

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

ORIGINAL

PRINTED: 04/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/09/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - BELLA VISTA	STREET ADDRESS, CITY, STATE, ZIP CODE 302 ST CLOUD STREET RAPID CITY, SD 57701
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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 4/7/15 through 4/9/15. Areas surveyed included resident abuse and neglect and residents' falls. Golden Living Center Bella Vista was found not in compliance with the following requirement: F323. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, interview, and policy review, the provider failed to ensure the safety of one of one sampled resident (1) who had a history of falls. Findings include: 1. Interview on 4/8/15 at 3:00 p.m. with resident 1's son revealed: *The son found his mother lying on her side on the floor beside her bed on 9/17/14 about 9:45 a.m. when he came to visit her. *Her pants were pulled down and her buttocks were exposed with bowel movement on her skin. *He went to the doorway of the room and called out for staff assistance to get her off the floor.	F 000	STATEMENT OF COMPLIANCE: The following represents the plan of correction for the alleged deficiencies cited during the survey that was conducted on April 9, 2015. Please accept this plan of correction as the living center's Credible Allegation of Compliance with the completion date of May 29, 2015. The completion and execution of this plan of correction does not constitute an admission of guilt or wrong doing on the part of the living center. This plan of correction is completed in good faith and as the living center's commitment to quality outcomes for the residents. In addition, this plan of correction is completed as it is required by law. F 323 G Post fall guideline for Resident 1 has been reviewed with appropriate actions taken Residents residing in the facility have the potential to be affected in a similar manner.	5/29/15
F 323 SS=G		F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Margaret Drence* TITLE: *Executive Director* (X6) DATE: *4/30/15*

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 323	<p>Continued From page 1</p> <p>*The nursing staff assisted her off the floor and checked her over for injuries, and none were found.</p> <p>*The nursing staff had told him they had assisted the resident to the bathroom (time unknown) and then all the staff had a "stand-up" meeting they had every morning. They thought the resident was in the bathroom alone "for only maybe a minute." "There should have been some staff left on the nursing wing to attend to residents."</p> <p>***The resident should not have been left alone in the toilet."</p> <p>*The resident was dependent on the staff to get in and out of the bathroom, but he thought she got tired of waiting for the staff to come get her. She was unsteady on her feet, and her balance was impaired.</p> <p>*The resident had an unwitnessed fall on 5/19/14 and sustained a facial laceration.</p> <p>*The resident had a few other falls (unsure of dates) where she did not sustain injuries.</p> <p>*They had gotten her a different chair in her room to make it easier for her to get out of if she forgot and tried to get up on her own.</p> <p>*After the fall nursing staff told him they were not going to use the toilet anymore for her due to her dementia (memory loss) and inability to understand using the toilet any longer. The nursing staff told him in the care plan meeting they were "going to check and change her adult undergarment every hour."</p> <p>*Sometimes family came to visit her and no nursing staff come into her room for two to three hours.</p> <p>*The family had told the provider they would still like her taken to the toilet especially for her bowel movements.</p> <p>*There was some nursing staff that were better than others with making sure the resident's soiled</p>	F 323	<p><i>ALL dem</i></p> <p>^ Residents residing in the facility will have their assessments reviewed and revised to reflect the resident's current status with the next scheduled MDS assessment</p> <p><i>Nursing staff be educated by DNS or designee regarding #1 Resident toileting plan. dem</i></p> <p>Licensed Nurses have been reeducated with regard to post-fall guidelines</p> <p><i>4 residents dem</i></p> <p>The DNS or designee will audit post fall documentation weekly for 1 and resident month, monthly for 2 months. <i>toileting per plan dem</i></p> <p>Results of the audits will be reviewed at QAPI meetings for further recommendations. <i>monthly dem</i></p> <p><i>DNS will report the dem</i></p>		

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F 323	<p>Continued From page 2</p> <p>undergarment was changed more often, but they were not sure it was every hour.</p> <p>Review of resident 1's 9/19/14 at 9:50 a.m. post fall analysis/plan revealed: *Fall details- "Lost balance." *Prior to fall- "Resident ambulating." *History of falls. *Impaired safety/awareness/judgement. *Time last toileted/voided- "Wet." There was no time for that entry. *Medications given in the last eight hours prior to fall- "Antidepressant and antipsychotic." *Recommendations and interventions post fall- "Bed in low position. Toileting schedule. Do not leave resident unattended in the bathroom." *Care plan revised- "No."</p> <p>Review of resident 1's 5/19/14 through 3/15/15 nursing progress notes revealed: *5/19/14- "Resident ambulating [walking] in hallway. Certified nursing assistant heard a noise and saw resident laying in doorway on left side. Has history of falls as well as needing encouragement to slow down while ambulating. Ambulates in hallway frequently. Large laceration [cut] to left side of eye brow and down side of left eye. Swelling to left lower lip. Abrasion [scraped area] to left hand knuckles. Redness to both knees. Glasses are bent and at nurse's station for repair by family. Sent to emergency room." *5/28/14- "Resident witnessed falling. Poor safety awareness." *8/3/14- "Resident found laying on the floor in front of the chair in the room. She appears to have slid out of the chair onto the floor. She has a history of falls and impaired judgement. Resident does have dementia." *9/19/14- "Resident's son came into room and</p>	F 323		
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F 323	<p>Continued From page 3</p> <p>found resident laying on floor next to bed and reported to staff. Resident is 73 year old and diagnosed with dementia."</p> <p>*12/6/14- "Resident is found on the floor in her room. History of dementia and impaired safety awareness. A small amount of blood is noted to be coming from an abrasion to her posterior [back] scalp."</p> <p>*1/17/15- "Found lying on the mat on the floor in another resident's room. History of falls and dementia."</p> <p>*1/19/15- "Resident attempting to sit down on the bed and slid off bed onto the floor. Writer witnessed event. Resident is a 76 year old with dementia. Resident is able to ambulate without assist. Gait is slow and unsteady."</p> <p>*3/1/15- "Resident began to slide out of shower chair and was lowered to the floor. No injuries."</p> <p>*3/15/15- "Resident found sitting on floor in front of couch at end of west. History of falls and dementia. No new injuries noted."</p> <p>Review of resident 1's undated care plan revealed:</p> <p>*At risk for falls related to wandering, use of medication, and history of falls. Date initiated 1/17/13.</p> <p>*Footwear to prevent slipping.</p> <p>*Do not leave resident unattended in the bathroom.</p> <p>*Incontinence of bowel and bladder. History of urinary tract infections. Date initiated 1/17/13.</p> <p>*Assist to the bathroom upon arising in the morning, before and after meals, before going to bed at night, and during nightly rounds as resident allows.</p> <p>*Use of briefs/pads for incontinence protection.</p> <p>*Incontinence care and comfort as needed.</p>	F 323			

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F 323	<p>Continued From page 4</p> <p>Review of resident 1's 1/1/15 through 4/8/15 activities of daily living flow sheet log revealed: *Twenty-nine, eight hour shifts where no toileting assistance was documented. *Three night (10:00 p.m. to 6:00 a.m.) shifts toileting assistance was coded 8/8 (indicative activity did not occur).</p> <p>Interview on 4/8/15 at 3:30 p.m. with registered nurse Minimum Data Set coordinator A regarding resident 1 revealed: *Their policy was for residents who were considered at high risk for falls were not to be left unattended in the bathroom. *The resident had been identified as a high fall risk prior to her 9/19/14 fall when she had been left unattended in the bathroom. *During the morning stand-up meeting the nursing wing was never left unattended. When the certified nursing assistants had about a ten minute meeting the supervisors usually watched the wing. *Whoever had assisted her into the bathroom on 9/19/14 should have stayed with her or gotten someone else to remain with her in the bathroom.</p> <p>Review of the provider's 1/13/15 Incontinence Management/Bladder Function Guideline policy revealed: *Care plans reflect individualized program. *Observation of care provided matches the plan of care. *There was no documentation residents who were considered at high risk for falls were not to be left unattended in the bathroom.</p> <p>Review of the provider's 1/22/15 Falls Management Guideline policy revealed: *Each living center implemented the falls</p>	F 323			

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F 323	Continued From page 5 prevention and intervention program. *"At risk residents are identified through a fall alert communication system to care givers." *"The interdisciplinary team evaluates the fall prevention plan of care for residents at risk for falls." *Following a resident's fall appropriate interventions were implemented, and the care plan was updated.	F 323			