was determined that the incident/accident resulted from abuse or neglect. The two hour event report and the twenty-four hour event report would be completed by the charge nurse, DON, or social worker. *Incidents that required an event report include: abuse, neglect, serious bodily injury, falls resulting in serious injury or hospitalization, injuries of unknown origin, theft of a resident's items or misappropriation of resident's funds, death (other than natural causes), and missing resident/elopements.</p>	F 323			

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F 323	Continued From page 36	F 323		
F 490 SS=G	<p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 18387 Based on observation, record review, policy review, interview, and job description review, the provider failed to report, investigate, and implement fall prevention interventions for eight of eight sampled residents (2, 4, 5, 6, 7, 8, 9, and 10) who had histories of falls. Findings include:</p> <p>1. During the survey from 3/11/15 through 3/12/15 the director of nursing and the administrator confirmed a thorough investigation had not been completed for when the above residents had fallen. Only incident reports had been completed.</p> <p>Review of the South Dakota Department of Health Reporting of Injuries of Unknown Source and Reasonable Suspicion of a Crime form specific for falls revealed: *NOT all falls are reportable. Those falls that</p>	F 490	<p>F490</p> <p>Residents 2, 4, 5, 6, 7, 8, 9, and 10 were reviewed to ensure fall prevention interventions were reported, investigated, and implemented.</p> <p>All other residents with histories of falls were reviewed to ensure fall prevention interventions were reported, investigated, and implemented.</p> <p>DON or designee will audit all new residents with falls to ensure fall prevention interventions were reported, investigated, and implemented one time per week for four weeks and monthly for two more months.</p> <p>DON or designee will present findings from these audits at the monthly QAPI meetings for review.</p>	5/1/2015

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F 490	<p>Continued From page 37</p> <p>involve injury of a serious nature should be reported.</p> <p>*If a fall occurs and the provider determines there were no injuries at the time but later there is discovery of an injury and it is not a serious nature, then the fall should be reported.</p> <p>*All falls whether reportable or not should reflect a thorough internal investigation. The investigation should ascertain if there were injuries, appropriate treatment, and a determination if there may have been contributing factors, include any review or revision of individual care plan or facility practices.</p> <p>Surveyor: 22452 Review of the provider's 8/5/13 administrator job description revealed: *"Administers, directs, and coordinates all activities of the care center to carry out it's objectives as to the care of the individuals who need nursing care." *"Develops and monitors all departments within the facility to meet the standards put forth by the governing board, management, and state and federal regulations."</p> <p>Review of the 1/15/14 director of nursing (DON) job description revealed: *"Directs the licensed and non-licensed staff who provide health care and nursing services to the residents of the facility." *"The DON's prime responsibility is to ensure the provision of quality nursing care on a 24-hour basis to the residents of the care center in accordance with federal, state, and local standards and regulations." *"Assures there is compliance with the regulations pertaining to care plans and resident assessments."</p>	F 490			

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F 490	Continued From page 38 **Collaborates with outside providers such as hospice, contract therapy, and pharmacy companies to enhance the quality of care for the residents." **Reviews grievances and must show professional judgement in managing personnel or resident concerns/issues." **Participates in various committees/meetings for quality review such as falls, skin condition, pharmaceutical and physical/chemical restraining policies and procedures. This position assures that committee recommendations are carried out and reviews and responds to incident reports." Refer to F224, F225, and F323.	F 490			