

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

ORIGINAL PRINTED: 09/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/02/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS Surveyor: 32572 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/1/15 through 9/2/15. Areas surveyed included resident safety, quality of care/treatment, resident abuse/neglect, oxygen safety, and staffing. Golden LivingCenter - Prairie Hills was found not in compliance with the following requirements: F281, F323, and F356.	F 000	STATEMENT OF COMPLIANCE: The following represents the plan of correction for the alleged deficiencies cited during the survey that was conducted on September 2, 2015. Please accept this plan of correction as the living center's Credible Allegation of Compliance with the completion date of September 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 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: 20031 A. Based on record review, interview, and policy review, the provider failed to ensure professional standards were followed for one of one sampled resident (5) who was: *Identified as a high risk for falls. *To have been monitored for anti-anxiety and anti-depressant drug side effects. *To have had neurological assessment checks done after a fall. *To have had a fall analysis documented on her after the fall. Findings include: 1. Review of resident 5's current care plan revealed the following focus areas: **At risk for falls related to: Unsteadiness with transitions and use of psychotropic meds	F 281	F281 Professional Standards Monitoring side effects of antidepressant and anti-anxiety medications has been implemented for Resident #5. Orders for wound care have been clarified and transcribed correctly and are being followed for resident #2. Resident #5 fall was not recent therefore the absence of neurological assessments cannot be corrected	9/29/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Emergency Permit Holder</i>	TITLE RECEIVED	(X6) DATE 9/24/15
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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 281	<p>Continued From page 1 [medication]." -That focus area was initiated on 3/19/14. -There were also handwritten notes from the past director of nursing services (DNS) that stated: -- "Fall 2/1/15; Nurse needs to remind aide when this Resident receives a laxative to monitor closely." --"Fell on 2/19/15." **"Potential for drug related complications associated with use of psychotropic medications related to: Anti-Depressant medication, Anti-psychotic medication, PRN [as needed] Antiquity." -That focus area was initiated on 3/19/14.</p> <p>The typed interventions for the above focus areas were: **"Monitor for side effects and report to physician: Antidepressant-Sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia [faster than normal heart rate], muscle tremor, agitation, headache, skin rash, photo sensitivity, and excess weight gain." **"Monitor for side effects and report to physician: Antipsychotic medication-sedation, drowsiness, dry mouth, constipation, blurred vision, EPS [extra pyramidal symptoms (unstable walk and muscle spasms)], weight gain, edema [swelling], postural hypotension [light-headed upon standing], sweating, loss of appetite, urinary retention." -The interventions were to be initiated on 3/19/14. -Handwritten notes with the same wording were written above the above interventions. They were dated 3/20/15 and 1/5/15 respectively.</p> <p>The responsible position for the above interventions were NS (nursing services) and SS (social services).</p>	F 281	<p>A fall evaluation has been completed for resident #5 and plan of care has been revised as indicated.</p> <p>Residents residing in the facility who are at high risk for falls have the potential to be affected in a similar manner. Residents who are at high risk for falls will be evaluated to ensure the plan of care is appropriate.</p> <p>Residents residing in the facility with incorrectly transcribed orders have a potential to be affected in a similar manner. Physician orders will be audited to ensure transcription is accurate.</p> <p>Licensed nursing staff have been re-educated on the Golden Living Change of Condition Guideline, Falls Management Guideline, Neurological Check Guideline and accurate transcription of physician orders.</p> <p>Director of Nursing Services or designee will complete random audits weekly x 4 weeks then monthly x 2 months on 5 residents to ensure appropriate change of condition documentation, fall analysis, appropriate follow up, interventions</p>	
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F 281	Continued From page 2 Interview on 9/2/15 at 4:10 p.m. with the interim DNS revealed: *She had located a monthly behavior/mood assessment dated April 2015 that had been completed by the SS. *She stated the behavior mood committee met monthly to monitor for side-effects of medication. *She agreed the side-effects listed on the April 2015 assessment for resident 5 were mental and not physical. *She had no other documentation from NS to ensure a physical assessment as requested in the care plan interventions had been completed on resident 5. *She had no evidence the April 2015 assessment had been sent to resident 5's physician. Review of the provider's 11/13/14 Falls Change of Condition Guidelines for Completion policy revealed: **"To assess individual condition after a fall occurs and to identify the reason and/or risk factors for the fall in order to prepare a plan of care to reduce the potential for future falls. *The interdisciplinary Care Plan team will complete a review of the Change in condition Report-Post Fall Investigation. This will be completed within 72 hours." Review of the provider's 1/22/15 Falls Management Guideline policy revealed: **Following a resident's fall: The licensed nurse assesses the resident for injuries (including neuro checks if indicated) and provides necessary treatment and initiates the Change in Condition Report - Post Fall/Trauma." **Licensed nurse completes Change in Condition Report - Post Fall Analysis following a resident	F 281	and care plan revisions has been completed. Director of Nursing Services or designee will complete random audits weekly x 4 weeks then monthly x 2 months on 5 residents to ensure accurate transcription of physician orders has occurred. Results of these audits will be brought to the monthly QAPI meeting by the Director of Nursing Service or designee for further review and recommendations.	

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F 281	Continued From page 3 fall." Neurological Checks policy dated 12/18/14 revealed: **1. Conduct neurological checks as follows: -Every 15 minutes for the first hour; -Every 30 minutes x [times] 4; -Every 60 minutes times 2; then Every shift for 72 hours." **2. Neurological checks shall be documented on the designated record and changes in neurological status reported immediately to the resident's physician by licensed nursing staff. 15-minute checks shall be reinitiated whenever there is a deterioration in the neurological status until the physician can give further guidance and/or consider further diagnostic testing." *3. Neurological assessment and documentation on the flow sheet shall include: a. date and time of assessment b. eye opening c. verbal response d. motor response e. pupillary response f. limb response g. vital signs." Review of resident 5's chart revealed: *A 2/1/15 neurological assessment had been completed by a nurse every fifteen minutes after a fall with a head injury. *A 5/21/15 neurological assessment had only one column completed for a fall with a head injury. Additional information had been completed on a vital signs and weight flow sheet. There were one hour gaps between 10:50 p.m., 11:50 p.m., and 12:50 a.m. There were four hour gaps between 00:50 a.m. and 4:50 a.m., 8:50 a.m. and 12:50 p.m.	F 281	(this page left blank intentionally)		

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F 281	<p>Continued From page 4</p> <p>--No assessment information was written for the 8:50 a.m. check.</p> <p>--No information was given for the 5/22/15 assessment after 12:50 p.m.</p> <p>--The 5/21/15 9:05 p.m. comments were:</p> <p>--"0 [with a line through the zero] Injury"</p> <p>--"resident A & O [alert and oriented]."</p> <p>--All other comments were "PERLA [pupils equal, reactive to light and accommodation] - resting in bed."</p> <p>--No comments were given for 08:50, 12:50, and the additional date after 12:50.</p> <p>- No base lines were given for:</p> <p>--BP (blood pressure)</p> <p>--Temperature</p> <p>--Pulse</p> <p>--Respirations.</p> <p>--The on-call physician had been notified when:</p> <p>--The BP was "190/130"</p> <p>--Temperature was "97.2"</p> <p>--Pulse was "204" resting</p> <p>--Respiration was "40"</p> <p>--O2 (oxygen saturation) was "72% (percent)".</p> <p>--There was no physician notification on 5/21/15 at 21:50 when:</p> <p>--The BP was "58/44"</p> <p>--Temperature was "96.7"</p> <p>--Pulse was "117" resting</p> <p>--Respiration was "24"</p> <p>--O2 was "91".</p> <p>Review of the nurses notes (NN) and progress notes from 2/18/15 through 5/22/15 revealed:</p> <p>*"2/20/15 11:15 [11:15 a.m.] NN: Resident was found on bathroom floor, with blood on R [right] elbow. Was called into resident bathroom by aide. Resident states she was transferring back to wheelchair when she slipped."</p> <p>*No post fall analysis/plan or assessment could</p>	F 281	(this page left blank intentionally)	

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F 281	<p>Continued From page 5 be located by the interim DON for that date. Surveyor: 26632 B. Based on record review, interview, and policy review, the provider failed to transcribe and follow physician's orders for one of three sampled residents (2). Findings include:</p> <p>1. Review of resident 2's medical record revealed: *A 6/26/15 physician's order from the wound care clinic (WCC) for the treatment of her right lower extremity (leg) venous ulcerations (open wound caused by poor blood circulation) included: --"Apply Lopress [type of compression wrap] (small wrap 4" [inches] and 6" large) from base of toes up LE [lower extremity], 1" below bend of knee. re-wrap every 12 hours." *A 7/9/15 physician's order from the WCC included: --"Lopress wraps to RLE [right lower extremity]. Start with smaller wrap, beginning at base of right toes, wrapping upward overlapping wrap 50%. When smaller wrap runs out, tape in place. then use larger lopress wrap and being at ankle, Wrap upwards, overlapping 50% to 1" below bend of knee, secure in place with tape." *A 7/23/15 physician's order from the WCC included: --"Lopress wraps to RLE [right lower extremity]. Start with smaller wrap, beginning at base of right toes, wrapping upward overlapping wrap 50%. When smaller wrap runs out, tape in place. then use larger lopress wrap and being at ankle, Wrap upwards, overlapping 50% to 1" below bend of knee, secure in place with tape." *A 7/30/15 physician's order from the WCC included: --"Lopress wraps to RLE [right lower extremity]. Start with smaller wrap, beginning at base of right</p>	F 281	(this page left blank intentionally)		

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F 281	<p>Continued From page 6</p> <p>toes, wrapping upward overlapping wrap 50%. When smaller wrap runs out, tape in place. then use larger loproress wrap and being at ankle, Wrap upwards, overlapping 50% to 1" below bend of knee, secure in place with tape."</p> <p>Review of the narrative documentation from the WCC included: *7/8/15 "Pt [patient] not wearing loproress wraps-Type of ACE [compression] wrap in place." "Type of ACE wraps in place to BLEs [bilateral (both) lower extremity], no loproress wraps noted to the RLE as previously ordered. When asked, pt stated that the wraps were applied by a person at GLC [facility name]. Pt reported that staff person insisted that both legs be wrapped, but had to use ACE wraps instead of Loproress wraps as they were out of supplies." *7/23/15 "No loproress wraps noted to RLE as previously ordered. When asked, pt stated the wraps haven't been applied for 3 days." *7/30/15 "ACE wraps in place to legs, note that wraps are not the previously ordered loproress wraps. No dressing noted to the right posterior knee wound, wound open to air and draining. Optifoam Gentle dressing covering the right lateral leg, with what appeared to be silvadene and dry 2x2 gauze beneath. When asked, the pt stated that the SNF [skilled nursing facility] staff do not always change the silvadene dressing twice a day as instructed, pt state that sometimes the staff only change it once a daily."</p> <p>Review of resident 2's treatment administration records (TAR) for June, July, and August 2015 revealed: *June 2015 TAR included: -"-Order Date-6/26/15 1606 [4:06 p.m.] wrap LLE [left lower extremity] with 4 and 6" ace wraps q</p>	F 281	(this page left blank intentionally)		

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F 281	<p>Continued From page 7</p> <p>[every] 12 hours. Two times a day wrap over wound care dressing."</p> <p>*July 2015 TAR included: -"-Order Date-6/26/15 1606 [4:06 p.m.] wrap LLE [left lower extremity] with 4 and 6" ace wraps q [every] 12 hours. Two times a day wrap over wound care dressing." -"-Order Date-7/10/15 1500 [3:00 p.m.] Wrap RLE with loproress wraps q12 hours per Dr. _____[physicians name]."</p> <p>*August 2015 TAR included: -"-Order Date-6/26/15 1606 [4:06 p.m.] wrap LLE [left lower extremity] with 4 and 6" ace wraps q [every] 12 hours. Two times a day wrap over wound care dressing." -"-Order Date-7/10/15 1500 [3:00 p.m.] Wrap RLE with loproress wraps q12 hours per Dr. _____[physicians name]."</p> <p>Review of the documentation on the July 2015 TAR revealed "Wrap RLE with loproress wraps q12 hours" had not been documented as having been done four times.</p> <p>Review of the documentation on the August 2015 TAR revealed "Wrap RLE with loproress wraps q12 hours" had not been documented as having been done five times.</p> <p>Interview on 9/2/15 at 2:00 p.m. with the interim director of nursing confirmed: *The 6/26/15 WCC physician's order had not been transcribed to the TAR correctly. *The 7/10/15 WCC physician's order had not been completed as ordered eight times.</p> <p>Review of the provider's revised 5/13/15 Non-Control Medication Order Requirements policy and May 2012 Medication Administration</p>	F 281	(this page left blank intentionally)	

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F 281	Continued From page 8 -General Guidelines policy revealed no information on transcribing physician's orders to the TAR.	F 281		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, interview, record review, and policy review, the provider failed to ensure the safety for one of one sampled resident (4) from elopement (leaving the facility without staff knowing). Findings include: 1. Random observations of resident 4 throughout the survey from 9/1/15 through 9/2/15 revealed: *He ambulated with a walker with a steady gait (sequence of foot movement). *He ambulated throughout the facility without assistance. Interview on 9/2/15 at 2:10 p.m. with certified nursing assistant (CNA) A revealed: *She had been working and assigned to care for resident 4 the evening of his elopement on 7/16/15. *There had been one nurse and three CNAs working on the second floor.	F 323	F 323 Accidents/Hazards Resident # 4 has been re-evaluated for continued risk for elopement. Appropriate interventions have been implemented on the resident care plan. Residents residing in the facility who are at high risk for elopement have the potential to be affected in a similar manner. These residents have been re-evaluated and appropriate interventions have been implemented on the resident care plan. Staff will be re-educated on the Golden Living Elopement Guideline. Director of Nursing Services or designee will complete random audits weekly x 4 weeks then monthly x 2 months on 5 residents to ensure the Golden Living Elopement Guideline procedures are in place. Results of these audits will be brought to the monthly QAPI meeting by the	9/29/15

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F 323	<p>Continued From page 9</p> <ul style="list-style-type: none"> -That had been the usual staffing pattern. *The resident's wife had been visiting. -He had a history of becoming more agitated with his wife's visits. -His wife had left the facility about 3:00 p.m. -The wife had said to her "Watch out he is in a mood." *He had a Wanderguard (a device that would set off an alarm of an equipped door as he passed through it) applied to his walker and on his belt. *He had been cued to go to the dining room for the supper meal. *She had been busy with another resident who had been having "escalating behaviors." *After supper she went to find him and could not find him. *She notified her supervisor. -At that same time another resident's family member had called the facility to tell them resident 4 was at [name of restaurant]. *She stated the front doors were locked at "7:00 p.m." -The nurses were "responsible for locking them." -She had seen the nurses locking them. -The alarms went off "frequently" due to visitors to the facility. <p>Review of the dietary intake record in the electronic medical record revealed resident 4 had consumed 100 percent of his evening meal. This meal had been served at approximately 5:30 p.m. according to the dining room service times.</p> <p>Review of resident 4's medical record revealed:</p> <ul style="list-style-type: none"> *He had been admitted on 5/6/15. *His diagnoses were: <ul style="list-style-type: none"> -Dementia (decline in mental abilities) with behavioral disturbances. -Chronic kidney disease. 	F 323	<p>Director of Nursing Service or designee for further review and recommendations.</p>	

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F 323	<p>Continued From page 10</p> <ul style="list-style-type: none"> -Diabetes (problem with blood sugar levels). -Cancer of the bladder. -Hypercholesterolemia (high cholesterol). -Alzheimer's disease (decline in mental abilities). -Hypothyroidism (low thyroid function). -Coronary Athrosclerosis (narrowing of the arteries of the heart). <p>*He had been identified as an elopement risk upon admission.</p> <p>*He had three Wanderguard's in place (two on his walker and one on his belt).</p> <p>*The treatment administration records (TAR) for May, June, July, August, and September 2015 revealed no documentation of monitoring the Wanderguard's.</p> <p>*The 5/13/15 Minimum Data Set assessment (MDS) revealed a Brief Interview for Mental Status (BIMS) test had a score of six. That score indicated severe cognitive (thought process) impairment.</p> <p>Review of the nursing progress notes from admission to current revealed:</p> <ul style="list-style-type: none"> *5/25/15 at 10:26 a.m. "Has wanderguard as attempts to leave building." *5/28/15 at 11:41 p.m. "Elopement risk." *5/30/15 at 2:16 p.m. "Resident went out the side door of the building and went and sat in the courtyard. The alarm was sounding [door alarm]." *6/3/15 at 3:15 p.m. "Resident found exit seeking at front door. Resident does have wanderguard in place which is attached to his walker. Resident made his way downstairs without his walker." *6/13/15 at 8:14 p.m. "Resident was standing in elevator (elevator locked d/t [due to] Wanderguard) without his walker." *6/13/15 11:04 p.m. "Wanderguard in place. Exit seeking behavior noted this evening." *6/16/15 2:25 p.m. "Gait unsteady without walker." 	F 323	(this page left blank intentionally)		

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F 323	<p>Continued From page 11</p> <p>Has history of exit seeking behaviors, none noted this shift."</p> <p>*6/17/15 at 11:11 p.m. "Wanderguard in place. History of exit seeking. Walks independently with wheeled walker and steady gait."</p> <p>* 6/25/15 at 10:30 a.m. "[name of physician] states to have [name of nurse practitioner] in for psych [psychological (thought processes)] eval [evaluation] and to check UA [urine sample]."</p> <p>*6/26/15 at 11:30 a.m. "Urine sample collected by clean catch."</p> <p>*7/14/14 at 12:38 p.m. "Resident evaluated by [name of facility]."</p> <p>*7/15/15 at 10:02 a.m. "[name of nurse practitioner] in to see resident to day, no new orders."</p> <p>*7/17/15 at 1:52 p.m. "Resident is being re-evaluated by [name of facility]. SSA [social services assistant] notified spouse of the evaluation and added wanderguard."</p> <p>*7/17/15 at 2:16 p.m. "[name of physician] recommendation to transfer pt [patient] to [name of facility] locked unit when possible."</p> <p>*7/18/15 at 8:09 a.m. "Resident checked often due to wandering outside of building. Checked wanderguard this AM."</p> <p>*7/20/15 at 10:50 p.m. "Wanderguard placed on belt and on walker. Resident is an elopement risk."</p> <p>*8/5/15 at 3:54 p.m. "Resident has been exit seeking, and has wanderguard on his walker but does leave his walker behind. Refuses to have wanderguard bracelet on self. Resident a need to be evaluated for [name of facility]."</p> <p>*There had been no 7/16/15 progress note that had been the date of the elopement.</p> <p>Review of the urine analysis obtained on 6/26/15 at 11:30 a.m. revealed:</p>	F 323	(this page left blank intentionally)	

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F 323	<p>Continued From page 12</p> <p>*The physician had been faxed the results on 6/29/15.</p> <p>*The results indicated a "few" bacteria, with none of the "criteria met to perform a culture" (to determine which antibiotics were needed to treat an infection).</p> <p>Review of resident 4's care plan revealed:</p> <p>*An immediate plan of care for elopement risk had been implemented on 8/6/15.</p> <p>*There had been a care plan that had a focus area of "I forget things and it creates possible safety risks for me. DX [diagnosis] of dementia, new environment.</p> <p>-It had been initiated on 5/15/15.</p> <p>*Handwritten below the above was "Elopement risk;" there had be no initialized date.</p> <p>*The interventions for the elopement risk were:</p> <p>- "8/5/15 [date written] Be aware that resident refuses wanderguard on self and has left his walker behind."</p> <p>- "8/5/15 [date written] Family will consider placement in [name of facility]."</p> <p>Review of the behavior log for the time frame of 7/15/15 through 7/17/15 revealed "None of these behaviors apply."</p> <p>Review of the ADL (activities of daily living) detail report for 7/16/15 revealed he had been independent with no set-up or physical help from staff for:</p> <p>*Bed mobility (repositioning self).</p> <p>*Transfers.</p> <p>*Walking in room and corridor.</p> <p>*Locomotion (getting around) on unit and off unit.</p> <p>*Dressing.</p> <p>*Eating.</p> <p>*Toilet use.</p>	F 323	(this page left blank intentionally)		

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F 323	<p>Continued From page 13</p> <p>*Personal hygiene.</p> <p>Review of the evaluation completed on resident 4 for [name of facility] revealed there was: *No date the assessment had been completed. *No name of the person completing the assessment. *A total score of 3.6 that revealed between "Mild, minimal impairment that is clinically verifiable with detailed questioning and Moderate, marked impairment which is readily evidenced clinically."</p> <p>Review of the 1/29/09 Golden Living Admission/Discharge Criteria to Alzheimer Care Units revealed "The resident must score between 4.5 and 6.5 on the Global Deterioration Scale."</p> <p>Interview on 9/2/15 at 10:00 a.m. with social service assistant (SSA) B revealed: *Resident 4 lived on the second floor at the time of the elopement on 7/16/15. *She stated, "He had taken the elevator down to the first floor, went out the front door, turned right and went to [name of restaurant]." *At that time he had Wanderguards on his "walker and his belt." *"He was taking the Wanderguards off." *She stated the incident had occurred after 5:00 p.m. -She knew that because it happened after she had left for the day. *She stated the front door was alarmed at 5:00 p.m.</p> <p>Observation throughout the survey revealed the front door exited toward a busy four lane highway with no crosswalk or signal lights in front of the building.</p>	F 323	(this page left blank intentionally)		

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F 323	<p>Continued From page 14</p> <p>Interview on 9/2/15 at 12:00 noon with resident 3's mother revealed:</p> <ul style="list-style-type: none"> *She had been the one that had found resident 4 at [name of restaurant]. *She had called the facility to inform them of the resident's whereabouts. *She had brought him back to the facility. *The incident had occurred after the supper meal. *She had entered the facility, noted the alarms sounding, and had shut them off herself. -There usually had been no staff around when she had shut the alarms off. <p>Review of the provider's undated Elopement Guideline policy revealed:</p> <ul style="list-style-type: none"> *The definitions of elopement was "Elopement, for purposes of this policy and procedure, is defined as that situation where a resident with impaired decision-making ability, who is oblivious to his/her own safety, needs, and therefore at risk for injury outside the confines of the living center, has left the living center without knowledge of staff." *Under prevention for this policy had been "Staff will: <ul style="list-style-type: none"> -Observed that each resident's bracelet alarm/device is still in place each shift. -Establish a process to check bracelet alarm/device batteries according to manufactures directions. -Document findings on the TAR or other form of documentation." *Door alarms and resident protection alarms section revealed: <ul style="list-style-type: none"> -"Door alarms are tested daily." -The provider was to "Maintain roster of bracelet battery expiration dates and replace prior to expiration date." *Monitoring compliance section revealed: 	F 323	(this page left blank intentionally)		

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F 323	<p>Continued From page 15</p> <p>- "Care plans for elopement are in place and interventions individualized and implemented per physical observation."</p> <p>- "Door alarms are checked and documented in Building Engines."</p> <p>- "Alarm bracelet function is checked daily and documented."</p> <p>Review of the 2015 Signaling Device Testing Calendar for resident 4 revealed: *He had been stared on a Wanderguard on 5/29/15. *The device had not been documented as checked on the following dates: -6/30/15. -7/3/15 and 7/4/15. -7/6/15 through 7/18/15. -7/20/15 through 7/23/15. -7/26/15 through 9/1/15.</p> <p>Review of the provider's updated 9/13/13 Door Security Policy and Procedure revealed: *"The front door/main entrance will be locked at 10:00 p.m." *"The front/main entrance will be disarmed at 8:00 a.m. until 4:30 p.m. M-F [Monday through Friday] while monitored by the business office personnel. The front/main entrance will be alarmed M-F 4:30 p.m. until 8:00 a.m., from 4:30 p.m. Fridays until 8:00 a.m. Monday and any other times that business office personnel are not available to monitor this exit." *"Those exits that require continuous monitoring and/or alarms are alarmed through our [specific brand name] wander management system..."</p> <p>Interview on 9/2/15 at 1:50 p.m. with the interim</p>	F 323	(this page left blank intentionally)	

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F 323	Continued From page 16 executive director and the field services clinical director revealed: *The front door was alarmed when business office personnel were not present. *The alarms randomly activated in the evening. *Door alarms were monitored daily.	F 323		
F 356 SS=D	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p>	F 356	<p>F 356 – Post Nurse Staff Information</p> <p>No residents were identified as being affected in the statement of deficiency.</p> <p>Residents residing in the facility are not affected by this deficient practice.</p> <p>The Interdisciplinary team has been reeducated on the requirement of Federal Regulation F 356</p> <p>Executive Director or designee will complete random audits weekly x 4 weeks then monthly x 2 months to ensure the required nurse staffing information is posted. Results of these audits will be brought to the monthly QAPI meeting by the Executive Director or designee for further review and recommendations.</p>	9/29/15

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F 356	Continued From page 17 This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, record review, and interview, the provider failed to ensure nursing staff hours had been consistently posted. Findings include: 1. Random observations on 9/1/15 from 10:15 a.m. through 6:00 p.m. and on 9/2/15 from 7:30 a.m. through 1:00 p.m. revealed: *There was a clear plastic holder attached to the wall outside of the conference room on the first floor. *In that holder were facility census (the number of resident's in the facility) and the nursing staffing hours documents. *The census and nursing hours documents within that folder were for: -8/13/15. -8/14/15. -8/19/15. -8/20/15. Interview on 9/2/15 at 1:50 p.m. with the interim executive director confirmed the following: *The director of nursing was the person responsible to post the census and staffing hours. *The posting had not been current during the survey. The facility had been asked for a staffing policy twice, and none had been provided prior to the end of the survey.	F 356			