

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/10/2015
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY MILLER	STREET ADDRESS, CITY, STATE, ZIP CODE 421 EAST 4TH ST MILLER, SD 57362
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F 000	INITIAL COMMENTS Surveyor: 22452 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 11/9/15 through 11/10/15. Areas surveyed included neglect and mistreatment of residents. Good Samaritan Society Miller was found not in compliance with the following requirements: F224, F226, F281, and F323.	F 000	*Addendums noted with an asterisk per 12/2/15 per telephone with facility administrator. KR/SDDO/H/L	
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. This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, interview, and policy review, the provider failed to conduct a thorough investigation to rule out neglect or mistreatment for one of one sampled resident (1) who had extensive bruising and a fracture of unknown origin. Findings include: 1. Review of resident 1's medical record revealed: *A 5/21/03 admission date. *Diagnoses of dementia (memory loss) and osteoarthritis (painful joint limitations). *She was hospitalized 10/15/15 with a left femur	F 224		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Laurie Pospisil</i>	TITLE <i>Administrator</i>	(X6) DATE 12/3/2015
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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 224	Continued From page 1 (long bone in upper part of leg). *She returned to the facility on 10/19/15. *She expired (died) on 10/29/15. Review of resident 1's 8/5/15 and 10/26/15 Brief Interview for Mental Score (BIMs, memory test) revealed: *8/5/15, A score of 2 out of 15. *10/26/15, A score of 5 out of 15. *BIMS scoring: -Memory intact (okay) 13 to 15. -Moderately impaired memory 8 to 12. -Severely impaired memory 0 to 7. Review of resident 1's 10/5/15 through 10/15/15 nursing progress notes revealed: *10/5/15 at 2:47 p.m., "Daily skin check. Profere boot [treatment of stasis (caused by poor circulation) ulcers] intact to left leg. Right leg is pink with 3+ edema [swelling]. Has dry scaly patches to left thigh and lower right leg. Cream applied: Under breasts and abdominal fold are intact." *10/6/15 at 3:30 a.m., "Tylenol give for voicing of pain all over. Rates pain at a 9 [0 is no pain and 10 being severe pain]." *10/8/15 at 10:41 a.m., "Tylenol given for left leg discomfort." *10/8/15 at 11:27 a.m., "Noted a dark bruise in the inner part of resident's right ear. Bruise is dime sized. Unsure how bruise occurred." *10/8/15 at 1:04 p.m., "Resident still complaining of severe left knee pain." *10/8/15 at 2:37 p.m., "Facsimile [fax] to physician. Resident is complaining of severe left knee pain. When leg is lifted up or moved she yells out. Leg is not warm to touch or reddened. Resident does have a rashy area on her left inner thigh [upper leg] that goes from her knee up to	F 224 F224	1. Resident #1 is deceased. 2. Currently Administrator, DNS and Social Services Designee are going over all incident reports daily with [redacted] investigation. 3. The Center will provide education and training to all staff & volunteers in regards to abuse, neglect, mistreatment, and misappropriation of property [redacted] & [redacted] DNS and Staff Development Coordinator will also educate staff on risk factors that most commonly lead to abusive behaviors such as poor attitudes, burnout, conflict, disruptive behaviors, aggression, lack of supervision, failure to enforce patient abuse laws & short staffing. Change of Condition assessments are now being done by Charge Nurses and the Stop & Watch procedure has been implemented in the Center to improve communication between frontline staff, family, visitors and the nurses. 4. DNS or designee will audit incident reports daily to ensure full investigation has been done: X 1 month, then weekly X 1 month, then monthly x 1 year and bring all reports of audits to QAPI Coordinator and DNS or Designee will report finings at monthly QAPI meetings and consult QAPI Committee for recommendations. 5. Plan of Correction for education will be completed by 12/8/2015.	12/30/2015	

*Thorough
KR/SDDOHE/EL

*11/19/15
KR/SDDOHE/EL

*11/18/15
KR/SDDOHE/EL

*Q11
KR/SDDOHE/EL

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F 224	Continued From page 2 her perineal [groin] area. Tylenol was given this morning with no relief. Resident does not have anything stronger to give." *10/8/15 at 6:27 p.m., "Tylenol given for complaints of left knee pain at a 4 to 5 pain rating." *10/8/15 at 9:43 p.m., "The system has identified a possible drug allergy for the following order: Ultram. Communication sent to physician via facsimile [fax]." *10/9/15 at 5:30 a.m., "Tylenol given for pain in left knee/leg." *10/10/15 at 7:50 a.m., "Tylenol given for left leg pain of 8." *10/10/15 at 2:28 p.m., "Daily skin check. Profore boot remains intact to left lower leg. Circulation, motion, and sensation [CMS] remains unchanged to toes. Dull pink rash to inner thighs. Treatment as ordered." *10/10/15 at 5:40 p.m., "Tylenol given for complaints of left knee pain." *10/10/15 at 9:50 p.m., "Resident transferred to bed via [by] stand-up lift [mechanical lift that required resident to be able to bear some weight on their legs]. Certified nursing assistant [CNA] called charge nurse in room. Voiced to charge nurse concerning large purplish bruising [no size documented] to left outer breast and under left arm. Bruising very likely occurred while resident being transferred via stand-up lift, area pinched or rubbing against area while being lifted. Skin intact. Resident denies any discomfort, voiced she did not even know it was there." *10/11/15 at 1:42 a.m., "At 9:50 p.m. last evening 10/10/15, CNA called charge nurse in regarding a large bruise [no size documented] on resident's left outer breast and under left axillary [armpit]. Note large purplish bruise, non-tender to touch. Resident voiced she did not even know it was	F 224			

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F 224	Continued From page 3 there. Type of bruising likely to occur during transferring with stand-up lift. Area pinched by lift harness if not appropriately place in the right position while lifting." *10/11/15 at 7:11 a.m., "Family has been notified of bruise. Voiced understanding." *10/11/15 at 8:30 a.m., "Tylenol given for left knee pain." *10/11/15 at 3:48 p.m., "Resident has been more lethargic [sleepy]. Requires more cueing [verbal reminders] and at times physical assist with meal. Sleeps through the meal if left alone. Resident more confused, wanting her parents. If not sleeping she is wandering in her wheelchair. Does not go far but has no idea where she is headed. Temperature 97. 2 degrees [normal 98.6]." *10/11/15 at 5:50 p.m., "Tylenol given for left knee pain." *10/12/15 at 10:40 a.m., "Tylenol given for complaints of pain/aches all over." *10/12/15 at 9:30 p.m., "Tylenol given for left knee pain." *10/12/15 at 10:30 p.m., "Able to sleep when left alone, but still screams when she is moved. Tried repositioning her leg with pillows, helps for awhile." *10/13/15 at 4:44 a.m., "Tylenol given for pain in her left leg." *10/13/15 at 10:42 a.m., "Ultram [narcotic-like pain medication] given per request for left knee pain." *10/13/15 at 11:29 a.m., "Seen by physician for increased pain to left knee. Left knee more swollen, red, and warm to touch. Resident to be seen at clinic at 1:10 p.m. today for x-ray and labs [laboratory tests] and to be seen via physician." *10/13/15 at 12:10 p.m., "Ultram given for discomfort to left knee."	F 224			

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F 224	Continued From page 4 *10/13/15 at 4:16 p.m., "Returned to facility with new diagnosis of gout [recurrent attacks of acute inflammatory arthritis]." *10/13/15 at 5:22 p.m., "Noted left knee continues to be swollen/warm to touch, very painful to touch." *10/13/15 at 8:51 p.m., "Indocin [anti-inflammatory medication] not available from pharmacy." *10/13/15 at 9:55 p.m., "Still remains with a lot of soreness in left knee. Left knee remains very swollen, red, warm to touch and has a large bruise type area on inner part of knee." *10/14/15 at 12:36 a.m., "Resting in bed continues to have a lot of pain in left leg, especially knee area. Left knee remains very swollen, red, and has a large bruise noted on inner side of left knee. Screams out at times with movement. Majority of left breast and under left arms remains with dark bruised area." *10/14/15 at 10:03 a.m., "Indocin not available. Will come up from pharmacy tonight." *10/14/15 at 3:00 p.m., "Tylenol given for leg pain. Continues to be tender to the touch with some relief obtained at this time." *10/14/15 at 5:10 p.m., "Ultram given for severe pain to left knee." *10/14/15 at 8:25 p.m., "Left knee is swollen, bruised and red, and warm to touch. Extremely tender to the touch. Resident yells out ouch, ouch, ouch the entire time during transfers or movement or touch to the left leg. Rocephin [antibiotic injection] scheduled. Had a small emesis [vomiting] after lunch. Resident given Ultram with some relief at rest. Will monitor. Physician was notified of bruising over the phone and stated to monitor pain at this time. There is no need for an x-ray at this time as she was seen in the clinic yesterday. Stated it will take time for	F 224			

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F 224	<p>Continued From page 5</p> <p>the gout and inflammation to settle down and for the pain to go down. Need to notify the clinic if resident runs a fever or if pain becomes unmanageable."</p> <p>*10/14/15 at 10:25 p.m., "Ultram given for knee pain with some relief."</p> <p>*10/15/15 at 12:50 a.m., "Ultram given for pain in knee."</p> <p>*10/15/15 at 1:59 p.m., "Resident having severe pain in left leg. Resident screams with any movement in any area of her body. Called clinic and requested she be seen."</p> <p>*10/15/15 at 3:44 p.m., "Transferred to hospital for uncontrolled pain in front of left knee and front of left thigh. She was hospitalized for a fracture and return is anticipated."</p> <p>Review of resident 1's 10/10/15 9:50 p.m. investigation form revealed: *Name of witnesses: None. *If no witnesses, list names of caregivers/staff for past seventy-two hours: -Registered nurse (RN) F. -CNA G. -There were no other caregivers documented. **CNA [not identified] found large bruise [no size documented] purple to outer left breast and into left axillary area. Area non-tender. Type of bruising likely occurs during use of stand-up lift, area gets pinched or rubbed via lift harness if not appropriately placed under resident's arms while lifting." *Corrective action: -Make sure harness placed in right position to prevent further injury. -Facility staff will complete the corrective action. *The form was signed by the administrator and director of nursing (DON) on 10/12/15. *The form was not signed by the social worker.</p>	F 224			

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F 224	<p>Continued From page 6</p> <p>*Resident oriented (alert) to name. She was not documented as oriented to time and place.</p> <p>*Predisposing (before) environmental factors was equipment/assistive devices.</p> <p>*Report was prepared by RN F.</p> <p>*Son notified on 10/10/15 at 10:00 p.m.</p> <p>*Physician notified on 10/11/15 at 1:40 p.m.</p> <p>*Administrator notified on 10/11/15 at 1:40 p.m.</p> <p>Review of resident 1's 10/7/15 through 10/10/15 CNA documentation revealed:</p> <p>*10/7/15, CNAs C, I, and J documented assistance with bed mobility, personal hygiene, transfers, and toilet use.</p> <p>*10/8/15, CNAs G and J documented assistance with bed mobility (moving and changing position), personal hygiene, transfers, and toilet use. CNA K documented assistance with bathing.</p> <p>*10/9/15, CNAs C, H, and I documented assistance with bed mobility, personal hygiene, transfers, and toileting.</p> <p>*10/10/15, CNAs G and H documented assistance with bed mobility, personal hygiene, transfers, and toileting.</p> <p>Review of resident 1's 10/8/15 physician's orders revealed "Ultram 50 milligrams every six hours as needed for pain. Monitor rash, if worse, needs to be seen."</p> <p>Review of resident 1's 10/8/15 through 10/13/15 medication administration record revealed the Ultram was not administered until 10/13/15. That was the day she was sent to the clinic and was diagnosed with gout.</p> <p>Review of resident 1's 10/13/15 physician's clinic ambulatory progress notes revealed:</p> <p>***Staff report over the weekend, today being</p>	F 224			

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F 224	<p>Continued From page 7</p> <p>Tuesday, that she had a very painful left knee. She would holler whenever it was moved." *"Today there has been some erythema [redness] and some warmth to the knee. No fever. She is still complaining of pain." *"She complains of pain with just minimal movement of that leg." *"Unable to rate pain." *"She does have some history of degenerative joint disease [DJD] with chronic knee pain and is taking Ultram for that at this time [was ordered on 10/8/15 and was not administered until this morning on 10/13/15]." *"No recent fall." *Impression DJD and gouty arthritis. *"We will given her Kenalog [anti-inflammatory injection]. We will also do Rocephin for three days. We will start her on Indocin three times a day for one week. She should recheck in the clinic in one week."</p> <p>Review of resident 1's 10/15/15 physician's hospital progress notes revealed: *"90 year old lady with significant pain with movement of the left hip and knee." *"She denies any falls and no falls noted on the face sheet from the nursing home." *"She was seen two days ago for knee pain as well. She was started on antibiotics and given intramuscular steroid." *"She does have severe dementia [memory loss] and does not remember things very well and denies falling." *"Staff reports she screams out in pain with minimal movement." *"Pain in left leg. Unable to rate." *"Left knee is swollen with bruising on the left medial [middle] side. She has pain with any movement. Tender to palpitation [touch]."</p>	F 224		

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F 224	<p>Continued From page 8</p> <p>**"Closed fracture of distal [far] end of left femur."</p> <p>Review of resident 1's 10/15/15 hospital physician's consultation report revealed: **"She does not recall how she injured the leg. She does have bruising along her left side, but no documented falls." **"X-rays reviewed and demonstrate an acute displaced oblique [neither parallel or at a right angle] fracture of the distal femur with significant posterior [back] angulations [position] and osteoporosis. There is severe DJD noted as well with bone-on-bone changes in the medial compartment." **"Left lateral hemithorax [one side of chest] and breast ecchymoses [bruising] likely related to lift usage."</p> <p>Review of resident 1's 10/16/15 physician's surgical report revealed "Open reduction, internal fixation [surgical procedure to fix a severe bone fracture or break] left distal femur fracture."</p> <p>Interview on 11/10/15 at 9:50 a.m. with RN L regarding resident 1 revealed she: *Sent a facsimile to the physician on 10/8/15 as the resident was having pain with any movement. *Did not work after 10/8/15 with the resident, so she was unaware the nurses were not administering the Ultram to her. *Agreed the Ultram should have been given for greater pain control instead of the Tylenol. "At least they gave her something."</p> <p>Interview on 11/10/15 at 10:30 a.m. with the DON regarding resident 1 revealed she: *Never talked to CNA G regarding the resident's bruising from 10/10/15. *Confirmed CNA G had worked with the resident</p>	F 224			

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F 224	<p>Continued From page 9</p> <p>from 7:00 a.m. until the bruising was reported on 10/10/15.</p> <p>*Had thought RN F would have spoken to him, but she had failed to document that.</p> <p>*Did not know about the resident's bruising until 10/12/15.</p> <p>*Only talked to the nurses on duty, and "I told them we had to be more careful with the straps on the lift to prevent further reoccurrences."</p> <p>*Had looked at her bruising and also agreed it was likely due to the harness on the stand-up lift not being appropriately placed.</p> <p>*Nor any of the other nurses watched a transfer with the resident after the incident on 10/10/15.</p> <p>*Nor any of the other nurses had completed a lift assessment on the resident after 10/10/15 to see if that was the appropriate way she should have been transferred.</p> <p>*Had not re-educated any of the staff, including the agency temporary staff after the incident on 10/10/15.</p> <p>*Felt it was not necessary to review the different mechanical lifts with all the agency temporary CNAs, as that would have been included in their CNA training.</p> <p>*Had not investigated the resident's bruising, because they were sure it had been caused by the stand-up lift.</p> <p>*Knew the potential allergy to Ultram had been reported to the physician and did not know why it had not been followed-up on.</p> <p>Interview on 11/10/15 with the administrator regarding resident 1 revealed she:</p> <p>*Had not investigated the resident's bruising.</p> <p>*Had not reported the bruising or fracture of unknown origin to the South Dakota Department of Health.</p> <p>*Stated it was the social worker's responsibility to</p>	F 224			

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F 224	<p>Continued From page 10</p> <p>initially investigate and report injuries of unknown origin.</p> <p>*Stated when the social worker was done with her investigation she gave the report to her and the DON.</p> <p>*Should have investigated and reported the bruising and fracture when she had signed the investigation report on 10/12/15 and saw that it had not been done.</p> <p>*Stated the social worker was on vacation during the survey and was unable to be interviewed.</p> <p>Phone interview on 11/10/15 with the consultant pharmacist regarding resident 1 revealed he:</p> <p>*Had sent a note along with the Ultram on 10/8/15 to watch for any sensitivities to the medication as she had sensitivities to other medications.</p> <p>*Would have called the physician or had the nursing staff if he had noted "a red flag" alerting him to an allergy to Ultram.</p> <p>*Had sent fifteen tablets of Ultram to the facility on 10/8/15 about 5:30 p.m.</p> <p>*Was unsure why they had not administered the Ultram to the resident for pain control until 10/13/15.</p> <p>Review of the agency temporary staff list provided revealed:</p> <p>*CNAs C and H had received safe patient [resident] handling in April 2015.</p> <p>*CNAs G, T, U, and V had no documentation of receiving the safe patient handling.</p> <p>*Nurses V, W, and X had no documentation of receiving the safe patient handling.</p> <p>Refer to F226 B, finding 1 regarding abuse and neglect training.</p>	F 224			

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F 224	<p>Continued From page 11</p> <p>Review of the provider's February 2013 Abuse and Neglect policy revealed:</p> <p>*"The center will provide education and training to staff and volunteers in regards to abuse, neglect, mistreatment and misappropriation of property."</p> <p>*"Alleged or suspected violations involving any mistreatment, neglect or abuse including injuries of unknown origin will be reported immediately to the center administrator and to other officials in accordance with state law, including the state survey and certification agency. In the absence of the administrator from the center, the following individuals have the administrative authority of the administrator for purposes of immediate reporting of alleged violations: the DON or the director of social services."</p> <p>*"The center will have evidence that all alleged or suspected violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress."</p> <p>*"Results of all investigations will be reported to the administrator or designated representative and to other officials in accordance with state law, including to the state survey and certification agency within five working days of the incident, or sooner as designated by state law."</p> <p>*"The abuse/neglect policies and procedures cannot and do not guarantee that abuse will never occur. To prevent such occurrences, all reasonable measures within our control will be taken."</p> <p>Review of the provider's September 2012 Pain Management policy revealed:</p> <p>*"All residents will receive interdisciplinary consultations in managing pain."</p> <p>*"When a resident is identified as being in pain, the social worker, as part of the interdisciplinary team, will assess the psychosocial well-being of</p>	F 224		

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F 224	Continued From page 12 the resident." *"Individualized approaches will be developed to address the resident's pain management needs in a holistic manner." *"The RN will assess current pain levels and develop with the physician and interdisciplinary team interventions that may be non-pharmacological as well as pharmacological." *"The RN will review response to medication intervention and work closely with the physician to assist in the individualized pain measurement plan."	F 224			
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 35237 A. Based on observation, record review, interview, and policy review, the provider failed to thoroughly investigate incidents (abnormal event) for abuse and neglect for four of four sampled residents (1, 2, 3, and 4) with cognitive (memory and decision making) impairment. Findings include: 1. Review of resident 4's incident reports from October 2015 through November 2015 revealed: *On 10/6/15 at 1:30 p.m., she had a witnessed fall in the hallway. She:	F 226			

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F 226	<p>Continued From page 13</p> <p>-"Lightly hit her head" and had "a small reddened area to right forearm."</p> <p>-Had an elevated temperature of 99.5 (normal is 98.6).</p> <p>-Stated she "just doesn't feel good" and was "weak and tired but ok."</p> <p>-Was oriented to person and place only.</p> <p>*On 10/14/15 at 5:30 a.m., she had an unwitnessed fall in her bathroom doorway. She:</p> <p>-Stated she had been going to the bathroom and her foot gave out.</p> <p>-Hit her head.</p> <p>-Complained of pain in her right hip.</p> <p>-Was sent to the hospital by ambulance for a suspected fracture (broken bone).</p> <p>Random observations from 11/9/15 through 11/10/15 of resident 4 revealed she:</p> <p>*Utilized a wheelchair assisted by staff to move around in the facility.</p> <p>*Required staff assistance with a mechanical lift (equipment to move resident) to transfer to and from her wheelchair.</p> <p>*Was pleasant and interacted with staff.</p> <p>Review of resident 4's medical record revealed she:</p> <p>*Had diagnoses of dementia with behavioral disturbances (impaired memory and thinking), anxiety (nervousness), age-related osteoporosis (weak bones), and a history of falling.</p> <p>*Had a Brief Interview for Mental Status (BIMS) score of 9.</p> <p>*BIMS scoring:</p> <p>-Memory intact (okay): 13 to 15.</p> <p>-Moderately impaired memory: 8 to 12.</p> <p>-Severely impaired memory: 0 to 7.</p> <p>*Had fallen on 10/6/15 at 1:20 p.m.</p> <p>*Had fallen on 10/14/15 at 5:30 a.m. and was</p>	F 226		

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F 226	<p>Continued From page 14</p> <p>sent to the hospital for complaint of hip pain. *Was admitted to the hospital for a right hip fracture following her fall on 10/14/15. *Had been re-admitted to the provider on 10/17/15 following a surgical repair of her right hip fracture. *Required supervision and set-up help only with activities of daily living (ADL) (dressing, bathing, moving, toileting, hygiene, and eating) prior to her 10/14/15 fall. *Required extensive staff assistance with her ADLs after she had returned from the hospital on 10/17/15.</p> <p>Review of resident 4's 11/9/15 care plan revealed: *She had impaired cognitive function, impaired decision making, and short term memory loss. *She required staff assistance with ADLs since she was re-admitted from the hospital.</p> <p>Review of resident 4's investigation reports for the 10/6/15 and 10/14/15 incidents revealed they: *Were blank in the following areas: -"Names of witnesses" for the 10/14/15 fall. -"If no witnesses, list names of caregivers/staff for past 72 hours" for both reports. *They were both checked as repeat incidents. *To describe the corrective actions taken to prevent recurrence of the above incident several options could have been marked. -For the 10/6/15 fall, resident education/training or re-instruction was checked. --"Staff" was listed as who would have completed the corrective action. -For the 10/14/15 fall, employee and resident education/training or re-instruction was checked. --"Nursing" was listed as who would have completed the corrective action. *There were no specific interventions listed to</p>	F 226	<p>F 226</p> <ol style="list-style-type: none"> Residents 1,2,3, & 4 incident reports have been thoroughly investigated as of 12/1/2105. Administrator, DNS and Social Services Designee or their designees will review all incident reports at the Center Monday – Friday on non-holidays immediately after Stand up and monthly Department Director meetings no later than the next working day. Incident reports will be reviewed for completeness of GSS #451 including type of incident, investigation in progress, proper notifications of family/POA, Licensing Body(if applicable). Administrator, DNS Social Services or designee will address and complete all areas missing any items including need for further or on-going investigation will be conducted and documented. The Social Services Designee will update resident's Care Plan if a new intervention is put in place. The Center will prevent further potential abuse while the investigation is being conducted per policy. The Center will provide education and training to all staff and volunteers in regards to abuse, neglect, mistreatment & misappropriation of property on 12/2/2015 & 12/4/2015. DNS and Staff Development Coordinator will also educate staff on the risk factors that most commonly lead to abusive behaviors. Employees M,P,& R have had training on abuse & neglect. Employees O,S,H,T,U & V will have training completed by 12/8/2015. 		

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F 226	<p>Continued From page 15 prevent recurrence.</p> <p>*For the results of the investigation the following was written in: -On 10/6/15, "No abuse or neglect noted." -On 10/14/15, it was blank.</p> <p>*The reports had been signed by the director of nursing and administrator six and seven days after the incidents. -The social worker signature line was blank.</p> <p>Review of the provider's 10/14/15 initial report to the state agency revealed: *The charge nurse had completed the report. *The brief explanation of the event was "Resident states walking to bathroom and foot gave out. Complains of pain in right hip. Sent to ER [emergency room] via [by] ambulance. On-call physician called back to confirm fractured hip." *There were no further notes regarding an investigation on that form.</p> <p>2. Review of resident 3's 11/3/15 incident report revealed she: *Had a large skin tear to her right hand. *Voiced a "male CNA grabbed her hand and made the skin tear." *Was oriented to person only.</p> <p>Random observations from 11/9/15 through 11/10/15 of resident 3 revealed she: *Used a walker to move around by herself. *Was short and abrupt with her answers to staff.</p> <p>Review of resident 3's medical record revealed: *Her diagnoses included dementia, macular degeneration (impaired eyesight), obsessive-compulsive (unreasonable thoughts that cause repetitive behaviors) personality disorder, and severe depressive (sadness)</p>	F 226	<p>F226 continued</p> <p>4. All Temporary and newly-hired Center staff will be trained on abuse & neglect during orientation prior to caring for residents. Staff Development Coordinator and DNS will educate all new employees on abuse and neglect prior to resident care. This education will be documented after providing the education on the orientation check list.</p> <p>5. DNS or Designee will audit weekly X 1 month then monthly X 1 year for compliance of completion of training. DNS or Designee will provide results to QAPI Coordinator monthly and DNS or Designee will report monthly at QAPI meetings. DNS or Designee will audit incident reports daily M-F on non-holidays or next working day to make sure through investigation has been done X 1 month; then audit weekly X 1 month, then monthly X 1 year. DNS or Designee will provide results of audits to QAPI Coordinator and report monthly at QAPI meeting.</p> <p>6. Plan of Correction for provision of education to existing staff will be completed by 12/8/2015.</p>	12/30/2015	

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F 226	<p>Continued From page 16</p> <p>disorder with psychotic (abnormal thoughts and behaviors) symptoms.</p> <p>*She had a history of hollering out, refusing care, verbal and physical aggression, repetitive patting of her hands on her lap or the table.</p> <p>Review of resident 3's investigation report for the 11/4/15 skin tear revealed:</p> <p>*Written in for "Names of witnesses" was the symbol for none.</p> <p>-For "If no witnesses, list names of caregivers/staff for past 72 hours" two names were listed.</p> <p>*It was checked as a repeat incident.</p> <p>*Written in for the summary was "resident dislikes any male CNA to help her during cares, much more a ..., which she called...and called all names."</p> <p>*To describe the corrective actions taken to prevent recurrence of the above incident several options could have been marked.</p> <p>-For the 11/4/15 incident, resident education/training or re-instruction was checked. The registered nurse's signature was listed as who would have completed the corrective action.</p> <p>*There were no specific interventions listed to prevent recurrence.</p> <p>*For the results of the investigation it was blank.</p> <p>*The report had been signed by the director of nursing and administrator five days after the incident.</p> <p>-The social worker signature line was blank.</p> <p>Review of the provider's 11/5/15 initial and 11/8/15 final reports to the state agency revealed:</p> <p>*An investigation for the 11/4/15 skin tear for resident 3 had been conducted.</p> <p>*That report had included more information than the above investigation and had been completed</p>	F 226			

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F 226	<p>Continued From page 17 by the administrator.</p> <p>Surveyor: 22452</p> <p>3. Review of resident 1's 10/10/15 at 9:50 p.m. investigation form revealed: *Name of witnesses: None. *If no witnesses, list names of caregivers/staff for past seventy-two hours: -Registered nurse (RN) F. -CNA G. -There were no other caregivers documented. **CNA [not identified] found large bruise [no size documented] purple to outer left breast and into left axillary area. Area non-tender. Type of bruising likely occurs during use of stand-up lift, area gets pinched or rubbed via [by] lift harness if not appropriately placed under resident's arms while lifting." *Corrective action: -Make sure harness placed in right position to prevent further injury. -Facility staff will complete the corrective action. *The form was signed by the administrator and director of nursing (DON) on 10/12/15. *The form was not signed by the social worker. *Resident oriented to name (alert and knows self). She was not documented as oriented to time and place. *Predisposing (before) environmental factors was equipment/assistive devices. *Report was prepared by RN F. *Son notified on 10/10/15 at 10:00 p.m. *Physician notified on 10/11/15 at 1:40 p.m. *Administrator notified on 10/11/15 at 1:40 p.m. Refer to F224, finding 1.</p> <p>4. Review of resident 2's 10/28/15 investigation report revealed: **At 8:00 p.m. resident was found laying on her</p>	F 226			

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F 226	<p>Continued From page 18</p> <p>right side on the floor beside her bed. Wheelchair was beside her. Resident stated she was going to get into that bed."</p> <p>**Oriented to person only. Disoriented to time and place."</p> <p>**Range of motion [movement of arms and legs] within normal limits. Denies injury or pain. Assisted up per total lift [mechanical lift that requires no weight bearing ability of resident] and two staff."</p> <p>**No apparent unsafe condition."</p> <p>*Summarize facts that might have contributed to that incident: "Resident continues to self-transfer."</p> <p>*Describe the corrective actions taken to prevent recurrence of this incident was left blank.</p> <p>*Who would complete corrective actions was left blank.</p> <p>*Results of investigation was left blank.</p> <p>*Signature of social worker was left blank.</p> <p>Refer to F281, finding 1.</p> <p>Surveyor: 35237</p> <p>5. Interview on 11/10/15 at 11:00 a.m. with the director of nursing (DON) revealed:</p> <p>*The charge nurse completed the top portion of the investigation reports.</p> <p>-There was no area specifically for the nurse to sign.</p> <p>*She agreed there were several areas of the forms that were not completed.</p> <p>*The investigation reports should have been documented completely.</p> <p>*She agreed resident education was not an appropriate corrective action when a resident had impaired cognition.</p> <p>*Usually she, the administrator, and the social worker signed the investigation reports when they were completed.</p>	F 226		

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F 226	<p>Continued From page 19</p> <p>*She agreed the investigation reports for resident 4 had:</p> <ul style="list-style-type: none"> -Areas that had not been filled out including the witness or staff that had worked in the previous seventy-two hours. -Not identified interventions to prevent recurrence. -Not fully determined the cause of the falls. <p>*She agreed resident 4 had impaired cognition and education for her would not have been an appropriate corrective action.</p> <p>*She confirmed there were missing pieces to show that complete investigations had been done related to resident incidents.</p> <p>-They might have "gotten a little lax recently."</p> <p>Interview on 11/10/15 at 10:15 a.m. with the administrator regarding incidents and investigations revealed:</p> <ul style="list-style-type: none"> *They discussed incidents at daily stand-up meetings. *She, the DON, and the social worker did the investigations. *She agreed: <ul style="list-style-type: none"> -Resident education was not an appropriate corrective action for a cognitively impaired resident. -All incidents should have had a corrective action to prevent recurrence. *The nurse completed the top part of the investigation report, but there was not a place for them to sign. *She confirmed there were several blanks in the investigation reports, and they should have been done completely. <p>Review of the provider's revised September 2013 Abuse and Neglect policy revealed:</p> <ul style="list-style-type: none"> *The purpose included "To assure that staff are 	F 226			

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F 226	<p>Continued From page 20</p> <p>knowledgeable regarding reporting and investigative process of abuse and neglect allegations in the center." *"The center will have evidence that all alleged [charged or claimed] or suspected violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress."</p> <p>Review of the provider's revised August 2015 Incident Report policy revealed: *The purpose included "To conduct an investigation of each incident." *"The Incident Report is completed for each resident incident that occurs. When an incident occurs, ensure the care plan is updated if a new intervention is put in place." *"The investigation team consisting of the administrator, director of nursing services and social services will review each incident no later than the next business day."</p> <p>B. Based on interview, record review, and policy review, the provider failed to ensure ongoing abuse and neglect training had been completed by 7 of 59 employees (M, N, O, P, Q, R, and S) and 10 of 10 contract employees (C, G, H, T, U, V, W, X, Y, and Z). Findings include:</p> <p>1. Interview on 11/10/15 at 8:30 a.m. with the staff development/quality assurance nurse L regarding training revealed: *Facility employees would have had online training that was set-up by corporate to cover abuse and neglect upon being hired and annually. -Contract staff were not part of that scheduled online training. *They also had all-staff meetings quarterly to go over the topics of those online training topics</p>	F 226		

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F 226	<p>Continued From page 21 again and other areas as needed. -The staff that had not attended were supposed to make-up the training with her either by reading notes, reviewing, or taking a test. *She had not done training with the contract staff. -They sometimes met the contract staff only two hours before their first shift, and that did not leave a lot of time to train them on everything. *They tried to pair contract employees with facility employees for working together if able, but there was a potential of them working with other contract staff. *She agreed the contract staff would have been expected to follow all of the facility policies the same as facility employees.</p> <p>Review of the provider's Completion Report by Activity printed by staff development/quality assurance nurse L revealed: *Fifty-one employees had completed abuse and neglect fundamentals training from February 2015 through August 2015. *One employee had completed abuse and neglect full version in January 2015.</p> <p>Review of the provider's Activity Sign-In Sheet for the 2015 March All Staff meeting revealed: *Thirty-three employees had signed they were in attendance on 3/25/15. *There was no signature or documentation on the other twenty-eight employee names listed on that sheet.</p> <p>Review of the provider's Topic Exception Report by Topic for abuse and neglect revealed seven employees had not completed the training. Those employees were: *Dishwasher M. *Certified nursing assistant (CNA) N.</p>	F 226		

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F 226	<p>Continued From page 22</p> <ul style="list-style-type: none"> *Licensed practical nurse (LPN) O. *CNA P. *Registered nurse (RN) Q. *Director of social services R. *CNA S. <p>Review of the provider's list of contract (agency) staff from 10/1/15 through 11/9/15 included the following contract employees:</p> <ul style="list-style-type: none"> *CNAs: C, G, H, T, U, and V. *LPNs: W and X. *RN Y. *Dietary supervisor X. <p>Interview on 11/10/15 at 1:20 p.m. with the director of nursing revealed:</p> <ul style="list-style-type: none"> *No contract staff had completed abuse and neglect training in the facility. -They should have been trained by the agency they worked for. *She confirmed the documentation showed the social services director had not completed the annual abuse and neglect training. She had not attended the all-staff meeting in March 2015 that covered abuse and neglect either. -The social services staff director should have done the abuse and neglect training. *She agreed all staff would have been expected to follow the facility policies overall and to complete the assigned trainings. <p>Further interview on 11/10/15 at 1:30 p.m. with staff development/quality assurance nurse L confirmed:</p> <ul style="list-style-type: none"> *There were seven employees that had not completed abuse training according to the topic exception report. *The social services director had not completed the online training or attended the March 2015 all 	F 226			

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F 226	<p>Continued From page 23 staff meeting. -She should have completed that training.</p> <p>Interview on 11/10/15 at 2:40 p.m. with the administrator confirmed: *They had no documentation contract staff had been trained on abuse and neglect. -She would contact their agency for the training they had completed prior to starting work at their facility. *All staff should have completed abuse and neglect training upon being hire and annually.</p> <p>Review of the provider's September 2013 Abuse and Neglect policy revealed: "The center will provide education and training to staff and volunteers in regards to abuse, neglect, mistreatment and misappropriation of property.</p> <p>Review of the provider's 9/2/14 Dakota Travel Nurse agency agreement revealed: *Responsibilities of Dakota Travel Nurse Inc included: -"Dakota Travel Nurse Inc. shall supply healthcare facility with an employee file upon request. Such files shall be available for review by healthcare facility and shall contain, at the minimum, the following: --1. A completed applications including skills, training, specialties, and references. --2. Documentation of special education/training including CPR/ACLS [life-saving skills]." *Responsibility of healthcare facility included: -"a. Healthcare facility shall provide orientation for all personnel provided and accepted by healthcare facility."</p> <p>Review of the provider's 9/16/13 TriState agency agreement and 7/22/15 Prioricare agency</p>	F 226		

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F 226	Continued From page 24 agreements revealed: *"The agency agrees to properly orient all Workers to assure compliance with Federal, State, Local laws, rules and regulations." *"Orientation will include but will not be limited to:" -"a. State and Federal regulations..." -"f. Vulnerable Adult laws." Surveyor: 22452	F 226		
F 281 SS=G	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 22452 A. Based on observation, record review, interview, and policy review, the provider failed to follow professional standards of not moving a resident with acute pain and a suspected fracture for one of two sampled resident's (2) condition following a fall resulting in a fracture. Findings include: 1. Observation on 11/10/15 at 10:00 a.m. of resident 2 revealed she: *Was dependent on a wheelchair for mobility (movement). *Was transferred from the wheelchair into bed by certified nursing assistants (CNA) AA and BB. *Put toe-touch weight bearing on her right leg during the transfer. *Showed no discomfort during the transfer. Review of resident 2's 10/28/15 through 10/29/15 nursing progress notes revealed:	F 281	F281 1.+ Plan of Correction for resident #2 was a full investigation of incident. Resident was taken to hospital and transferred back to Center after surgery +Plan of Correction for resident #4 was a full investigation of incident. Resident returned from the hospital. +Nurse L was individually counselled by DNS on 11/10/2015, re: not transferring residents with suspected lower extremity fractures via wheel chair but to call the ambulance. +All nurses were coached and counseled 11/19/2015, on policies regarding documentation including Nursing Documentation Guidelines/Timelines, Physician/Practitioner orders and Fall Prevention and Management.	

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F 281	<p>Continued From page 25</p> <p>*10/28/15 at 11:37 p.m., "At 8:00 p.m. tonight resident was found laying on her right side on the floor beside her bed. Wheelchair was beside her. Range of motion [movement of arms and legs] within normal limits. Denies pain. Assisted up per two staff and total lift [mechanical lift that requires no weight bearing on legs from the resident]." No injury noted. Daughter came to facility and was informed of fall at 8:15 p.m. Will notify physician by facsimile [fax]."</p> <p>*10/29/15 at 7:30 a.m., "Transferred to hospital. Fractured hip."</p> <p>*There was no documentation of her condition from 10/28/15 at 11:37 p.m. until her transfer to the hospital on 10/29/15.</p> <p>Review of resident 2's 10/29/15 ambulance report revealed patient (resident):</p> <p>*Transferred from clinic to hospital with fractured right hip.</p> <p>*Complains of right leg and back hurting.</p> <p>*Was confused as to surroundings and reason for transport.</p> <p>Review of resident 2's 10/28/15 investigation report revealed:</p> <p>***Resident continues to self transfer."</p> <p>***Oriented [alert] to person. Disoriented [poor memory] to time and place.</p> <p>***Personal alarm system [body alarm that sounds when resident attempts to self-transfer]."</p> <p>***Alarm did not sound."</p> <p>Interview on 11/10/15 at 9:00 a.m. with registered nurse (RN) L regarding resident 2 revealed:</p> <p>*She came to work at 6:45 a.m. on 10/29/15 and had sent the resident to the clinic by 7:30 a.m. The clinic then sent the resident to the hospital for a right fractured hip.</p>	F 281	<p>F 281 continued</p> <p>2. + Nurses and CNA staff were educated on 11/18/2015 & 11/19/2015 on policies regarding documentation, Physician orders and Fall Prevention and Management. Nurses were instructed to ask Practitioners for orders to obtain urine specimens via "quick cath" sterile catheter process if unable to obtain a clean catch urine specimen if they know a resident will be difficult to obtain a clean specimen.</p> <p>+ DNS, Administrator, and Staff Development Coordinator met with Center Medical Director on 11/17/2015, and discussed recent Complaint Survey conducted 11/9/2015 & 11/10/2015, including obtaining urine specimens. Medical Director stated nurses should contact provider if they feel a urine specimen needs to be obtained via "quick cath."</p> <p>3. + Residents that fall or are found on the floor and are suspected of a fracture or spinal injury will not be moved by Center staff to the Fall policy, and ambulance will be contacted.</p> <p>+Orders from all Healthcare Providers will be carried out and followed according to policy.</p>	

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F 281	<p>Continued From page 26</p> <p>*The CNAs had called her into the resident's room when she had gotten there. She was in a lot of pain and could not move her right leg and was pulling at her right knee.</p> <p>*The resident rarely complained of pain so "I knew her well enough to know there was something wrong."</p> <p>*RN CC had worked the night shift and said she was okay in report.</p> <p>*RN CC came into the room with me and "Thought her pain was caused from her lying in bed all night."</p> <p>*She assessed the resident in bed for pain. The CNAs told her they were going to try and get her up in her wheelchair and see how she did.</p> <p>*She did not tell the CNAs not to get her up in her wheelchair since she was in so much pain, nor did she stay in the room and watch them transfer her.</p> <p>*She had no comment when asked why she had allowed the CNAs to transfer her into her wheelchair when she was having so much pain.</p> <p>*She had not documented her assessment of the resident in the medical record and should have.</p> <p>*The resident was unable to rate her pain, but she thought it was maybe a 5 or 6 out of 10 (0 being no pain and 10 being severe pain).</p> <p>Phone interview on 11/10/15 at 10:30 a.m. with RN CC and the director of nursing (DON) regarding resident 2 revealed:</p> <p>*The resident was put to bed at 10:30 p.m. on 10/28/15 and was having no pain yet.</p> <p>*Her daughter had come into the facility after the fall and pushed her around in her wheelchair for awhile.</p> <p>*She had not documented anything in her medical record, because she was okay and not having any pain.</p>	F 281	<p>F 281 continued</p> <p>4.+ DNS or Designee will review all resident orders from Healthcare Providers on a daily basis for completion or orders X 5 days, then weekly the day after routine Healthcare Provider rounds X 2 weeks, then monthly X 6 mo. Any missed orders will be completed and nurse failing to carry out the orders will be counseled by DNS or Designee. Currently Administrator, DNS and Social Services Designee are going over all incident reports daily with through investigation.</p> <p>5. DNS or Designee with report all findings to QAPI Coordinator and monthly QAPI meeting and consult with QAPI Committee for further recommendations.</p>	12/30/2015	

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F 281	<p>Continued From page 27</p> <p>*She was not sure but she should have been up to the bathroom a couple of times or the CNAs had provided incontinent care in bed.</p> <p>*The CNAs would have let her know if the resident was experiencing any pain.</p> <p>*She probably should have made some documentation in her medical record at least that she had been okay during the night shift.</p> <p>Review of the provider's September 2012 Documentation policy revealed: **"Documentation of all nursing care and observations, assessments and treatments, and effects will be written by an authorized professional using the PointClickCare system and Resident Services System of Forms." **"All documentation is expected to be legible, accurate, understandable, timely, and pertinent." **"Frequency of documentation will be determined depending on the condition of the resident." **"All of the following will be clearly documented according to the respective policies and procedures: -Physical health observations. -Reassessments [checking for change in resident status or condition]."</p> <p>Review of the provider's July 2015 Fall Prevention and Management policy revealed: **"For fallen resident: -Do not move the resident." **"For a fall with injury do the following: -Cover the resident and have him or her lay quiet until help arrives. -Do not move the resident if suspected spinal or hip fracture." **"A licensed nurse must observe the resident and perform a full-body examination to determine if there may be a suspected injury and direct</p>	F 281		

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F 281	Continued From page 28 whether to move the resident. Do not attempt to move the resident if spinal or hip fracture is suspected." Surveyor: 35237 B. Based on observation, record review, interview, and policy review, the provider failed to follow physician's orders in a timely manner for one of one sampled resident (4) with symptoms of an infection. Findings include: 1. Review of resident 4's medical record revealed she: *Had diagnoses of dementia with behavioral disturbances (impaired memory and thinking), anxiety (nervousness), age-related osteoporosis (weak bones), and a history of falling. *Had a Brief Interview for Mental Status (BIMS) score of 9. *BIMS scoring: -Memory intact (okay): 13 to 15. -Moderately impaired memory: 8 to 12. -Severely impaired memory: 0 to 7. *Had fallen on 10/6/15 at 1:20 p.m. and was noted to: -Have an elevated temperature of 99.5 degrees. -Have a strong urine odor. -Complained of feeling weak and "just doesn't feel good." *Had a physician's order to check a urinalysis (UA) following that fall on 10/6/15 at 4:13 p.m. *Became unsteady on 10/7/15 at 7:08 p.m. while walking by herself and had an elevated temperature of 99.8 degrees. -There was documentation "unable to get urine specimen today. Will continue to try to get specimen." -Did not have the UA completed until 10/8/15. *Was ordered an antibiotic (medication to treat	F 281			

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F 281	<p>Continued From page 29</p> <p>infection) by her physician to treat her urinary tract infection (UTI) on 10/9/15.</p> <p>-The first dose of the antibiotic was held that evening due to "resident was vomiting."</p> <p>-At 2:39 a.m. the charge nurse documented "Resident has UTI, antibiotic to start in the morning, Temperature 99.8 [degrees]. No complaints during the night."</p> <p>-That antibiotic did not get started until 10/10/15.</p> <p>Continued review of her medical record revealed she:</p> <p>*Still had low grade elevated temperatures (99.2 and 99.1 degrees) and complained of weakness on 10/11/15 and 10/12/15.</p> <p>*Was seen by the certified nurse practitioner in the nursing home on 10/13/15, and the antibiotic was changed to a different antibiotic medication.</p> <p>*Took the first dose of the new antibiotic on 10/13/15 at 8:00 p.m.</p> <p>*Had fallen again on 10/14/15 at 5:30 a.m. and was sent to the hospital for complaint of hip pain.</p> <p>*Was admitted to the hospital for a right hip fracture following her fall on 10/14/15.</p> <p>*Had been re-admitted to the facility on 10/17/15 following a surgical repair of that right hip fracture.</p> <p>*Required supervision and set-up help only with activities of daily living (ADL; dressing, bathing, moving, toileting, hygiene, and eating) prior to her 10/14/15 fall.</p> <p>*Required extensive staff assistance with her ADLs after she returned from the hospital on 10/17/15.</p> <p>Random observations from 11/9/15 through 11/10/15 of resident 4 revealed she:</p> <p>*Utilized a wheelchair assisted by staff to move around the facility.</p>	F 281			

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F 281	<p>Continued From page 30</p> <p>*Required staff assistance with a mechanical lift (equipment to move resident) to transfer to and from her wheelchair.</p> <p>*Was pleasant and interacted with staff.</p> <p>*Wore a disposable brief for urinary incontinence and was assisted with toileting and personal hygiene.</p> <p>Review of resident 4's 11/9/15 care plan revealed:</p> <p>*She had impaired cognitive function, impaired decision making, and short term memory loss.</p> <p>*She had bladder incontinence (unable to control urine).</p> <p>-Interventions for incontinence included:</p> <p>"Monitor/document for s/s [signs and symptoms] of UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp [temperature], urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns."</p> <p>*She had a history of falling, poor balance, and unsteady gait [walking].</p> <p>*She required staff assistance with ADLs since she had been re-admitted.</p> <p>Interview on 11/10/15 at 8:30 a.m. with registered nurse L regarding resident 4 revealed she:</p> <p>*Agreed:</p> <p>-The resident had symptoms of an infection on 10/6/15.</p> <p>-The physician's order for the UA was received on 10/6/15.</p> <p>*Was unsure why it took two days to obtain the UA for resident 3.</p> <p>-If they were having difficulty getting a UA they should have contacted the doctor and gotten an order for a quick cath UA (insert a tube into the bladder) since she had continued with symptoms</p>	F 281		

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F 281	<p>Continued From page 31 of an infection.</p> <p>*Confirmed she had not received her first dose of antibiotic to treat her UTI until 10/10/15, four days after the symptoms had started.</p> <p>*Held the dose of antibiotic on the evening of 10/9/15 due to the resident vomiting.</p> <p>*Did not know why the night nurse had not given the first dose of the antibiotic on 10/10/15 when the resident was feeling better.</p> <p>*Agreed the UA and antibiotics were not completed in a timely manner.</p> <p>Interview on 11/10/15 at 10:15 a.m. with the administrator regarding resident 4's orders for a UA and the start of antibiotics confirmed they were not completed in a timely manner.</p> <p>Interview on 11/10/15 at 11:00 a.m. with the director of nursing regarding resident 4 revealed: *When a physician ordered a UA for a resident it should have been completed as soon as possible. *If staff had difficulty obtaining a UA for a resident they should have contacted the doctor and gotten an order for a quick cath. *She agreed the resident had shown symptoms of a UTI on 10/6/15. *She confirmed the UA was not done timely, and the antibiotics did not start until 10/10/15.</p> <p>Review of the provider's September 2012 Physician/Practitioner Orders policy revealed the purpose was to: **"Provide individualized care to each resident by obtaining appropriate, accurate and timely physician/practitioner orders." **"Provide a procedure that facilitates [helps] the timely and accurate processing of physician/practitioner orders."</p>	F 281			

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F 281	Continued From page 32	F 281			
F 323 SS=D	<p>Review of Patricia A. Potter and Anne Griffin Perry et al, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, p. 236-237, revealed: *"Patients [residents] benefit most when their care represents a collaborative effort from the expertise of all health care team members. A plan of care is dynamic and changes as the patient's needs change." *"Priority setting is the ordering of nursing diagnoses or patient problems using determinations of urgency and/or importance to establish a preferential order for nursing actions."</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, interview, record review, manufacturer's instructions, and policy review the provider failed to: *Use the appropriate sling size for one of two observed mechanical lift (equipment used to move a resident from one place to another) transfers for a sampled resident (4). *Follow their mobilization tool assessment for safe transfer method for one of four observed residents' (2) transfers.</p>	F 323			

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F 323	<p>Continued From page 33</p> <p>Findings include:</p> <p>1. Observation and interview on 11/9/15 at 4:15 p.m. of resident 4's transfer with certified nursing assistants (CNA) A and B revealed: *She was lying in bed on her back with a mesh hygiene sling (special sling used for toileting with the mechanical lift) already underneath her. *They attached the sling to the mechanical lift and used the lift to assist her to sit on the commode (portable toilet). *When she was finished using the commode: -CNA B used to mechanical lift to raise her up. -During that process the mesh hygiene sling started to slide up the resident's back. -CNA A told CNA B to stop and lower her back down to the commode. -CNA A then adjusted that sling further down the resident's back. -It was noted to be a large-sized sling according to the tag. -When asked what size sling they were using with this resident CNA A stated "Medium, I think." -When asked what size sling they should have been using they gave no direct answer. -Once the sling was re-positioned they raised her back up and moved her back to her bed with the lift. *They both: -Agreed there was a risk of injury to the resident if they used a sling that was not the appropriate size. -Were unsure where it was documented what size sling they were supposed to have used. -Thought maybe it was listed on the resident's care plan, but they did not know how to get to that care plan.</p> <p>Interview on 11/9/15 at 4:25 p.m. with CNA C</p>	F 323	<p>F323</p> <p>1.+ Resident #4 has a medium sling. +Resident #2's Care Plan was updated to match the mobilization Tool and Care Plan according to resident's current status. 2. Care Plan Team or designees will review Care Plans and mobilization tools for each current resident by 12/30/2015, to ensure that mobilization tool & Care Plan match and reflect resident current status. 3.+ Mobilization Tool and Care Plan will be completed on any new admission, resident with noted change in condition, re-admission or resident having quarterly assessment. + All staff will be instructed on how to find correct sling and lift for each resident use on the Kardex. 4. Care Plan Team or designee will audit completion of mobilization tool and Care Plan to ensure they match and match resident's current status on 3 residents per week starting 12/2/2015. Residents to be selected will be those residents who had their Care Plan meeting that week. 3 random residents will be selected from the Care Plan list and audits completed weekly X 1 year. 5. Care Plan Team or Designee will report all findings to QAPI Coordinator and at QAPI monthly meetings.</p>	12/30/2015

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F 323	<p>Continued From page 34</p> <p>regarding mechanical lifts and slings revealed: *The correct sling size to use for a mechanical lift transfer would have depended on each resident's body size. *He was unsure where it would have been documented what size sling staff were supposed to have used for each resident. *He would have checked with the charge nurse if he had a question regarding sling size.</p> <p>Review of resident 4's medical record revealed: *She had fallen on 10/14/15 and broken her hip. *Staff had used the total lift since 10/28/15 to move her, because the doctor had ordered for her to be no weight bearing to her right leg. *Her care plan stated she required a full body (total) lift for transferring. *The CNA Kardex (kiosk, computer system with information for the CNAs) stated she: -Required a full body lift for transferring. -Used a medium sling for transfers. -Could use a hygiene sling for toileting to the commode.</p> <p>Interview on 11/10/15 at 11:00 a.m. with the director of nursing (DON) revealed she: *Agreed there was a risk for injury to residents if staff had not used the appropriate size sling during a mechanical lift transfer. *Confirmed resident 4 should have had a medium-sized sling for transfers.</p> <p>Observation and interview on 11/10/15 at 11:15 a.m. with CNA D and registered nurse (RN) E during resident 4's transfer revealed: *They transferred her from the bed to her wheelchair using a medium-sized sling and the total lift. *CNA D stated:</p>	F 323			

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F 323	<p>Continued From page 35</p> <ul style="list-style-type: none"> -They used a medium sling for this resident. -She was unsure where it was documented for what size sling to use. -She thought maybe it was on the care plan or the kiosk, but she had not looked. <p>Review of the provider's 1/9/06 EZ Lift manufacturer's instructions manual revealed "As patient's [resident] do vary in size, shape, weight, and temperament, these conditions must be taken into consideration when deciding which size of the EZ sling is most suitable for their needs."</p> <p>Review of the provider's July 2015 Fall Prevention and Management policy revealed an "Avoidable Accident - means that an accident occurred because the location failed to...Implement interventions, including adequate supervision, consistent with a resident's needs, goals, plan of care and current standards of practice in order to reduce the risk of an accident."</p> <p>Surveyor: 22452 2. Review of resident 2's medical record revealed a fall on 10/28/15 resulting in a right hip fracture.</p> <p>Observation on 11/10/15 at 10:00 a.m. of resident 2 revealed:</p> <ul style="list-style-type: none"> *She was sitting in her wheelchair. *She was transferred from the wheelchair into bed by certified nursing assistants (CNA) AA and BB with the use of a gait belt (used by staff to steady/assist in walking/getting up). No mechanical lift (equipment to assist with moving from on place to another) was used during the transfer. *She used toe-touch weight bearing on her right leg during the transfer. *The CNAs did not give her any cueing 	F 323			

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F 323	<p>Continued From page 36 (directions) during the transfer regarding bearing weight on her right leg.</p> <p>Interview at that time with CNA AA regarding resident 2 revealed she: *Thought the resident was not able to bear any weight on her right leg due to her recent hip fracture but was not sure. *Made no mention if a mechanical lift should have been used during the transfer.</p> <p>Review of resident 2's 11/2/15 care plan revealed: *"Assist resident to transfer with two assists." *"Resident is weight bearing as tolerated." *"May use stand-up lift [mechanical lift that requires the resident to be able to bear some weight on their legs]."</p> <p>Review of resident 2's 11/2/15 Mobilization Support Data Collection tool revealed: *"In a seated position, can the resident demonstrate leg strength in at least one leg by raising leg as if marching or kicking when moderate resistance/pressure is applied? -No, use sit-to-stand [stand-up type of mechanical lift]. -Harness size medium. -Two staff to assist." *"Weight bearing as tolerated to right leg."</p> <p>Interview on 11/10/15 at 2:30 p.m. with the director of nursing regarding resident 2 revealed she: *Was unsure why the care plan and the Mobilization Support Data Collection tool did not match. *Stated the resident should have been transferred with a sit-to-stand lift.</p>	F 323			

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F 323	Continued From page 37 Review of the provider's October 2013 Mobility Support and Positioning policy revealed: *"Always check the kiosk (computer program for CNA to use/document resident care) or care plan prior to the transfer or repositioning task for type and amount of assistance needed as identified on the resident's Mobilization Support Data Collection Tool." *"Follow any specific lift/transfer instructions for the resident."	F 323			