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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>43A075</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>03/04/2015</b> |
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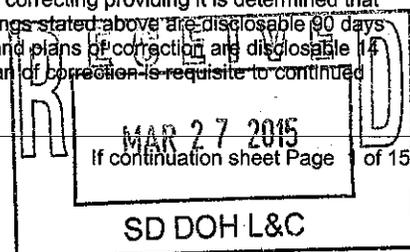
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>BENNETT COUNTY HOSPITAL AND NURSING HOME</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>102 MAJOR ALLEN POST OFFICE BOX 70<br/>MARTIN, SD 57551</b> |
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| F 000 | <p><i>Addendums noted with an asterisk per 3/30/15 telephone to facility DON. NS/SDD/MLF</i></p> <p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 28057<br/>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted on 3/4/15. Areas surveyed included quality of care/treatment and resident/patient/client neglect. Bennett County Hospital and Nursing Home was found not in compliance with the following requirements: F280, F314, F514, and F520.</p> <p>F 280<br/>SS=G<br/>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Surveyor: 28057</p> | F 000 | <p>Resident 2's care plan was reviewed and updated by the DON, to reflect current status and needs related to prevention and development of pressure ulcers by March 8, 2015. Resident 3's care plan was reviewed and updated by the DON to reflect current status and recent falls, noting any injuries from falls, and use of bed and wheelchair alarms by March 8, 2015. Both care plans are individualized, comprehensive and up to date.</p> <p>All active resident care plans will be reviewed by the DON or designee to ensure each care plan is comprehensive, individualized, and up to date by April 23, 2015.</p> <p>The DON or designee will update the facilities comprehensive care plan policy to state the MDS coordinator is responsible for noting significant changes to resident care plans and staff nurses are to modify care plans to reflect changes in care for individual residents as they occur. All nursing staff will be educated on this process by the DON by April 1, 2015.</p> | 4/23/15 |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br><i>Edell Martin</i> | TITLE<br><i>Administrator</i> | (X6) DATE<br><i>3/25/15</i> |
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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| F 280   | <p>Continued From page 1</p> <p>Based on record review, interview, and policy review, the provider failed to ensure care plans reflected the residents' current status for two of seven sampled residents (2 and 3). Findings include:</p> <p>1. Review of resident 2's medical record revealed he had been admitted on 10/29/14. He had developed pressure ulcers after he had been admitted to the facility. His care plan had not been updated in a timely manner to reflect his needs related to the prevention and development of those pressure ulcers. Refer to F314, finding 1.</p> <p>2. Review of the provider's incident reports revealed resident 3:</p> <p>*On 1/2/15 had fallen from his wheelchair.<br/>-Had been propelling himself by pulling himself along using the railing in the hallway.<br/>-Had no noted injuries from that fall.<br/>*On 2/1/15 had fallen from his wheelchair in the dining room.<br/>-Had stood up from the wheelchair and landed on the floor.<br/>-Hit his head and received a laceration that required treatment in the emergency room.</p> <p>Review of his medical record revealed he had been admitted on 12/25/11 with diagnoses of paralysis and spasmodic torticollis (twisting of the spine by muscle spasms) from a motor vehicle accident.</p> <p>Review of his nurses notes from 2/1/15 through 3/2/15 revealed:</p> <p>*He had been found on the floor by his bed on 2/9/15.<br/>*He had tried to take himself to the bathroom.<br/>*He had no injuries from that fall.</p> | F 280   | <p>A consultant has been engaged to advise the DON of methods to improve compliance and an in-service is to take place by April 1, 2015 by the DON. The in-service will be for all staff who are responsible for documentation, Care planning, and use of care plan and will cover accurate assessment, identification of problem, implementation and interventions, monitoring and revising plan of care, and documentation of the care process.</p> <p>MDS coordinator or designee will review 25 % of resident care plans weekly to ensure care plans are individualized, comprehensive, and up to date. Findings will be reported to QA monthly for 3 months then quarterly for 3 quarters, then per QA findings.</p> |   |

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| F 280   | <p>Continued From page 2</p> <p>*An order had been received to use a bed/wheelchair alarm at all times.<br/>*The addition of the alarm was due to his increase in falls.<br/>*The alarm was placed in the wheelchair.</p> <p>Review of resident 3's 3/2/15 physician's orders revealed an order for the use of a bed/chair alarm on at all times due to falls.</p> <p>Review of his last revised on 1/14/15 care plan revealed:<br/>*A focus he was at risk for injury related to falls.<br/>*The goal had been he would be free from falls through the review date of 4/21/15.<br/>*That goal had not been met related to the above fall on 2/1/15.<br/>*One of the interventions had been staff were to have discussed the use of a personal safety alarm to alert staff when he attempted to ambulate independently without staff assistance.<br/>*The use of that alarm had not been added to the care plan as of 3/4/15.</p> <p>Interview on 3/4/15 at 2:30 p.m. with the director of nursing (DON) confirmed the use of the personal alarm should have been added to the care plan. She expected interventions to have been added to a care plan when changes such as a fall had occurred.</p> <p>3. Interview on 3/4/15 at 2:20 p.m. with the Minimum Data Set (MDS) assessment nurse confirmed she had completed the care plans every quarter during the resident's assessment period. She had not reviewed them after that until the next quarter. She had relied on the charge nurses to update the care plans as needed until the next assessment period. She had not</p> | F 280   |   |   |

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| F 280   | <p>Continued From page 3</p> <p>completed any audits to ensure the care plans had been updated by the charge nurses during the quarter between MDS assessments.</p> <p>Interview on 3/4/15 at 4:30 p.m. with the DON confirmed:</p> <ul style="list-style-type: none"> <li>*Staff were last in-serviced on care planning in November 2014 in response to the last survey.</li> <li>*Staff were instructed on the updating of care plans in a timely manner to address resident changes and/or concerns at that time.</li> </ul> <p>Review of the provider's revised August 2002 Comprehensive Care Plan policy revealed:</p> <ul style="list-style-type: none"> <li>*The care plan was to provide an ongoing method of implementing, reviewing, and updating the resident's care.</li> <li>*Care plans were to have been reviewed at least quarterly.</li> <li>*It was to have been updated if there had been a significant change in condition.</li> <li>*It was to have been modified to reflect the care required for the resident.</li> <li>*It had not stated who specifically had been responsible for those changes that had occurred outside of the quarterly care conference meetings.</li> </ul> <p>Review of the information presented at the 9/10/14 staff in-service to include nursing staff revealed:</p> <ul style="list-style-type: none"> <li>*Care plans were to be updated with any significant changes by the MDS nurse.</li> <li>*Nursing staff were responsible to update the care plans.</li> <li>*Care plans were ongoing and should have reflected changes in the resident as they occurred.</li> </ul> | F 280   |   |                      |   |

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| <p>F 314<br/>F 314<br/>SS=G</p> | <p>Continued From page 4<br/>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Surveyor: 28057<br/>Based on interview, record review, and policy review, the provider failed to assess, identify, and implement interventions for residents at risk of developing pressure ulcers (injury to skin and tissue from prolonged pressure on it) for one of two sampled residents (2) with pressure ulcers acquired in the facility. Findings include:</p> <p>1. Review of resident 2's record revealed he had a diagnoses of a cerebral vascular accident (stroke) with paralysis on his right side, use of a gastric (stomach) tube for feedings, diabetes mellitus, Alzheimer's disease, altered mental status(thinking), acute respiratory failure with hypoxia (lowered oxygen level), and pneumonia.</p> <p>Review of resident 2's nurses' notes from 10/29/14 through 1/6/15 revealed he:<br/>*Had been admitted on 10/29/14.<br/>*Had arrived by ambulance on a stretcher.<br/>*Had a rash to his groin.<br/>*His skin was intact except for the rash in his</p> | <p>F 314<br/>F 314</p> | <p>F 314<br/>Residents 2's wound was assessed by the DON and Braden reviewed and revised to indicate mobility is an issue. The DON ensured appropriate interventions were in place due to high risk for skin breakdown. A date for a goal was added to resident 2's care plan. This was all done by March 8, 2015.</p> <p>Protocol for turning and repositioning developed by the DON. All nursing staff will be educated on use of turning and repositioning protocol by April 23, 2015 by the DON. All residents Braden scales will be reviewed and updated by the MDS Coordinator or designee by April 23, 2015, to monitor for any changes in resident needs and ensure appropriate measures are implemented for residents identified as High Risk.</p> <p>DON or designee will QA all active resident Braden scales monthly for 3 months, then quarterly for 3 quarters, then as per QA findings. Findings will be reported to the QA committee by the DON.</p> | <p>4/23/15</p> |
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| F 314   | <p>Continued From page 5</p> <p>groin when he was admitted.</p> <p>*Had a feeding tube and oxygen in place.</p> <p>*Was dependent on staff to be re-positioned.</p> <p>*Had been incontinent (unable to control) of bowel and bladder.</p> <p>*Had edema (swelling) to his right arm.</p> <p>*On 11/3/14 developed a skin abrasion to his right elbow and a skin abrasion/tear to his coccyx (bottom).</p> <p>*On 11/4/14 needed to be re-positioned.</p> <p>*On 11/24/14 developed a new open area on his right heel with a blister that had "ruptured." At that time new orders were received for the use of heel protectors.</p> <p>*On 11/25/14 was rubbing the heel protectors off while in bed.</p> <p>*Was rubbing his feet on the sheets and footboard of the bed.</p> <p>Review of resident 2's certified nurse practitioner (CNP) progress notes dated 11/3/14, 11/11/14, 11/17/14, and 11/24/14 revealed under "plan" heel and elbow protectors.</p> <p>Review of resident 2's November 2014 treatment record revealed:</p> <p>*Protective dressings were started on 11/3/14 for his coccyx and right elbow.</p> <p>-They were listed as "stage II."</p> <p>*An air mattress was to be on the bed starting on 11/3/14.</p> <p>*Silvadene was to be applied to the right heel and covered with a Mepilex dressing every other day.</p> <p>*Heel protectors were to have been on both feet starting on 11/24/14.</p> <p>*Those treatments had started on 11/24/14.</p> <p>Review of resident 2's initial care plan dated 10/29/14 revealed:</p> | F 314   | <p>ADON or designee will review all progress notes weekly to assure continuity of care and obtain clarification orders as needed. The ADON or designee will QA this process monthly for 3 months, then quarterly for 3 quarters, then per QA findings. Findings will be reported to the QA committee by the DON.</p> <p>The DON or designee will update the facilities comprehensive care plan policy to state the MDS coordinator is responsible for noting significant changes to resident care plans and staff nurses are to modify care plans to reflect changes in care for individual residents as they occur. All nursing staff will be educated on this process by the DON by April 1, 2015.</p> <p>A consultant has been engaged to advise the DON of methods to improve compliance and an in-service is to take place by April 1, 2015 by the DON. The in-service will be for all staff who are responsible for documentation, care planning, and use of care plan and will cover accurate assessment, identification of problem, implementation and interventions, monitoring and revising plan of care, and documentation of the care process.</p> |                      |   |

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| F 314   | <p>Continued From page 6</p> <ul style="list-style-type: none"> <li>*He was at risk for skin breakdown related to incontinence of bowel and bladder.</li> <li>*It had not stated mobility (ability to reposition oneself) as a problem for breakdown.</li> <li>*Interventions were to reposition the resident regularly to prevent pressure areas.</li> <li>*The resident was to have been kept clean and dry.</li> <li>*The goal had been the resident's skin would remain free of breakdown until the next review.</li> <li>*No date had been given for that goal/time frame.</li> </ul> <p>Review of resident 2's 11/10/14 care plan revealed:</p> <ul style="list-style-type: none"> <li>*A focus area dated 11/10/14 that stated the resident required one to two assistance (weight bearing support or completion of that task ie: dressing, walking, moving from one place to another) from staff for all activities of daily living (ADL).</li> <li>*Another focus area dated 1/15/14 stated the resident had "potential/actual impairment to skin integrity AEB [as evidenced by] stage 2 [pressure ulcer] area to his left heel requiring dressing changes. See EZ graph and TAR [treatment administration record]."</li> <li>*The goal for that focus area had been the resident's open area on his left heel would be healed by the next care plan review on 6/2/15.</li> <li>*Interventions had included an air mattress, sheepskin padding for protection, wear heel protectors, and float heels [position off the mattress] off the bed.</li> </ul> <p>Interview on 3/4/15 at 2:20 p.m. with the Minimum Data Set (MDS) assessment nurse confirmed she had completed the care plans every quarter during the resident's assessment period. She had not reviewed them after that until the next quarter.</p> | F 314   |   |                      |

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| F 314              | <p>Continued From page 7</p> <p>She had relied on the charge nurses to update the care plans as needed until the next assessment period. She had not completed any audits to ensure the care plans had been updated by the charge nurses during the quarter between MDS assessments.</p> <p>Review of resident 2's November 2014 ADL flow sheet revealed he had been turned/repositioned per protocol.</p> <p>Interview on 3/4/15 at 4:30 p.m. with the director of nursing (DON) confirmed:<br/>*Resident 2 should have been turned/repositioned every two hours to prevent skin breakdown.<br/>*Heel protectors should have been used to decrease pressure and prevent skin breakdown.<br/>*The air mattress, heel protectors, and gel cushion in the wheelchair had been added after the open areas occurred instead of before to prevent the development of those pressure ulcers.<br/>*Staff were last in-serviced on care planning in November 2014 in response to the last survey.<br/>*Staff were instructed on the updating of care plans in a timely manner to address resident changes and/or concerns at that time.</p> <p>Interview by e-mail with the DON on 3/5/15 at 11:53 a.m. confirmed there had been no policy on positioning or turning to reflect the above stated protocol.</p> <p>Telephone interview on 3/9/15 at 9:30 a.m. with licensed practical nurse (LPN) A confirmed the provider's progress notes were not always reviewed by the nurses when they had been received. She agreed the CNP had stated in her</p> | F 314         |   |                      |

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| F 314 | <p>Continued From page 8<br/>progress notes under plan the use of elbow and heel protectors.</p> <p>Telephone interview on 3/9/15 at 10:00 a.m. with the assistant director of nursing (ADON) confirmed:<br/>*The staff were expected to reposition or turn dependent/bed bound residents every two hours.<br/>*If the DON had been unable to supply a policy there had not been one for turning or repositioning.<br/>*When the nurse had reviewed the CNP's progress notes and noted the heel and elbow protectors it should have been clarified with the CNP to obtain an order for their use.</p> <p>Review of the provider's revised August 2002 Comprehensive Care Plan policy revealed:<br/>*The care plan was to provide an ongoing method of implementing, reviewing, and updating the resident's care.<br/>*Care plans were to have been reviewed at least quarterly.<br/>*It was to have been updated if there had been a significant change in condition.<br/>*It was to have been modified to reflect the care required for the resident.<br/>*It had not stated who specifically had been responsible for those changes as they had occurred outside of the quarterly care conference meetings.</p> <p>Review of the information presented at the 9/10/14 staff in-service revealed:<br/>*Care plans were to have been updated with any significant changes by the MDS nurse.<br/>*Nursing staff were responsible to update the care plans.<br/>*Care plans were ongoing and should have</p> | F 314 |  |  |
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| F 314   | Continued From page 9 reflected changes in the resident as they occurred.   | F 314   | F514 Resident 2 & 3's care plans updated (refer to F280). All care plans reviewed on all active residents by DON or designee to assure care plans are individualized, comprehensive, and up to date by April 23, 2015.   | 4/23/15              |   |
| F 514<br>SS=E   | 483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 28057<br>Based on record review, interview, and policy review, the provider failed to ensure complete and accurate documentation was maintained on:<br>*Care plans for two of seven sampled residents (2 and 3).<br>*Medication administration records (MAR) for three of seven sampled residents (2, 3, and 7).<br>*Treatment administration records (TAR) for one of seven sampled residents (2).<br>Findings include:<br><br>1. Review of residents 2 and 3's medical records and care plans revealed their care plans had not been maintained to reflect their current status and care needs. Refer to F280, findings 1 and 2. | F 514   | The MDS coordinator will audit 25% of active resident care plans weekly to assure care plans are individualized, comprehensive and up to date, reflecting current status. The MDS coordinator will report her findings to the QA committee monthly for three months, then quarterly for three quarters, and then per QA findings.<br><br>The DON or designee will update the facilities comprehensive care plan policy to state the MDS coordinator is responsible for noting significant changes to resident care plans and staff nurses are to modify care plans to reflect changes in care for individual residents as they occur. All nursing staff will be educated on the process by the DON by April 1, 2015. |                      |   |

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| F 514   | <p>Continued From page 10</p> <p>2. a. Review of resident 2's January 2015 through February 2015 MARs revealed the following medications had not been documented as given:<br/>*January:<br/>-Coreg (heart medication) two times.<br/>-Amlodipine (blood pressure medication) three times.<br/>-Aspirin three times.<br/>-Digoxin (heart medication) nine times.<br/>-Culterelle capsule (stomach medication) four times.<br/>*No reason had been documented for the missed doses.</p> <p>*February:<br/>-Coreg five times.<br/>-Amlodipine four times.<br/>-Aspirin five times.<br/>-Digoxin four times.<br/>-Culterelle capsule five times.<br/>-Nystatin mouthwash fourteen times.<br/>*No reason had been documented for the missed doses.</p> <p>b. Review of resident 3's January 2015 through February 2015 MARs revealed the following medications had not been documented as given:<br/>*January:<br/>-Vitamin D two times.<br/>-Flomax (helps with ability to urinate) two times.<br/>-Calcium three times.<br/>*No reason had been documented for the missed doses.</p> <p>*February:<br/>-Vitamin D four times.<br/>-Flomax three times.</p> | F 514   | <p>Nurses and medication aides will be educated on administration of medication policy by the DON or designee by April 23, 2015.<br/>*to include residents 2, 3 and 7. NKS/DDH/MF<br/>The DON or designee will review MAR's and TAR's weekly to assure accurate documentation. The DON will report her findings to the QA committee monthly for three months, then quarterly for 3 quarters, and then as determined by the QA committee. The DON will also report her findings back to nurses and med aides on their performance, provide education, and implement a plan for their performance improvement. As necessary, individual compliance will be included with performance evaluations for all nurses and med aides.</p> <p>A consultant has been engaged to advise the DON and an in-service is to take place by April 1, 2015 by the DON. The in-service will be for all staff who are responsible for documentation, Care planning, and use of care plan and will cover accurate assessment, identification of problem, implementation and interventions, monitoring and revising plan of care, and documentation of the care process.</p> |   |

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| F 514   | <p>Continued From page 11</p> <p>-Calcium three times.<br/>*No reason had been documented for the missed doses.</p> <p>c. Review of resident 7's January 2015 MAR revealed the following medications had not been documented as given:<br/>*January:<br/>-Prilosec (protects the stomach) two times.<br/>-Zetia (controls cholesterol levels) one time.<br/>-Lisinopril (blood pressure medication) one time.<br/>-Multivitamin one time.<br/>-Miralax (laxative) one time.<br/>-Calcium with vitamin D four times.<br/>-Colace (laxative) four times.<br/>-Risperdal (antipsychotic) one time.<br/>*No reason had been documented for the missed doses.</p> <p>d. Review of the provider's revised September 2002 Administration of Medication policy revealed omitted medications were to be documented to include the reason the medication had not been given. Medications were to have been given as ordered.</p> <p>3. Review of resident 2's February 2015 treatment administration record (TAR) revealed the following treatments had not been documented as completed:<br/>*February:<br/>-Wound care for his peg tube (feeding tube into the stomach) site three times.<br/>-Tube feeding five times.<br/>-Heel protectors two times.</p> <p>Interview on 3/4/15 at 2:30 p.m. with the director of nursing (DON) confirmed:<br/>*She had been aware of the missed or not</p> | F 514   |   |                      |   |

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| F 514   | Continued From page 12<br>documented doses of medication in the residents' MARs and undocumented TAR entries.<br>*Documentation audits had been completed in January and February 2015.<br>*The staff who had not documented the missed doses and treatments had been identified and educated.<br>*No further audits had been completed to see if improvement had occurred.<br>*An in-service was planned in March 2015.<br>*Documentation had been addressed in quality assurance.<br>*No benchmark goals had been identified to address those identified concerns.  | F 514   |   |                      |   |
| F 520<br>SS=E   | 483.75(o)(1) QAA<br>COMMITTEE-MEMBERS/MEET<br>QUARTERLY/PLANS<br><br>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.<br><br>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.<br><br>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. | F 520   | F520<br>DON, MDS coordinator, ADON and staff RN attended a webex on QAPI 101 on 3/19/2015.<br><br>All other staff who will be involved in QAPI will be educated by the DON or designee by April 23, 2015.<br><br>Policies and procedures will be developed on the QAPI process by April 23, 2015. | 4/23/15              |   |

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| F 520 | <p>Continued From page 13</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Surveyor: 28057<br/>Based on interview and record review, the provider failed to ensure the quality assurance (QA) program had identified concerns, developed, and implemented effective corrective actions related to care planning and documentation. Findings include:</p> <p>1. Review of the past three surveys (9/17/14, 9/25/13, and 7/11/12) revealed F280 had been written related to care plans not being updated to meet the residents' needs and conditions. Review of the plan of correction for the 9/17/14 survey revealed:<br/>*Twenty five percent of the residents' care plans would be reviewed and updated if needed.<br/>*The interdisciplinary team and nursing staff would be educated on the care plan process.<br/>*All of the cited residents' care plans were to have been updated.<br/>*Findings were to have been reported to QA on a quarterly basis by the director of nurisng (DON).</p> <p>Refer to F280, finding 2.</p> <p>2. Review of the past three surveys (9/17/14, 9/25/13, and 7/11/12) revealed F514 had been written related to documentation in residents' records that had not been maintained and was cited in 2012 and 2014. Review of the plan of correction for the 9/17/14 survey revealed:<br/>*The DON or designee would review the MARs</p> | F 520 | <p>QAPI methods will be initiated to replace the facilities current QI practice. Initial indicators to be focused on will include care plan and documentation compliance. The QI Coordinator Nurse will monitor effectiveness of QAPI process quarterly and report findings to the administrator.</p> |  |
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| F 520   | <p>Continued From page 14 and TARs on a weekly basis to ensure documentation was maintained and accurate. -That would be done for three months and then quarterly thereafter.</p> <p>*Nursing staff would receive education on appropriate and accurate documentation.<br/>*Staff identified through the QA process would be further educated.</p> <p>Review of the provider's 11/25/14 QA quarterly meeting minutes revealed:<br/>*Accurate documentation related to MARs and TARs had been reviewed.<br/>*Thirty-four of thirty-seven reviewed residents' MARs and five residents' TARs were incomplete on 10/19/14 .<br/>*Ten of thirty-nine reviewed residents' MARs and one resident's TARs were incomplete on 10/26/14 .<br/>*Fifteen of thirty-nine reviewed residents' MARs and two residents' TARs were incomplete on 11/2/14 .<br/>*No plan was identified to address the above information for correction or use of the information for QA purposes in the minutes.</p> <p>Review of the provider's 1/5/15 QA quarterly meeting minutes revealed:<br/>*Chart reviews had been completed.<br/>*Care plans were assessed to ensure they had been updated appropriately.</p> <p>Refer to F514, finding 2.</p> | F 520   |   |                      |  |