

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

ORIGINAL

PRINTED: 07/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/02/2015
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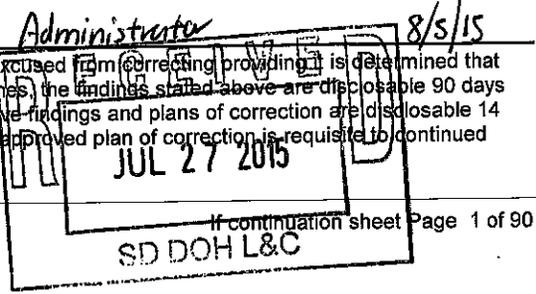
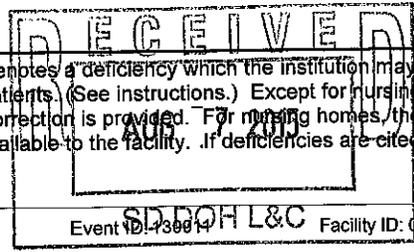
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - BLACK HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 NORTH 7TH STREET RAPID CITY, SD 57701
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY 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	<p><i>Addendums noted with an asterisk per 7/30/15 telephone to facility administrator and Don, KG/SDOH/JJ</i></p> <p>Surveyor: 26180 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/29/15 through 7/2/15. Areas surveyed included quality of care, restraints and seclusion, misappropriation of resident funds, facility staffing, nursing services, and physician services. Golden Living Center - Black Hills was found not in compliance with the following requirements: F166, F221, F222, F226, F278, F280, F281, F319, F325, F329, F353, and F441.</p>	F 000	<p>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</p>	
F 166 SS=E	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, record review, interview, and policy review, the provider failed to ensure call light concerns had been resolved for one of one resident group (resident council) and three of four confidential resident interviews. Findings include:</p> <p>1. Interview of residents on 6/30/15 at 10:00 a.m. during the resident council meeting revealed: *The residents had complained many times about call lights not having been answered in a timely manner. *It was not uncommon for staff to come into their</p>	F 166	<p>F 166E Right to prompt efforts by the facility to resolve grievances</p> <p>The facility is unable to correct past call light concerns.</p> <p>Residents residing in the facility have the potential to be affected in a similar manner.</p> <p><i>All * ^ KG/SDOH/JJ</i></p> <p>Staff members have been re-educated on ensuring call lights are answered promptly.</p> <p>Residents have been re-educated by the social worker by room to room interviews and during resident council meetings related to call light concerns and facility plan to resolve this concern.</p>	<i>*7/31/15 KG/SDOH/JJ</i>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Matthew Parson</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8/5/15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 166	<p>Continued From page 1 room and shut off their call light. -They would be told the staff would be right back, and they did not come back. -They forgot. *They did not want staff to shut the call light off and leave without helping them. *Sometimes they needed to get another person to help them, if the resident required two people to assist them. -They did not always come back. *At one time they had been told they would schedule more evening activities, so they did not get back to their room after their meals all at the same time and want help. -There was not a lot of evening activities. *They had not felt the resident council was getting the call light issue resolved.</p> <p>Observation of room 5 on 6/30/15 at 8:30 a.m. revealed: *The call light was on for twelve minutes. *Certified nursing assistant (CNA)/medication aide C was outside the room passing medications. -The medication cart was parked outside room 5. -She did not answer the call light.</p> <p>Observation of room 33 on 6/30/15 at 8:30 a.m. revealed: *The call light was on. *Registered nurse (RN) A walked down the hall and obtained her medication cart that was parked outside room 33. *RNA did not enter the room or check on the resident in room 33.</p> <p>Confidential interviews with three residents revealed: *They had to wait many times over one half hour</p>	F 166	<p>Resident council meetings will be held twice monthly for three months ^{* to address call light concerns,} Executive Director or designee will ^{KG/SOOH/JJ} complete 5 random resident interview audits of reported call light concerns weekly x 4 weeks then monthly x 2 months to ensure resident's call light concerns have come to resolution ^{* and report to QAPI monthly,} Results will be reviewed at monthly QAPI meetings for further ^{KG/SOOH/JJ} recommendations.</p> <p><i>* DON or designee will complete 5 random call light observations x 4 weeks then monthly x 2 months until the call light concerns are resolved. The DON will report the results to QAPI monthly. KG/SOOH/JJ</i></p>	

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F 166	<p>Continued From page 2 for their call light to be answered. *They did not feel they had enough staff to help everyone. *Their call lights might be answered, but the staff person would not help them saying they would be right back. -They did not come back. *It had not done any good to complain about call lights.</p> <p>Review of Resident Council minutes revealed: *New Business or concern: -January 2015 - "Need more CNAs [certified nursing assistants] call lights need to be answered in a timely manner. Did explain about 'high' call light times (before breakfast, after lunch, after supper). We need to implement engaging activities after meals." *February 2015 - "Call lights not answered in a timely manner." Residents very hostile [highly upset and agitated] about food missing and about call lights not being answered in a timely manner (after meals). Activity Director [AD] did state changes in activities, there would be an activity conducted in MDR [main dining room] after supper." *March 2015 - "Call lights not answered in a timely manner (twenty minutes wait). Did talk to residents about call lights not being answered in a timely manner. Residents stated they are sick of CNAs walking in, turning off the call light and stating they will be back in a minute. Stated that if they have the time to walk in, then they have the time to see what they want." *April 2015 - "Call lights. Three residents said the concern had not been resolved to their satisfaction. Director of nursing informed residents they were doing audits of call lights." *June 2015 - "Call lights not answered in a timely</p>	F 166		

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F 166	<p>Continued From page 3</p> <p>manner. Eight of twenty-one residents had this concern."</p> <p>Interview on 7/1/15 at 5:00 p.m. with the activity director revealed: *She was responsible for the resident council meetings. *The complaints about the call lights was an ongoing issue. *They had planned to have activities five nights a week to prevent residents from returning to their room and immediately turning their call lights on. -Their hours had been cut, so now she was unable to have evening activities more than three times per week.</p> <p>Interview on 6/30/15 at 11:45 a.m. with the executive director revealed: *They were aware how quickly call lights were answered was a frequent concern with residents. *They had done audits on the amount of time it took to answer call lights. *His expectation was that call lights: -Would have been answered by any staff member who walked by the room with the light on. -Should have been answered within five minutes.</p> <p>Review of the provider's 1/26/15 call light policy revealed "Answer ALL call lights promptly whether or not you are assigned to the resident."</p> <p>Review of the provider's 2009 Resident Council Process revealed "The Resident Council is an important part of the QA [Quality Assurance] process. It gives the residents the opportunity to address concerns, and the Living Center the opportunity to fix these concerns. In order for this system to work, once concerns are identified by the Council, they need to be addressed by the</p>	F 166			

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F 166	Continued From page 4 appropriate department and then brought back to the Council for the members to decide if the problem has been resolved.	F 166		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, policy review, and interview, the provider failed to ensure one of one sampled residents (14) with a seat belt had been assessed for that use. Findings include: 1. Review of resident 14's closed medical record revealed: *He was admitted on 5/8/15 with a diagnosis of encephalopathy (brain damage) related to a Traumatic Brain Injury (TBI). *A fax was sent to his physician on 5/15/15 stating "Due to resident's impulsiveness and frequent falls, nursing feels residents needs a seatbelt. May we have an order for a removable alarmed seatbelt in w/c [wheelchair]? Resident is able to remove belt on his own." -The physician responded with an order for an "Alarmed sb [seatbelt] in w/c only." Interview on 6/1/15 at 2:30 p.m. with the director of nurses regarding resident 2 revealed: *When a restraint was being considered for use on a resident, the Pre-Restraint Evaluation was	F 221	F221D The resident has the right to be free from any physical restraints Resident # 14 seatbelt assessment is unable to be completed as resident has been discharged from the facility. * 7/31/15 KG/5000H/JJ Residents residing in the facility utilizing restraints have the potential to be affected in a similar manner. Residents who are utilizing physical restraints have had assessment completed, physician order obtained, consent for restraint signed by power of attorney and care plan has been reviewed and revised. Nursing staff have been re-educated on the Golden Living Policy of Pre-restraint evaluation, informed consents for physical restraints and restraint reduction procedures Director of Nursing or designee will complete audits weekly x 4 weeks then monthly x 2 months to ensure restraint reduction evaluations are being completed in conjunction with the MDS schedule. Results will be reviewed at QAPI monthly meetings for further recommendations. to include any newly imposed restraints KG/5000H/JJ	

The DON will report the audit results to QAPI monthly.
KG/5000H/JJ

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F 221	Continued From page 5 completed by nursing. *This resident was able to release the seat belt. Review of resident 14's 5/8/15 care plan revealed: *Resident at risk for elopement due to his impaired cognition (thought process). *The goal was "Resident will not leave facility without assist." *Interventions - Seatbelt to remind resident not to get up without assist [assistance]. Resident is able to release seatbelt. *The care plan related to the fall risk did not address the use of the seatbelt. Further review of resident 14's closed medical record revealed there was not a Seatbelt or Pre-Restraint assessment completed to determine his ability to consistently remove the seatbelt. Review of the provider's 1/26/15 Physical Restraint Devices policy revealed the documentation guidelines for the use of the restraint may include: *Methods utilized before restraint device. *Assessment for restraint device use. *Frequency and length of time the restraint device is released. *Condition of the resident while restrained. *Care Plan documentation guidelines included a "Goal should lead to removal of restraints or use of less restrictive measures.	F 221		
F 222 SS=G	483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS The resident has the right to be free from any chemical restraints imposed for purposes of	F 222	F222G The resident has the right to be free from any chemical restraints	

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F 222	<p>Continued From page 6</p> <p>discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review, policy review, and interview, the provider failed to ensure an as needed (PRN) antipsychotic (mind-altering) medication (Haldol) had not been used for staff convenience and to chemically restrain two of seven sampled residents (10 and 14) with a PRN antipsychotic medication. Findings include:</p> <p>1. Review of resident 10's entire medical record revealed: *She had been admitted on 3/31/15. *She had diagnoses of: chronic airway obstruction (difficult breathing), depression, essential tremor (shaking of hands), urinary tract infection, cataract of the eye, anxiety, hypertension (high blood pressure), esophageal reflux (stomach acid returning to esophagus), and insomnia (trouble sleeping).</p> <p>Review of resident 10's 3/31/15 admission clinical health status assessment revealed she: *Was alert and her short and long-term memory were good. *Was independent with decision making. *Was able to make her self understood and understood others. *Had no indicators of depression, anxiety (nervousness), sad mood, or adjustment of new conditions. *Had no behavioral symptoms. *Had a risk for elopement (leaving the facility without staff knowing) assessment that had</p>	F 222	<p>Resident #10 and PRN psychoactive medications have been reviewed and PRN medications have been discontinued. Resident #14 has been discharged from the facility so no corrective action could be taken.</p> <p>Residents residing in the facility who receive PRN psychoactive medications have the potential to be affected in a similar manner. Residents who have an active order for PRN psychoactive medications have been reviewed and care plan has been reviewed and revised.</p> <p>Director of Nursing, Consultant Pharmacist and Medical Director have reviewed the Policy of Antipsychotic Medication Review.</p> <p>Nursing staff have been re-educated on the Golden Living Policy of Behavior Management guideline, behavior management techniques, targeted behaviors, non pharmacological interventions and the Golden Living Policy of Antipsychotic Medication Review.</p>	* 7/31/15 KG/SASH/ST

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F 222	<p>Continued From page 7</p> <p>indicated she was physically able to leave the building on her own and was a recent admission. Those answers had triggered a prevention plan of care for elopement should have been considered.</p> <p>*Smoked and a separate provider assessment had been completed on 3/31/15 indicateing she was able to smoke independently.</p> <p>Review of resident 10's 4/27/15 re-admission clinical health status assessment revealed she:</p> <p>*Was alert and her short-term memory was good. *Had a problem with her long-term memory. *Required assistance with decision making. *Was able to make her self understood and understood others. *Had no indicators of depression, anxiety, sad mood, or adjustment of new conditions. *Had no behavioral symptoms. *Had a risk for elopement assessment that had indicated she was physically able to leave the building on her own and was a recent admission. Those answers had triggered a prevention plan of care for elopement should have been considered. *Smoked and a separate provider assessment had been completed on 4/27/15 and was unclear on whether she was safe with smoking or not.</p> <p>Review of resident 10's interdisciplinary progress notes from 6/7/15 through 7/1/15 revealed:</p> <p>*On 6/7/15 at 6:45 a.m. "Resident is alert with confusion and able to make all needs know to staff using call light." *On 6/14/15 at 6:55 p.m. "Resident is alert and oriented with confusion at times." "Always ask staff to go out and smoke." *On 6/16/15 at 9:16 a.m. "Resident is alert and can be confused at times." "She requires</p>	F 222	<p>Director of Nursing or designee will complete audits weekly x 4 weeks then monthly x 2 months to ensure resident's are not receiving unnecessary PRN psychoactive medications. *Results will be reviewed at QAPI monthly meetings for further recommendations.</p> <p>of all PRN psychoactive medications used KG/SDDOH/JJ</p> <p>The DON will report the audit results to QAPI monthly. KG/SDDOH/JJ</p>	

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F 222	Continued From page 8 assistance to go out to smoke. She cannot pass the smoking assessment." *On 6/22/15 at 9:39 p.m. the following documentation revealed: -Situation: At about 1900, [7:00 p.m.] resident was reported to be in the middle of the facility parking lot and stating she was going to leave. Resident hit a parked car of another family member's and scratching it with her WC [wheelchair] and attempting to leave. -Background: History of UTI [urinary tract infection], altered mental status [not thinking clearly], dementia [decreased thought process]. -Assessment: Resident refused any and all cares and vital signs [blood pressure, pulse, and breathing per minute] but is noted to be confused and combative towards staff. Resident trying to stand and get out of chair while WC is being pushed by staff and grabbing staff's hands. -Response: Resident was assisted by staff back onto the sidewalk and back into facility. Resident's sister called as requested. Once sister arrive, resident was assisted down to her room. At 1955 [7:55 p.m.] on call MD [medical doctor] was paged. At 2030 [8:30 p.m.] MD paged again. At 2120, [9:20 p.m.] call from _____ [MDs name] received with orders noted." *On 6/23/15 at 2:54 a.m. "St. [straight] cath [catheterization (tube to drain urine) of urinary bladder] done as ordered. Resident tolerated well. Results pending." *On 6/23/15 at 1:38 p.m. "Received UA [urinalysis] [urine test results] and faxed to _____ [MDs name]." *On 6/23/15 at 8:25 p.m. a note by the social services (SS) worker revealed: "Earlier a mood assessment was completed with resident. She scored 5 for mild depression. She answered yes to thoughts that she would be better off dead and	F 222			

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F 222	<p>Continued From page 9</p> <p>that she has had thoughts in the past of hurting herself but not at the time. As SS was leaving for home this evening found resident in the street trying to leave. Brought her back to facility and she refused to come in. She continued to try to leave and 4 times almost tipped chair over going down the sloping drive and off the curb. She made comments that hurting her self would be ok and being better off dead. These comments were made a few times. She is refusing to come into facility. She states that her behavior is ok and disagrees that being in the road is a safety risk."</p> <p>*On 6/23/15 at 9:00 p.m. the following documentation revealed:</p> <p>-"Situation: At 1900, [7:00 p.m.] facility SS worker found resident in the street trying to leave facility. SS brought her back to facility and resident refused to come in. Resident continue to try and leave 4 times and almost tipped her w/c [wheelchair] over while going down the sloping driveway and off the curb.</p> <p>-Background: Hx [history] of altered mental status, UTI.</p> <p>-Assessment: Resident apparently disoriented and confused. Resident is not thinking clearly and cognitive [thinking; reasoning] status is severely altered. Resident refuses any care from any and all staff.</p> <p>-Response: Resident was brought back several times for safety purposes. One on one and at times two staff to 1 for safety and monitoring. PRN [as needed] medication administration attempted and refused. Call to her niece made. Niece arrived to assist in reassuring resident but resident continued to be agitated and attempt to elope. Call to MD at 2025 [8:25 p.m.] with order to send to _____ [name of hospital] for psych [psychiatric] eval [evaluation] via [by] ambulance. Ambulance on scene and here to transport</p>	F 222			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - BLACK HILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1620 NORTH 7TH STREET RAPID CITY, SD 57701		
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F 222	<p>Continued From page 10</p> <p>resident at 2035 [8:35 p.m.]. At 2040, [8:40 p.m.] report called to _____ [name of registered nurse at hospital]. Awaiting update at this time."</p> <p>*On 6/24/15 at 1:44 a.m. "At 2330, [11:30 p.m.] call received from _____ [name of hospital] ER [emergency room] that resident is being sent back to facility. Resident verbalized no intentions to harm self in ER and displayed no behaviors while in the ER. Resident returned at 0030, [12:30 a.m.] with new orders for antibiotics for present UTI as well as progress notes regarding medications administered while in the ER. Resident assisted to bed with no concerns noted at this time. Will continue to monitor."</p> <p>*On 6/24/15 at 6:43 p.m. "Received orders for Ativan [anti-anxiety medication] solution 2 mg [milligram] per ml [milliliter] injection et [and] for a wanderguard [personal alarm device] R/T [related to] recent attempts to leave."</p> <p>*On 6/24/15 at 9:30 p.m. Medication administration of 1 mg of Haldol (antipsychotic medication) intramuscularly (IM). "Resident is exit seeking and combative to staff."</p> <p>*On 6/24/15 at 10: 43 p.m. the following documentation revealed:</p> <p>-Situation: "Resident is repeatedly attempting to elope from facility. Has opened exit doors at least x [times] 3 starting at 1930 [7:30 p.m.] exiting x 2. Resident hitting at staff and grabbing door handles and side rails and attempting to stand when wheel chair is in motion.</p> <p>-Background: Present UTI-currently on antibiotics therapy. Eloping and combative behaviors noted previous two days.</p> <p>-Assessment: Resident is noted to be confused, combative, and danger to self at this time.</p> <p>-Response: Earlier this shift, order was received for IM Ativan. Pharmacy called for medication. Medication unavailable at this time and not in our</p>	F 222		

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F 222	Continued From page 11 medication dispensing unit. Pharmacy continued with communications with MD for alternative medication. New order received. During this time, resident was supervised 1 on 1 [one staff person for one resident] at nurse's station by staff to prevent elopement. PRN oral medication administration attempted without success. IM injection of Haldol given as ordered. Family was notified and came to facility to help facilitate ADLs [activities of daily living that includes dressing, toileting, eating and personal care] with success. Family appreciative towards staff. Will continue to monitor and assess." *On 6/25/15 at 4:58 p.m. "Haldol 2 mg IM given. Resident left building three times. On third time, resident became combative with staff, attempting to hit staff, swinging at CNA [certified nursing assistant], nurse, et management. Resident re-directed for brief time et [and] brought into the hallway, where she then pulled the fire-alarm." *On 6/25/15 at 5:19 p.m. "Resident left building three times, stating that she was 'leaving this damn place'. Resident was stopped by nurse et CNA and explained to her why she needs to stay here for her safety. Resident re-directed back into building. A different resident left the building to leave with her son et this resident attempted to leave with the other resident. Nursing was able to re-direct resident, but she became combative, swinging to hit staff et kicking at nurse. Resident brought back into building et re-directed for a short time. Resident went down the hallway et pulled the fire-alarm, after being asked not to by nurse. Nurse assigned CNA to do one-on-one with resident; PRN dose of IM Haldol given per MAR [medication administration record]." *On 6/26/15 at 8:44 p.m. a late entry "Resident was trying to get out of the facility, and telling everyone that she will pull the fire alarm. Resident	F 222		

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F 222	Continued From page 12 was stopped by nurse et CNA and explained to her why she needs to stay here for her safety. Nursing was able to re-direct but she's trying to hit staff. Given PRN dose of IM Haldol given per eMAR [electronic medication administration record]. She tries to kick staff while given the injection. After that she pours water on the laptop and still mad because she wants to go out." *On 6/28/15 at 8:19 p.m. "Haldol 2 mg IM given. Resident was trying to go out of the facility, and was very agitated." *On 6/28/15 at 9:49 p.m. "Resident was trying to get out the facility again at 2000, [8:00 p.m.] and she want [wanted] to go out and smoke. She was confused, she stated that she want to talk to the doctor on what's going on. Explained to the resident that she's living here and needs to stay here for her safety. Give PRN dose of IM Haldol given per eMAR. Resident is still agitated called her sister and they came to help calm her down. Resident sister help her to bed and finally goes to sleep." *On 6/30/15 at 9:09 p.m. "Haldol 2 mg IM given." *On 6/30/15 at 10:03 p.m. "Resident with increased agitation, admin [administered] one IM shot of Haldol and called family to come up to see res.[resident] Res. then called 911 and police officer showed up, explained situation to police without any issues. res is resting in bed at this time, family just left. will cont [continue] to monitor." *On 7/1/15 at 12:43 p.m. a note by the SS worker. "Faxed _____ [MD] regarding resident behaviors. Family member is concerned about the behavior and said they have a Dr appt [appointment] schedule with _____ [MD] on 7/10/15. Discussed that we have request bed on 2nd fl [floor] _____ [another facility] for her safety."	F 222			

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F 222	<p>Continued From page 13</p> <p>Review of a 7/1/15 facsimile note sent to resident 10's primary physician by the SS worker included: *"Resident begins behaviors around 2:30 - 3:30 [p.m]. *She is agitated not easily redirected, combative, verbally abusive. *Calls the police and pulls the fire alarm, dumped water on computer. *See notes and med [medication] list. *Please review and provide direction."</p> <p>Surveyor: 26180 Observation and interview on 7/2/15 at 10:00 a.m. with resident 10 revealed: *"Everything had gone pretty good here until recently. "She got mad a little while back and was upset, because her brother-in-law had died. So you know how that can stress you out?" *She used to be able to go outside and have a cigarette. Now she needed a supervisor with her if she wanted to go out and have a cigarette. That was new. *She just wanted to go out and talk with people the way she used to. *She was stressed and could not get a supervisor to go out with her. She got angry. "Talk about acting like a 10 year old. I was real angry." -So she went out and was in the parking lot, then when she had to come back in, she got so mad she pulled the fire alarm. *"That was when they stuck me. They gave me a shot and told me it was to make me sleep. I don't take meds [medications] that I don't know what they are for. -They did that to me four or five times. It didn't make me sleep. It made me angry. -They should put a picture of a dog on my door that says "Beware of Dog." That is how I feel.</p>	F 222		

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F 222	<p>Continued From page 14</p> <p>*She thought a couple of the nurses are bull dogs. They were the ones that gave her the shots. They said I was combative. I was not combative."</p> <p>*Now they wanted her to move to another facility "because I am combative."</p> <p>*She relayed that one certified nursing assistant (CNA) who was holding her when they gave her the shot, the resident used her long fingernails to get the CNA and pointed to her neck were she had "gotten" the CNA.</p> <p>*A new resident had come in on 7/1/15, and that resident also smoked. When the staff saw her warning this new resident about not being able to smoke they moved resident 10 to a different table away from the new resident.</p> <p>Surveyor: 26632 Review of a 5/4/15 psychosocial history and assessment for resident 10 by the social services (SS) worker revealed: *A history of depression and anxiety. *An active smoker and required supervision to smoke for safety as she had failed the smoking assessment. Due to her history of falls she required supervision. *Was alert and oriented to person, place, time, and self. She was limited regarding safety awareness. *Was able to make herself known and was able to understand others well. *"Was pretty upbeat and usually did not trigger for any mood indicators." *Would have rather lived on her own but understood she was not able to do that due to her medical limitations.</p> <p>Review of resident 10's physician's orders from 6/23/15 through 6/29/15 revealed:</p>	F 222		

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F 222	<p>Continued From page 15</p> <p>*A 6/23/15 1:40 p.m. order to await a culture from her urinalysis results.</p> <p>*A 6/24/15 1:00 a.m. order from the ER physician for Keflex 250 mg for her UTI.</p> <p>*A 6/24/15 untimed order for Ativan one mg for one time and for a Wanderguard due to her elopement risk.</p> <p>*A 6/24/15 at 12:08 p.m. order for Haldol 1 mg IM every six hours as needed for combativeness and anxiety related to UTI and anxiety.</p> <p>*A 6/24/15 at 9:15 p.m. order for Haldol one to two mg IM every six hours as needed.</p> <p>*A 6/29/15 untimed order for a urinalysis and to make an appointment with her primary physician.</p> <p>Review of resident 10's 5/6/15 alterations in ADLs related to a recent hospitalization included an intervention that had been initiated on 4/27/15. Those interventions included:</p> <p>***Resident will be safe when smoking and staff to assist with removing O2 [oxygen] prior to going outside to smoke. Resident will follow smoking policy and pass smoking assessment. She is to wear smoking apron."</p> <p>*Handwritten addendums (additions) on 6/22/15 were supervised smoking and cigarettes kept at nurses station/medication room.</p> <p>An immediate plan of care for the risk of elopement was initiated on 6/25/15. That plan included:</p> <p>*Problems of resident stated "I'm leaving" and active exit seeking.</p> <p>*Interventions included:</p> <ul style="list-style-type: none"> -Evaluate need for wandering management program. -Check resident every two hours and as needed. -Involve resident in activities of her liking. -Accutech bracelet (personal alarm). 	F 222		

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F 222	<p>Continued From page 16</p> <p>-Communicate with resident to determine reason for the behavior.</p> <p>-Involve the resident in decision making regarding daily choices.</p> <p>Surveyor: 26180</p> <p>2. Review of resident 14's 5/8/15 physician's orders revealed:</p> <p>*He was admitted on 5/8/15 and discharged on 6/18/15.</p> <p>*His diagnoses included:</p> <p>-A traumatic brain injury (TBI).</p> <p>-Mild cognitive impairment.</p> <p>*The following psychotropic (medications effecting mood and behavior) had been ordered:</p> <p>-Haldol (treatment for psychosis/severe mental disorder) inject 2 milligram (mg) intramuscularly (IM) PRN (as needed) every eight hours for severe agitation. Start date 5/10/15. There was no time limit on the use of that medication.</p> <p>-Risperidone (treatment for psychosis/severe mental disorder) tablet - 0.25 mg per PEG Tube (tube placed into the stomach for nutrition and medication) three times a day related to mild cognitive impairment. Start date 5/14/15.</p> <p>-Seroquel (for psychosis) tablet 25 mg per PEG tube every four hours as needed for severe agitation.</p> <p>-Trazodone (depression) HCL (hydrochloride) tablet 25 mg every six hours as needed for ABS (agitated behavior scale) greater than 27. Start date 5/8/15.</p> <p>-Trazodone HCL tablet 50 mg every 6 hours as needed for ABS greater than 27. Start date 5/8/15.</p> <p>Review of resident 14's 6/1/15 physician's orders revealed:</p> <p>*His diagnoses remained unchanged from 5/8/15.</p>	F 222			

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F 222	<p>Continued From page 17</p> <p>*The following psychotropic had been ordered: -Haldol inject 2 milligram (mg) intramuscularly every eight hours for severe agitation. Start date 5/10/15. -Risperidone - 0.25 mg by mouth three times a day related to mild cognitive impairment. Start date 5/14/15 -Seroquel tablet 25 mg by mouth every four hours as needed for severe agitation. -Trazodone HCL 25 mg every six hours as needed for ABS greater than 27. Start date 5/8/15. -Trazodone HCL 50 mg every six hours as needed for ABS greater than 27. Start date 5/8/15.</p> <p>Review of nurses progress notes and the Medication Administration Records for May and June 2015 revealed: *He received the Haldol 2 mg IM 5/20/15 for severe agitation. *He received the Seroquel 25 mg on 6/10/15 for severe agitation. *The nurses had documented he had: -Attempted to leave the building. -Fallen. -Attempted to stand up and required assistance. -Become agitated. -A Wanderguard on. -A fall mat by his bed (to prevent injury if he fell).</p> <p>Review of resident 14's 5/18/15 care plan revealed there were no resident specific interventions to reduce agitation other than medications.</p> <p>Review of resident 14's behavior log revealed: *From 5/8/15 through 6/18/15 he exhibited behaviors thirteen times.</p>	F 222		
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F 222	<p>Continued From page 18</p> <p>*Those behaviors included: -Rejecting care four times. -Wandering four times, -Verbal behavior twice. -Physical behavior twice. -Other behavior once. *On 5/20/15 he exhibited verbal behavior one time. *On 6/10/15 he wandered one time.</p> <p>Interview on 7/2/15 at 10:40 a.m. with the director of nurses regarding resident 14 revealed: *He was very confused and restless. *He was assigned a one-on-one staffing ratio to monitor him when he first came in, because he was constantly trying to leave the building and was a fall risk. *The ABS scale was a scale the TBI unit used that he came from. -They did not have a copy of that scale and had not used it. -The nurses should have addressed that when they got the order for using a medication based on an assessment (scale) they did not have. *She agreed the diagnoses of mild cognitive impairment and severe agitation were not appropriate indicators for the use of an antipsychotic. -Those were diagnoses he was admitted with. *She acknowledged the behavior documentation had not reflected the extent of his behaviors. *She confirmed the nurses should have addressed those diagnoses with the admitting physician.</p> <p>Review of the provider's 1/29/14 antipsychotic medication review policy revealed: *The Procedure was to "Ensure that the Medical Record of any Resident who receives</p>	F 222		
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F 222	<p>Continued From page 19</p> <p>antipsychotic medication contains documentation supporting the appropriateness and necessity for the use of the drug.</p> <p>*Antipsychotics are a class of psychiatric medication primarily used to manage psychosis (including delusions, hallucinations, or disordered thought) particularly in schizophrenia and bipolar disorder, and is increasingly being used in the management of non-psychotic disorders."</p> <p>*The Assessment of Psychotropic medications was a part of the policy.</p> <p>Review of the provider's 2/12/15 Behavior Management Guideline policy revealed:</p> <p>*The use of any medication to control behaviors should always have been considered a last resort to assist with managing a patient's/resident's behavior.</p> <p>*Antipsychotic drugs would not be used unless the clinical record documented the patient/resident has one or more of the following specific conditions as dictated and documented by the physician:</p> <p>*A. Conditions other than Dementia included a list of twelve diagnoses and had not included:</p> <ul style="list-style-type: none"> -Mild cognitive impairment. -Severe agitation. <p>*Criteria: "All of the above highlight conditions/diagnosis where antipsychotic medications may possible be appropriate, but diagnosis alone do not warrant the use of an antipsychotic unless the following criteria are also met:</p> <ul style="list-style-type: none"> -The behavioral symptoms present a danger to the patient/resident or others AND one or both of the following: -The symptoms are identified as being due to mania (hyperactive thinking) or psychosis (such as auditory, visual or other hallucinations; 	F 222		

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F 222	Continued From page 20 delusions, paranoia, or grandiosity); OR -Behavioral interventions have been attempted and included in the plan of care, except in an emergency."	F 222		
F 226 SS=D	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: 26632 Based on record review, interview, and policy review, the provider failed to thoroughly investigate one of one sampled resident (10) who had eloped (left the facility without staff knowledge) and one of one sampled resident (2) who had an incident involving missing property. Those incidents had also not been reported to the South Dakota Department of Health (SD DOH). Findings include: 1. Review of resident 10's interdisciplinary progress notes from 6/22/15 through 6/23/15 revealed: *On 6/22/15 at 9:39 p.m. the following documentation revealed: -"Situation: At about 1900, [7:00 p.m.] resident was reported to be in the middle of the facility parking lot and stating she was going to leave. Resident hit a parked car of another family member's and scratching it with her WC [wheelchair] and attempting to leave.	F 226	F226D Develop/Implement abuse neglect policies <i>* (see page 22 of 90) KG/SDOH/JJ</i> <i>first asterisk</i> Unable to correct past investigation for resident #10 and #2 Resident's residing in the facility have the potential to be affected in a similar manner. Staff has been re-educated to the abuse and neglect policy including the investigative and reporting protocols. ED and/or DNS will contact Field Service Clinical Director and/or Area Vice President to advise of any potential abuse/neglect allegations and send reports for further guidance. Field Service Clinical Director and/or Area Vice President will review abuse/neglect allegations and provide guidance for development of process improvement plan if indicated at the monthly QAPI meetings x 3 months.	<i>* 7/31/15</i> <i>KG/SDOH/JJ</i>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/02/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - BLACK HILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1620 NORTH 7TH STREET RAPID CITY, SD 57701		
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F 226	<p>Continued From page 21</p> <p>-Background: History of UTI [urinary tract infection], altered mental status [not thinking clearly], dementia [decreased thought process].</p> <p>-Assessment: Resident refused any and all cares and vital signs [blood pressure, pulse, and breathing per minute] but is noted to be confused and combative towards staff. Resident trying to stand and get out of chair while WC is being pushed by staff and grabbing staff's hands.</p> <p>-Response: Resident was assisted by staff back onto the sidewalk and back into facility. Resident's sister called as requested. Once sister arrive, resident was assisted down to her room. At 1955 [7:55 p.m.] on call MD [medical doctor] was paged. At 2030 [8:30 p.m.] MD paged again. At 2120, [9:20 p.m.] call from _____ [MDs name] received with orders noted."</p> <p>*On 6/23/15 at 8:25 p.m. a note by the social services (SS) worker revealed: "Earlier a mood assessment was completed with resident. She scored 5 for mild depression. She answered yes to thoughts that she would be better off dead and that she has had thoughts in the past of hurting herself but not at the time. As SS was leaving for home this evening found resident in the street trying to leave. Brought her back to facility and she refused to come in. She continued to try to leave and 4 times almost tipped chair over going down the sloping drive and off the curb. She made comments that hurting her self would be ok and being better off dead. These comments were made a few times. She is refusing to come into facility. She states that her behavior is ok and disagrees that being in the road is a safety risk."</p> <p>*On 6/23/15 at 9:00 p.m. the following documentation revealed:</p> <p>-"Situation: At 1900, [7:00 p.m.] facility SS worker found resident in the street trying to leave facility. SS brought her back to facility and resident</p>	F 226	<p>* Resident 10 now has a bracelet in place to sound the alarm if she exits unattended. Her care plan was reviewed and revised for interventions when she is exit seeking or requests to be outside.</p> <p>Resident 2's care plan was revised to alert staff to check the residents pockets before sending clothing to laundry and to also alert the charge nurse if money is found in his room.</p> <p>KG/SODH/JJ</p> <p>* The Social Service Designee will audit weekly X4 weeks then monthly X2 months to ensure all reports of elopements and missing property are reported and investigated properly. The Social Service Designee will report the results of these audits to QAPI monthly for further recommendations.</p> <p>KG/SODH/JJ</p>	

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F 226	<p>Continued From page 22</p> <p>refused to come in. Resident continue to try and leave 4 times and almost tipped her w/c [wheelchair] over while going down the sloping driveway and off the curb.</p> <p>-Background: Hx [history] of altered mental status, UTI.</p> <p>-Assessment: Resident apparently disoriented and confused. Resident is not thinking clearly and cognitive [thinking; reasoning] status is severely altered. Resident refuses any care from any and all staff.</p> <p>-Response: Resident was brought back several times for safety purposes. One on one and at times two staff to 1 for safety and monitoring. PRN [as needed] medication administration attempted and refused. Call to her niece made. Niece arrived to assist in reassuring resident but resident continued to be agitated and attempt to elope. Call to MD at 2025 [8:25 p.m.] with order to send to _____ [name of hospital] for psych [psychiatric] eval [evaluation] via [by] ambulance. Ambulance on scene and here to transport resident at 2035 [8:35 p.m.]. At 2040, [8:40 p.m.] report called to _____ [name of registered nurse at hospital]. Awaiting update at this time."</p> <p>Interview on 7/1/15 at 10:30 p.m. with the administrator revealed the above elopements for resident 10 had not been reported to the SD DOH. He stated since resident 10 had not left the facility property it was not considered an elopement.</p> <p>Review of the provider's undated Elopement Guideline policy revealed: *Elopement was defined as a situation where a resident with impaired decision-making ability had left the facility without staff knowledge. *The executive director (administrator) would</p>	F 226		

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F 226	<p>Continued From page 23 notify the state agency as necessary by state requirement.</p> <p>Surveyor: 32355 Interview on 7/1/15 at 5:30 p.m. with the social services designee regarding resident 10 revealed: *She had been aware of the resident's two elopements from the facility on 6/23/15 and 6/24/15. *She was aware no incident reports had been completed on both of those elopements. *She could not give a reason why there were no incident reports completed. *She stated "I reported them to my supervisor." *She confirmed her supervisor had been the administrator.</p> <p>Surveyor: 26180 2. Review of resident 2's 11/17/14 progress notes revealed: "Residents daughter brought in resident's wallet. Said charge nurse called her last evening at resident's request to let her know the wallet was found. She wanted us to know it appeared to have gone through the laundry. Told her the last time it was lost it had gone through laundry. Resident's daughter said the wallet was lost last week, and the resident told her there was about thirty dollars in it. Today she told the business office there was one-hundred-fifty dollars in the wallet. She opened an account with the business office today, as staff had continued to tell her residents were discouraged from having more than five dollars on them."</p> <p>Interview on 7/1/15 at 11:50 a.m. with resident 2's daughter revealed:</p>	F 226			

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F 226	<p>Continued From page 24</p> <ul style="list-style-type: none"> *He had recently misplaced his wallet. *The wallet had been found by the staff, and all the cards were still in it. -It looked like it had gone through the laundry. -There was no money in the wallet when it was found. *She thought there had been about one-hundred-thirty dollars in it. *The staff had been made aware of the missing money, but nothing more had been done about it. *they had started an account that he could keep money in and have access to it. *He also got travel money from the Veteran's Administration when he went to see his doctor, but she let him keep that money. -She did not know what he did with the travel money or how much he got when he received it. <p>Interview on 7/1/15 at 2:00 p.m. and review of the provider's Verification of Investigation (VOI) report the executive director (ED) regarding resident 2's missing money revealed:</p> <ul style="list-style-type: none"> *The VOI: <ul style="list-style-type: none"> -Was undated and "approx [approximately] Mid November" was written in the Date/Time of occurrence box on the form. -The detailed description of event/allegation read: "Resident family member reports missing money, varying amounts, after wallet went through laundry services. Resident states he lost \$150." -It had not identified who had reported the money missing. -There was not an investigation completed or documented. *The ED: <ul style="list-style-type: none"> -Had spoken to the resident's daughter about the missing wallet and money. -Could not say the name of the person (daughter) he had spoken to, but knew what she looked like. 	F 226		
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F 226	<p>Continued From page 25</p> <ul style="list-style-type: none"> -He was unsure if it was the resident's daughter or the daughter-in-law -Reported the daughter's store kept changing about how much money was in the wallet. -He did not think the report was valid, because the amount of money kept changing, so he did not report it to the state agency (South Dakota Department of Health) (SD DOH). -He understood reports of missing money would have been reported to law enforcement and the SD DOH. -He again confirmed he did not report it to the SD DOH because the amount of money that had been reported missing, kept changing. -Confirmed the VOI had not been completed at the time of the incident. It had just been completed when this surveyor requested it. <p>3. Review of the provider's 1/15/15 Reporting Alleged Abuse Violation policy revealed:</p> <ul style="list-style-type: none"> ***The ED or DNS [director of nursing services] conducts all investigation, in the event an alleged violation occurs when neither of these people are in the center, the charge nurse is responsible for initiating the investigation procedure. *The investigation includes interviews, of employees, visitors or residents who may have knowledge of the alleged incident. Only factual information is documented - not assumptions or speculation. *Federal law requires the center to have evidence of investigations of alleged violations. *The attached VOI form is completed after the investigation is complete and provided to survey agencies when requested or required by state or federal law. *Any employee who suspects an alleged violation immediately notified the ED or designee. The ED notifies the appropriate state agency in 	F 226		

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F 226	Continued From page 26 accordance with state law and the regional vice president."	F 226		
F 278 SS=D	Surveyor: 32355 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	F278D Accuracy of Assessment Resident #1 and 15 MDS has been reviewed and revised. Residents residing in the facility who have skin concerns have the potential to be affected in a similar manner. The Clinical Assessment Reimbursement Specialist will complete a coding audit of residents currently residing in the facility with skin concerns to ensure accurate coding MDS Coordinator has been reeducated on the RAI coding guidelines for section M of the MDS Clinical Assessment Reimbursement Specialist or designee will complete 5 audits weekly x 4 weeks then monthly x <u>2 months to ensure section M of the MDS is coded accurately</u> . This will be completed in conjunction with the MDS schedule. Results will be reviewed at QAPI monthly meetings for further recommendations.	<i>*7/31/15</i> <i>KG/SAAH/JJ</i>

and report results to QAPI monthly.
KG/SAAH/JJ

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F 278	Continued From page 27 This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on interview, record review, and policy review, the provider failed to ensure the Minimum Data Set (MDS) assessments had been completed accurately for 1 of 15 sampled residents (8). Findings include: 1. Review of resident 8's 6/23/15 MDS assessment revealed: *He had one stage 2 pressure ulcer (open area with skin missing). *It had slough (dead off colored skin) present in the wound bed. Review of the resident's progress notes from 4/13/15 through 6/30/15 revealed he had slough present in the wound bed. Review of the provider's 2007 Pressure Ulcer Staging Guide revealed that the resident's pressure ulcer had been unstageable when slough had been present.	F 278	The Director of Nursing, Medical Director and Interdisciplinary team have reviewed the Golden Living Skin Integrity policy. MDS Coordinator and Interdisciplinary team has been reeducated on the RAI care plan guidelines. Nursing staff has been reeducated on following individualized care plans for residents. Director of Nursing or designee will complete 5 audits weekly x 4 weeks then monthly x 2 months to ensure care plans are accurately reflective of residents needs. This will be completed in conjunction with the MDS schedule. Results will be reviewed at QAPI monthly meetings for further recommendations.		
F 280 SS=F	Refer to F314, finding 1. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the	F 280	F 280 F Right to participate in Care plans/revise care plans Resident # 1, 2, 3, 4, 5, 8, 10 and 11 have had care plans reviewed and revised to reflect current needs. Resident #9 has been discharged.		

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F 280	<p>Continued From page 28</p> <p>comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, record review, interview, professional standard, job description, and professional standard review, the provider failed to ensure 9 of 13 sampled residents (1, 2, 3, 4, 5, 8, 9, 10, and 11) care plans had been reviewed and revised as resident care needs had changed. Findings include:</p> <p>1. Random observation of resident 2 from 6/29/15 in the afternoon through 7/2/15 in the morning revealed: *He came out to the dining room for most meals. *After meals he returned to his room and laid down on his bed. *He remained in bed most of the day and was quiet. *He enjoyed talking about being in the military. *He did not visit with other residents in the dining room. *His clothes oftentimes were soiled with food spills. *His room at times had a urine odor.</p>	F 280	<p>Residents residing in the facility have the potential to be affected in a similar manner. Care plans will be reviewed and revised in conjunction with next MDS to ensure current resident needs are reflected on the care plan</p> <p>The Dietary Manager, Registered Dietician, Director of Nursing and Interdisciplinary team have reviewed the Golden Living Weight Monitoring and Nutrition Risk Meeting policy.</p> <p>*Director of Nursing or designee will complete 5 audits of resident care plans weekly X4 weeks then monthly X2 months to ensure care plans are accurately reflective of residents needs. The DON will report the results of the audits to QAPI monthly. This will be completed in conjunction with the MDS schedule. Results will be reviewed at QAPI monthly meetings for further recommendations. KG/SOOH/JJ</p>	* 7/31/15 KG/SOOH/JJ	

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F 280	<p>Continued From page 29</p> <p>Interview on 6/1/15 at 11:50 a.m. with resident 2's daughter revealed he: *He liked his ethnic food as that was part of his culture and background *He needed more help with grooming and making sure he got to the toilet. -She had told the staff he might be more cooperative with bathing if he had a male caregiver. *His room sometimes had a urine odor in it. *He had recently been to the dentist and needed to have a lot of dental work done. -She was going to take him to those appointments. *He had always been very difficult to talk to; a very quiet man. -Liked to talk about his time in the military and being on a ship.</p> <p>Review of resident 2's weight record revealed: *On 3/5/15 he weighed 157.5 pounds (lb). *On 4/2/15 he weighed 140.5 lb. -That was a 17 lb or 10.7% weight loss in one month.</p> <p>Review of resident 2's June 2015 blood sugar (BS) record revealed: *His BS was below 100 three times. *His BS was between 101-199 thirty-one times. *His BS was between 200-299 forty-one times. *His BS was between 300-399 thirty-four times. *His BS was over 400 six times. *Normal levels from that were 70 to 100.</p> <p>Interview on 6/30/15 at 11:20 a.m. with the dietary services manager (DSM) revealed: *He had a significant weight loss. *They had reviewed him at their monthly weight</p>	F 280			

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F 280	<p>Continued From page 30 meeting for a month.</p> <ul style="list-style-type: none"> -His weight had stabilized now. *They encouraged his family to bring ethnic food for him because he liked that kind of food. *He came out to the dining room very early in the morning and always ate two packets of peanut butter and a cup of hot chocolate. -He then returned to his room. -It was sometimes difficult to get him to come back out. *When he selected his own meals he circled everything on the menu. -When the food came he had four or five glasses of juice and milk plus all the food. -He would not eat very much of any of it. -Their plan was to assist him in ordering a more reasonable meal, so he might eat more. *They had also started him on a daily nutritional supplement drink. <p>Telephone interview with the registered dietitian on 6/30/15 at 4:30 p.m. revealed he confirmed the above interview with the DSM.</p> <p>Review of the nutrition care team meeting minutes revealed resident 2's weekly meal intake from 4/20/15 through 5/12/15 was 40% or less.</p> <p>Interview on 6/30/15 at 2:00 p.m. with certified nursing assistant G regarding resident 2 revealed he:</p> <ul style="list-style-type: none"> *Got up at 5:30 a.m. every day and went to the bathroom *Always wore one piece jumpsuits and he had about twenty of them. *Frequently missed the toilet when he went to the bathroom. *Refused to sit down when he went to the toilet, because he did not want to remove the jumpsuit. 	F 280		

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F 280	<p>Continued From page 31</p> <ul style="list-style-type: none"> *If he used the urinal he sometimes spilled it. -That contributed to the urine odor in his room and his falls. *Wanted to be very independent and would not let staff help him. *Loved peanut butter and hot chocolate, and his ethnic food. *Lost his wallet a lot. <p>Review of resident 2's 5/18/15 care plan revealed:</p> <ul style="list-style-type: none"> *It had not addressed: -His significant weight loss. -How they ensured a staff person sat with him to select his meals. -The nutritional supplement. -How the provider accommodated his preference for food. -How they assisted him with using the urinal without spilling it. -How they assisted him with toileting. -His high BS. -The preference for a male caregiver. -Any dental concerns. <p>Surveyor: 26632</p> <p>2. Review of the physician's ordered outpatient wound care therapy orders regarding resident 1 revealed:</p> <ul style="list-style-type: none"> *On 3/3/15 "Bedrest with no backlying. Pt. [patient] to reposition from side to side in bed Q [every] 1 hr [hour] offloading {taking pressure off} all bony prominences, meals in bed with HOB [head of bed] elevated. HOB to be lowered after meals are finished with placing pt. back on side." *On 5/20/15 "Geomatt {special chair cushion} chair cushion provided 4/22 [4/22/15]. Pt to be 	F 280		

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F 280	<p>Continued From page 32</p> <p>laying on her L [left] side with R [right] leg positioned over L; lift R buttock [bottom] for wound visualization/consistency with measurements. Pt. to use Geomatt chair cushion when sitting in w/c [wheelchair] to attend appts [appointments]."</p> <p>*On 5/27/15 "Reposition from side to side every 1-2 hours, NO LAYING ON BACK. Recommend use of elbow protectors bilaterally to maintain skin integrity {no open areas}."</p> <p>*On 6/4/15 the wound vac [vacuum; device for draining a wound] was ordered to be held and wet-to-dry dressings applied daily.</p> <p>Review of resident 1's revised 6/2/15 care plan revealed the following interventions implemented: *3/6/15, She was only to have been positioned on her back for meals then onto her left side. Turn every one and one-half to two hours to her sides only. *3/19/15, Wound vac applied with changes on Monday, Wednesday, and Friday. *4/1/15, Meals in bed with head of bed raised and staff assistance. *Those interventions were related to her stage IV (four) (full thickness tissue loss exposing bone, tendon, or muscle) sacrum (tailbone area) pressure ulcer.</p> <p>3. Review of resident 9's medical record revealed an undated chemotherapy list for safety precautions during and after chemotherapy.. Resident 9 was currently receiving intravenous (through a vein)chemotherapy (cancer medication) daily. She received the chemotherapy through an implanted port (access to a large vein) to her left upper chest.</p> <p>Review of resident 9's 5/20/15 care plan revealed</p>	F 280		

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F 280	<p>Continued From page 33</p> <p>no focus, goals, or interventions related to her chemotherapy, chemotherapy precautions, or the implanted port.</p> <p>4. Review of resident 10's 5/6/15 care plan revealed: *A focus area that she wished to smoke, a goal she would follow the smoking policy, and interventions she would have been safe to smoke. *An undated handwritten addendum to the interventions of "supervised smoking." *A 6/22/15 handwritten addendum "Cigarettes kept @ [at] nurses station/med [medication] room."</p> <p>Review of a 5/4/15 psychosocial history and assessment for resident 10 by the social services designee worker included: *An active smoker and required supervision to smoke for safety as she had failed the smoking assessment. *Due to her history of falls she was deemed (decided) to require supervision.</p> <p>Interview on 7/2/15 at 8:00 a.m. with the registered nurse/Minimum Data Set (MDS) assessment coordinator revealed: *She was aware she had not kept all residents' care plans updated to their current status. *She did not have enough time to keep them all updated and keep up with all of the MDS assessments that were due.</p> <p>Surveyor: 28057</p> <p>5. Review of resident 8's care plan in use until 6/30/15 and his revised 6/30/15 care plan revealed:</p>	F 280			

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F 280	<p>Continued From page 34</p> <p>*It failed to adequately address his pressure ulcers to prevent further breakdown and worsening of the pressure ulcer on his ischium (bottom). *It had failed to prevent breakdown to his heels. *Staff had not followed the care plan adequately to ensure breakdown had not occurred or worsened in those areas. Refer to F314, finding 1.</p> <p>Surveyor: 32355 6. Review of resident 3's medical record revealed: *An admission date of 10/31/14. *Diagnoses of total right knee replacement with a history of infection, congestive heart failure (poor heart functioning), pain, dementia (forgetfulness), anxiety (anxiousness), and depression (sadness). *Upon admission he had required extensive to limited assistance of one staff member with transfers, dressing, personal hygiene, eating, and toileting. *He had been at risk for falls.</p> <p>Review of resident 3's 5/13/15 quarterly Minimum Data Set (MDS) assessment revealed: *He had improved and was currently independent with transfers, personal hygiene, eating, and toileting. *He remained at risk for falls.</p> <p>Random observations from 6/29/15 through 7/1/15 of resident 3 revealed: *He had: -Been eating independently after set-up. -Transferred independently from his bed to his</p>	F 280		
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F 280	<p>Continued From page 35</p> <p>wheelchair (w/c) multiple times.</p> <ul style="list-style-type: none"> -Toileted himself without staff assistance. -Dressed himself without staff assistance. -A scoop mattress on his bed to help prevent falls. <p>*His bed had never been lowered to the floor when he was resting in bed.</p> <p>Interview on 6/30/15 at 2:45 p.m. with resident 3 revealed:</p> <ul style="list-style-type: none"> *He had rarely asked the staff to assist him with any activities of daily (ADL) tasks. *He had used the scoop mattress since admission to the facility. *He could not recall his bed being lowered to the floor while he had been resting in it. <p>Review of resident 3's undated MDS Kardex report revealed:</p> <ul style="list-style-type: none"> *It had failed to identify: <ul style="list-style-type: none"> -The amount of staff support he required to successfully complete his ADL tasks. -The interventions put in place to prevent falls. <p>Review of resident 3's undated care sheet revealed:</p> <ul style="list-style-type: none"> *He had required one staff member to assist him with transfers. *For safety: <ul style="list-style-type: none"> -His bed was to have been lowered to the floor. -Failed to identify the use of a scoop mattress. <p>Review of resident 3's revised care plan of 5/19/15 revealed:</p> <ul style="list-style-type: none"> *It had failed to identify his independence with transfers, personal hygiene, eating, and toileting. *Failed to adequately support: <ul style="list-style-type: none"> -The use of a scoop mattress for a fall prevention measure. 	F 280			

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F 280	<p>Continued From page 36</p> <p>-His bed was to have been lowered to the floor when he was resting in it.</p> <p>7. Review of resident 4's medical record revealed:</p> <ul style="list-style-type: none"> *An admission date of 12/7/11. *Diagnoses of Type II diabetes (uncontrollable blood sugar levels), pain, depression, and diabetic ulcers (wounds) to her legs due to poor circulation (blood supply). *Currently had three diabetic ulcers with one on her right calf, one on left great toe, and one on the left heel. *She had been on comfort measures and under the support of hospice care since 3/4/15. *The diabetic ulcer on her left heel had tested positive for methicillin resistant staphylococcus aureus (MRSA) (bacterial infection that is resistant to many antibiotics and highly contagious (easily spread to others) in February 2015. *She had required staff support with transfers, dressing, personal hygiene, and toileting. *She had been at risk for: <ul style="list-style-type: none"> -Skin breakdown and required the use of prevalon boots (type of pressure relieving) for her legs and feet. -Falls. <p>Random observations from 6/29/15 through 7/2/15 of resident 4 revealed:</p> <ul style="list-style-type: none"> *She had a scoop mattress on her bed. *The bed had not been in the low position when she was resting in it. *She had worn the prevalon boots at all times. *No identifiable precautionary directions for the MRSA infection had been posted on her door or in her room for visitors or staff to follow. 	F 280		
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F 280	<p>Continued From page 37</p> <p>Review of resident 4's undated MDS Kardex report revealed:</p> <ul style="list-style-type: none"> *She had skin and ulcer treatments with a "dressing to her feet." *It had failed to identify: <ul style="list-style-type: none"> -How many diabetic ulcers she had and the locations. -Her comfort measures with hospice support and interventions. -The MRSA infection to her left heel and any precautionary interventions that should have been used by the staff when assisting her with dressing changes and ADLs. -Her risk for skin breakdown and the use of the prevalon boots. -The use of a scoop mattress for a preventative fall intervention. <p>Review of resident 4's undated resident care sheet revealed:</p> <ul style="list-style-type: none"> *For safety measures and fall interventions her bed was to have been in the low position. *She was not to have worn the prevalon boots while she was resting in bed. *It had failed to identify: <ul style="list-style-type: none"> -The diabetic ulcers to her left foot and right calf. -The MRSA infection to her left heel and any precautionary interventions that should have been used by the staff assisting her. -Her comfort measures with hospice support and interventions for staff to follow. -The use of a scoop mattress as a preventative fall intervention. <p>Review of the provider's 6/29/15 daily stand-up information revealed it had not identified resident 4's MRSA infection to her left heel. And it did not identify any precautionary interventions that should have been followed by the staff.</p>	F 280		

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F 280	<p>Continued From page 38</p> <p>Review of resident 4's revised 6/16/15 care plan revealed: *Failed to adequately support: -The use of a scoop mattress for a fall prevention measure. -That her bed was to have been lowered to the floor when she was resting in it or not. *Failed to identify: -The diabetic ulcers to her left great toe and the right calf. -The MRSA infection in her left heel until 6/23/15. No precautionary interventions had been in place for the staff to follow when assisting her with ADLs or dressing changes. *She was to have worn her prevalon boots at all times. That had been a conflict from the directions provided on the resident care sheet.</p> <p>8. Review of resident 5's medical record revealed: *An admission date of 2/18/13. *Diagnoses of dementia (forgetfulness), seizures (uncontrollable body movements), depression, congestive heart failure (poor heart function), and Type II diabetes. *She had recently been hospitalized on 6/4/15 for fluid overload (retaining of fluid in the body). *When she had returned from the hospital on 6/5/15 she had been placed on a 1200 cubic centimeter (cc; type of measurement) fluid restriction per day.</p> <p>Random observations from 6/29/15 through 7/1/15 of resident 5 revealed: *She had been provided with three 6 ounce (oz) glasses of fluids to drink at all meals. *She had an 8 oz glass of fluid in her room to drink at all times.</p>	F 280		

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F 280	<p>Continued From page 39</p> <p>Interview on 6/30/15 at 3:45 p.m. with the dietary manager regarding resident 5 revealed: *She had confirmed the resident had been on a 1200 cc fluid restriction per day. *She should have had one 8 oz glass of fluid for all meals. *They would have given her more than 8 oz of fluid with a meal if she had requested more. *When residents were on a fluid restriction she would have provided the staff with the amount they were to have at meals only. *The nursing staff were to have determined and recorded the amount of fluids the resident should have in their rooms and with medication administration. *She would not have monitored the daily intake of fluids for any resident on a fluid restriction.</p> <p>Review of resident 5's undated MDS Kardex report revealed: *Under fluid management it had failed to identify: -That she had a fluid restriction of 1200 cc per day. -The breakdown on the amount of fluids she was to have received for meals, in her room, and during medication administration.</p> <p>Review of resident 5's undated resident care sheet revealed: *Under nutritional needs it had failed to identify: -That she had a fluid restriction of 1200 cc per day. -The breakdown on the amount of fluids she was to have received for meals, in her room, and during medication administration.</p> <p>Review of the provider's 6/29/15 daily stand-up information regarding resident 5 revealed:</p>	F 280		

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F 280	<p>Continued From page 40</p> <p>*She had a fluid restriction of 1200 cc per day. *The fluid restriction had failed to identify the breakdown on the amount of fluids she was to have received for meals, in her room, and during medication administration.</p> <p>Review of resident 5's revised care plan of 6/5/15 revealed: *She had a fluid restriction of 1200 cc per day. *It had not identified the amount of fluids she was to have received for meals, in her room, and during medication administration.</p> <p>Interview on 6/30/15 at 4:00 p.m. with the DON revealed: *She had confirmed resident 5 had been on a fluid 1200 cc fluid restriction per day. *The nursing staff would have informed the dietary department when a resident had physician's orders for a fluid restriction. *The nursing staff would have followed the fluid breakdown for meals and medication pass provided by the dietary department. *There should not have been any fluids provided in the resident's room when on a fluid restriction. *Each nursing staff member was to have recorded the amount of fluids she had consumed during their shift. *She had not been aware the fluid restriction breakdown for resident 5 during meals, in her room, and medication pass had not been provided for the staff to follow. *All of the documents reviewed above should have provided the necessary daily fluid breakdown for all of the residents on a fluid restriction.</p> <p>Review of the provider's undated Fluid Restriction policy revealed:</p>	F 280		

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F 280	<p>Continued From page 41</p> <p>*"All fluid restrictions are ordered by the physician."</p> <p>*"Responsibility for fluid allotment is divided between the dining services and nursing departments."</p> <p>*There was an example for specific breakdown and designation: -"Physician's order." -"Nursing medication pass." -"Breakfast." -"Lunch." -"Supper."</p> <p>*Documentation "Total cc designations, as ordered by the physician and amount supplied by the dining services department, should be clearly documented on the patient's tray card, and the dining services progress notes in the patient's chart, as well as in the interdisciplinary care plan."</p> <p>9. Review of resident 11's medical record revealed: *An admission date of 10/22/14. *Diagnoses of Type II diabetes, chronic kidney disease with dialysis (removal of wastes in the blood and the extra fluid retained by the body) three times a week, and depression. *She had been placed on a 1800 cc fluid restriction per day.</p> <p>Random observations on 7/1/15 and 7/2/15 of resident 11 revealed: *She had been in her room. *On her bedside table there had been a mug of water. The mug had marks on it indicating there was approximately 400 cc of fluids in the mug.</p> <p>Interview on 7/1/15 at 3:15 p.m. with resident 11 revealed: *She had been aware of her 1800 cc fluid</p>	F 280		

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F 280	<p>Continued From page 42 restriction. *She would have received two mugs of water everyday.</p> <p>Observation and interview on 7/1/15 at 3:20 p.m. with certified nursing assistant (CNA) I revealed: *She had been: -Passing fresh water to all of the residents' rooms. -Able to identify that residents 5 and 11 had been on a fluid restriction. -Unsure how much fluid the two residents should have received in their room. *The CNAs had documented the residents' fluid intake for meals. *She was unsure who documented the amount of fluid the residents would have consumed in their rooms.</p> <p>*Review of resident 11's undated resident care sheet revealed: *Under nutritional needs it had failed to identify: -That she had a fluid restriction of 1800 cc per day. -The breakdown on the amount of fluids she was to have received for meals, in her room, and during medication administration.</p> <p>Review of the provider's 6/29/15 daily stand-up information revealed: *She had a fluid restriction of 1800 cc per day. *The fluid restriction had failed to identify the breakdown on the amount of fluids she was to have received for meals, in her room, and during medication administration.</p> <p>Review of resident 11's 5/6/15 revised care plan revealed: *The staff were to have followed her diet and fluid</p>	F 280		
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F 280	<p>Continued From page 43 restrictions as ordered.</p> <p>*It had not identified:</p> <ul style="list-style-type: none"> -The total amount of fluids she was to have received per day. -The amount and breakdown of fluids she was to have received for meals, in her room, and during medication administration. <p>10. Interview on 6/30/15 at 5:10 p.m. with the MDS coordinator and the infection control nurse revealed:</p> <ul style="list-style-type: none"> *They confirmed there had been several sheets and forms for the staff to review, use, and guide them when taking care of the residents. *The MDS Kardex would have been filled out upon admission of the resident. It would not have been updated thereafter. The staff were to have used it for a quick reference guide. *The care sheets were used by the staff daily to guide them with the care they provided for the residents. Their goal was to update them every two weeks, but that had not always occurred. There had not been any specific staff assigned for the updating of those sheets. *The daily stand-up form was used by the staff. *All of the staff had been responsible for the updating and revising of the care plans. There had not been a person assigned to oversee that process. They had been reviewed and revised every quarter and as needed with the resident's care conference. *They had agreed: <ul style="list-style-type: none"> -Not all of the above information reviewed for the above residents had been revised and updated appropriately and accurately. -Their process for providing information to the staff on the necessary care for all the residents should be re-assessed. 	F 280			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/02/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - BLACK HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 1620 NORTH 7TH STREET RAPID CITY, SD 57701		
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F 280	<p>Continued From page 44</p> <p>Interview on 6/30/15 at 5:30 p.m. with the DON revealed:</p> <ul style="list-style-type: none"> *She confirmed there had been too many forms and sheets for the staff to help guide them with resident care. *She agreed there were many conflicts and discrepancies with all of the above forms and sheets reviewed for each resident. *She agreed their process for guiding the staff with the appropriate care they needed to provide for the residents had been confusing and required a change. *It had been a part of the MDS coordinator's job to ensure the care plans had been accurate, reviewed, and revised by all the departments. <p>Review of the provider's unsigned and undated RN Assessment Coordinator job description revealed:</p> <ul style="list-style-type: none"> *"Accurate and thorough completion of the MDS, care area assessments, and care plans, in accordance with current federal and state regulations and guidelines that govern the process." *"Acts as an in-house case manager demonstrating detailed knowledge of residents health status, critical thinking skills to develop an appropriate care pathway and timely communication of needed information to the resident, family, other health care professionals and third party payers." <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, p. 257, revealed "After reassessing a patient, review the care plan and compare assessment date to validate the nursing diagnoses and determine whether the nursing interventions remain the most appropriate for the</p>	F 280			

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F 280	Continued From page 45 clinical situation. If a patient's status has changed and the nursing diagnosis and related nursing interventions are no longer appropriate, modify the nursing care plan. An out-of-date or incorrect care plan compromises the quality of nursing care."	F 280		
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, professional standard review, and policy review, the provider failed to ensure physician orders for notification of physician for: *Withholding of insulin for one of one sampled resident (2) without a physician order. *Wound care for one of two sampled residents (1) with a pressure ulcer. Findings include:</p> <p>1. Review of resident 2's nurses progress notes revealed: *On 4/20/15, "BS [blood sugar] low 149 before dinner and held insulin Novolog [medication to control BS for diabetics] until after supper." -There was no documentation the physician had been notified. *6/12/15, "Resident BL [blood sugar level] running low. 125 after hs [hour of sleep] snack. I am holding Lantus [a medication to control BS for diabetics] this evening." -There was no documentation the physician had been notified.</p>	F 281	<p>F281D Meet professional standards of quality</p> <p>Resident # 2 physician has reviewed current insulin orders and glucose readings</p> <p>Resident #1 physician has reviewed current orders related to skin integrity</p> <p>Residents residing in the facility have the potential to be affected in a similar manner.</p> <p>Licensed nursing staff have been re-educated on the Golden Living Policy 'Notification of Change in Resident Health Status' and following physician orders</p> <p>Director of Nursing or designee will complete 5 random audits weekly x 4 weeks then monthly x 2 months to ensure physician and responsible party notification has been completed when a resident experienced a condition change. Results will be reviewed at monthly QAPI meetings for further recommendations.</p>	<p>* 7/31/15 K6/SSD/H/PJ</p>

and/or
skin
breakdown
K6/SSD/H/PJ

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F 281	<p>Continued From page 46</p> <p>Review of resident 2's physician's orders and Medication Administration Record (MAR) revealed: *For the Lantus insulin, "Call MD [medical doctor] if blood sugar is greater than 500." *For the NovoLog insulin, "Call MD if blood sugar is greater than 500." *There were no orders to hold the insulin when it was low.</p> <p>Interview on 6/30/15 at 11:10 a.m. with the director of nurses (DON) regarding resident 2 revealed: *Based on professional standards she thought the insulin should have been given if his BS was above 100. *She was unsure why a nurse would hold the insulin when the resident's BS was 149. -She could not speak for the nurses that had made the decision to hold the insulin without notifying the MD. -Sometimes it was a nurse's judgment and that might have been why the nurse had withheld it.</p> <p>Review of the provider's May 2012 Medication Administration - Preparation and General Guidelines policy revealed: **If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnoses or condition, the nurse calls the provider pharmacy for clarification prior to the administration of the medication or if necessary contacts the prescriber for clarification." **If a dose of regularly scheduled medication is withheld, refused, not available or given at a time other than the scheduled time the space provided on the front of the MAR for that dosage</p>	F 281			

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NAME OF PROVIDER OR SUPPLIER

GOLDEN LIVINGCENTER - BLACK HILLS

STREET ADDRESS, CITY, STATE, ZIP CODE

**1620 NORTH 7TH STREET
RAPID CITY, SD 57701**

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F 281	<p>Continued From page 47</p> <p>administration is initialed and circled. -If two consecutive doses of a vital medication are withheld, refused or not available the physician is notified."</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, p. 306, revealed "Nurses follow health care provider's orders unless they believe the orders are in error or harm patients."</p> <p>Surveyor: 26632</p> <p>2. Review of the physician's ordered outpatient wound care therapy orders regarding resident 1 revealed:</p> <p>*On 3/3/15 "Bedrest with no backlying. Pt. [patient] to reposition from side to side in bed Q [every] 1 hr [hour] offloading {taking pressure off} all bony prominences, meals in bed with HOB [head of bed] elevated. HOB to be lowered after meals are finished with placing pt. back on side."</p> <p>*On 5/20/15 "Geomatt {special chair cushion} chair cushion provided 4/22 [4/22/15]. Pt to be laying on her L [left] side with R [right] leg positioned over L; lift R buttock [bottom] for wound visualization/consistency with measurements. Pt. to use Geomatt chair cushion when sitting in w/c [wheelchair] to attend appts [appointments]."</p> <p>*On 5/27/15 "Reposition from side to side every 1-2 hours, NO LAYING ON BACK. Recommend use of elbow protectors bilaterally to maintain skin integrity {no open areas}."</p> <p>*On 6/4/15 the wound vac [vacuum; device for draining a wound] was ordered to be held and wet-to-dry dressings applied daily.</p>	F 281		

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F 281	Continued From page 48 Review of resident 1's revised 6/2/15 care plan revealed interventions implemented on: *3/6/15. She was only to have been positioned on her back for meals then left side. Turn every one and one-half to two hours to her sides only. *3/19/15. Wound vac applied with changes on Monday, Wednesday, and Friday. *4/1/15. Meals in bed with head of bed raised and staff assistance. *These interventions were related to her stage four (full thickness tissue loss with exposed bone, tendon, or muscle) sacrum pressure ulcer. Interview on 6/30/15 at 10:45 a.m. with licensed practical nurse and wound care nurse P revealed: *She was not aware of the positioning for resident 1 during dressing changes. *She was not aware of using a Geomatt cushion in her wheelchair. Resident 1 had a gel cushion that was used. Interview on 7/2/15 at 7:45 a.m. with the DON confirmed the above orders had not been followed.	F 281		
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Surveyor: 26180	F 319	F319D Treatment/Service for mental/psychosocial difficulties Resident #10 psychosocial history has been reviewed and revised Residents residing in the facility with psychosocial concerns have the potential to be affected in a similar manner.	* 7/31/15 KG/SDDH/JJ

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F 319	<p>Continued From page 49 Surveyor: 26632 Based on record review, guideline review, interview, and job description review, the provider failed to ensure one of six sampled residents (10) with behaviors, mental, and psychosocial needs had been met. Findings include:</p> <p>1. Observation and interview on 7/2/15 at 10:00 a.m. with resident 10 revealed: *"Everything had gone pretty good here until recently." "She got mad a little while back and was upset, because her brother-in-law had died. So you know how that can stress you out?" *She used to be able to go outside and have a cigarette. Now she needed a supervisor with her if she wanted to go out and have a cigarette. That was new. *She just wanted to go out and talk with people the way she used to. *She was stressed and could not get a supervisor to go out with her. She got angry. "Talk about acting like a 10 year old. I was real angry." -So she went out and was in the parking lot, then when she had to come back in, she got so mad she pulled the fire alarm. *"That was when they stuck me. They gave me a shot and told me it was to make me sleep. I don't take meds [medications] that I don't know what they are for. -They did that to me four or five times. It didn't make me sleep. It made me angry. -They should put a picture of a dog on my door that says "Beware of Dog." That is how I feel. *She thought a couple of the nurses are bull dogs. They were the ones that gave her the shots. They said I was combative. I was not combative." *Now they wanted her to move to another facility "because I am combative."</p>	F 319 <i>within the next 30 days</i> <i>KG/SPAH/DJ</i>	<p><i>*All KG/SPAH/DJ</i> Residents with psychosocial concerns will be reviewed and care plans revised as indicated <i>KG/SPAH/DJ</i> to ensure resident's psychosocial needs are being met <i>KG/SPAH/DJ</i> by the Social Service Director with the Social Service Consultants. Social Service Director has been re-educated on care plan development to meet residents' psychosocial needs.</p> <p>Director of Nursing or designee will complete 5 random audits weekly x 4 weeks then monthly x 2 months to ensure residents with psychosocial needs have been met. Results will be reviewed at monthly QAPI meetings for further recommendations.</p>	
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F 319	<p>Continued From page 50</p> <p>*She relayed that one certified nursing assistant (CNA) who was holding her when they gave her the shot, the resident used her long fingernails to get the CNA and pointed to her neck were she had "gotten" the CNA.</p> <p>*A new resident had come in on 7/1/15, and that resident also smoked. When the staff saw her warning this new resident about not being able to smoke they moved resident 10 to a different table away from the new resident. Refer to F222, finding 1.</p> <p>Review of a 5/4/15 psychosocial history and assessment for resident 10 by the social services (SS) worker revealed:</p> <p>*A history of depression and anxiety.</p> <p>*An active smoker and required supervision to smoke for safety as she had failed the smoking assessment. Due to her history of falls she required supervision.</p> <p>*Was alert and oriented to person, place, time, and self. She was limited regarding safety awareness.</p> <p>*Was able to make herself known and was able to understand others well.</p> <p>*"Was pretty upbeat and usually did not trigger for any mood indicators."</p> <p>*Would have rather lived on her own but understood she was not able to do that due to her medical limitations.</p> <p>Review of the provider's 12/1/14 Admission Guidelines for Smoking revealed:</p> <p>*Should the resident choose to smoke they would have to be assessed for safety.</p> <p>*If they were determined to have been independent to smoke they could do so outside.</p> <p>*If they did not pass the assessment then arrangements could be made with family to come</p>	F 319		
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F 319	Continued From page 51 up and assist resident. Interview of 7/1/15 at 4:30 p.m. with the SSD revealed resident 10 had not passed the smoking assessment to have been able to smoke unsupervised. She agreed staff had been supervising resident 10 when she smoked. She had not thought that resident 10's behaviors had been related to her not being able to smoke. She had thought resident 10's behaviors were only related to dementia. Resident 10 did not have a physician's diagnosis of dementia. Review of the provider's August 2011 SSD job description revealed: "General Purpose: Identify and provide for each residents social, emotional and psychological needs, and the continuing development of the resident's full potential during his/her stay at the facility and to assist in the planning of his/her discharge."	F 319		
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by:	F 325	F325G Maintain Nutritional Status unless unavoidable Resident #2 nutritional status has been reviewed and revised by the Registered Dietician. Residents residing in the facility experiencing weight loss or have a nutritional risk have the potential to be affected in a similar manner Residents who are experiencing weight loss or have a nutritional risk have had their nutritional status reviewed and revised by the Registered Dietician.	7/31/15 KCF/SD00H/JJ

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F 325	<p>Continued From page 52 Surveyor: 26180 Based on observation, record review, interview, and professional standard review, the provider failed to ensure one of one sampled residents (2) at nutritional risk received care to ensure no further weight loss or nutritional concerns.. Findings include:</p> <p>1. Review of resident 2's entire medical record revealed he had several diagnosis that nutrition and diet might impact including: *He was an insulin dependent diabetic. *Had a diagnosis of: -Depression (mood was feeling down). -Congestive heart failure. -High blood pressure. -High cholesterol.</p> <p>Review of resident 2's weight record revealed: *On 3/5/15 he weighed 157.5 pounds (lb). *One month later on 4/2/15 he weighed 140.5 lb. -This was a 17 lb (or 10.7%) weight loss in one month. *His weight on 6/3/15 was 145.5 lb.</p> <p>Review of resident 2's progress notes revealed his physician was not notified of the above 17 lb weight loss.</p> <p>Review of resident 2's June 2015 blood sugar (BS) record revealed: *His BS was below 100 three times. *His BS was between 101-199 thirty-one times. *His BS was between 200-299 forty-one times. *His BS was between 300-399 thirty-four times. *His BS was over 400 six times.</p> <p>Random observation of resident 2 from 6/29/15 in the afternoon through 7/2/15 revealed:</p>	F 325	<p>The Dietary Manager, Registered Dietician, Director of Nursing and Interdisciplinary team have reviewed the Golden Living Weight Monitoring and Nutrition Risk Meeting policy.</p> <p>Nursing staff have been reeducated on following care plan interventions to prevent weight loss.</p> <p>Registered Dietician or designee will complete 5 random audits weekly x 4 weeks then monthly x 2 months to ensure care plans are being followed for residents with nutritional risk to prevent weight loss. Results will be reviewed at monthly QAPI meetings for further recommendations.</p> <p>of resident weights to include resident 2 KG/SDDH/JJ</p> <p>The RD will report the results to QAPI monthly. KG/SDDH/JJ</p> <p>* all resident weight variances of a 5 pound loss or gain must be reweighed and reported to the charge nurse. The charge nurse will then notify the dietary services manager for followup. KG/SDDH/JJ</p>	
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F 325	<p>Continued From page 53</p> <p>*He came out to the dining room very early every morning.</p> <p>*He liked hot chocolate and peanut butter.</p> <p>*After meals he returned to his room and laid down on his bed.</p> <p>*Staff had to encourage him to come out to the dining room for breakfast.</p> <p>*He had a big container of cheese balls in his room.</p> <p>Interview on 6/1/15 at 11:50 a.m. with his daughter revealed he:</p> <p>*He liked Mexican food as that was part of his culture and ethnic background</p> <p>-She tried to bring him Mexican food whenever she could.</p> <p>-She was unaware he had lost any weight.</p> <p>*He had recently been to the dentist and needed to have a lot of dental work done.</p> <p>Interview on 6/30/15 at 11:20 a.m. with the dietary services manager (DSM) revealed:</p> <p>*He had a significant weight loss.</p> <p>*They had reviewed him at their monthly weight meeting for a month at the time he lost the weight.</p> <p>-His weight had stabilized now.</p> <p>*They encouraged his family to bring Mexican food for him because he liked that kind of food.</p> <p>*He came out to the dining room very early in the morning and always ate two packets of peanut butter and a cup of hot chocolate.</p> <p>-He then returned to his room.</p> <p>-It was sometimes difficult to get him to come back out to the dining room.</p> <p>*When he selected his own meals, he circled everything on the menu.</p> <p>-When the food came he had four or five glasses of juice and milk, plus all the food.</p>	F 325			

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F 325	<p>Continued From page 54</p> <ul style="list-style-type: none"> -He would not eat very much of any of it. -Their plan was to assist him in ordering a more reasonable meal, so he might eat more. *They had also started him on a daily nutritional drink supplement. *She was unaware of any dental concerns. <p>Review of resident 2's 4/14/15 nutrition assessment revealed :</p> <p>*" [name of resident] with weight loss over that past 2 months. Stating he just doesn't feel like eating. PO [per oral/eating] approximately 25% daily. RSD [resident] has been taking snacks. discussed the importance of eating more at meals. RSD is open to fortified foods. stating no new issues with chew or swallow. DM [diabetic mellitus] with glucometers in fair control (150-250's) .</p> <p>*Interventions:</p> <ul style="list-style-type: none"> -ConCHO diet order (diet for diabetics). -Offering/encouraging TID [three times per day] snacks. <p>Begin to fortify (boost nutritional value of food served) all meals.</p> <p>Review of the nutrition care team meeting minutes revealed his weekly meal intake from 4/20/15 through 5/12 15 was 40% or less.</p> <p>Telephone interview on 6/30/15 at 4:00 p.m. with the registered dietitian on 6/30/15 revealed he confirmed the above interview with the DSM.</p> <p>Interview on 6/30/15 at 4:15 p.m. with the social services designee regarding resident 2 revealed:</p> <ul style="list-style-type: none"> *He denied he was depressed when she had assessed him. *She had not seen any indicators of depression with him. 	F 325		
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F 325	<p>Continued From page 55</p> <ul style="list-style-type: none"> -He slept a lot and was a loner. -When she had spoke earlier in the day with his daughter about his weight loss, the daughter said a family member had commented to him about gaining weight. He had always been very concerned about his weight - so he probably quit eating when that comment was made. <p>Interview on 7/2/15 at 8:15 a.m. with the Minimum Data Set (MDS) assessment coordinator regarding resident 2 revealed:</p> <ul style="list-style-type: none"> *He had not indicated he had any dental concerns when she did the Dental portion of the MDS. *He would not always talk to her when she went to do the assessment - if he will not talk to you there is nothing more that I could do. *They had not received any information back from the dentist regarding his dental concerns. -They had two referral forms from the dentist from his last visits but there was no information on them. <p>Review of resident 2's 5/18/15 care plan revealed activity interventions included invite to food related activities. Review of his activity participation records revealed he had not been invited to any food related activities.</p> <p>Review of resident 2's 5/18/15 care plan revealed:</p> <ul style="list-style-type: none"> *It had not addressed: <ul style="list-style-type: none"> -His significant weight loss. -His daily average meal intake was currently between 35-40%. -How they ensured a staff person sat with him to select his meals. -The nutritional supplement. -How the provider accommodated his preference for Mexican food if the family was unable to do 	F 325		

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F 325	Continued From page 56 so. -His high BS. -How they addressed the high BS nutritionally. -How they fortified his food. -Any dental issues.	F 325			
F 329 SS=G	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on interview, record review, and policy	F 329	F329G Drug Regimen is free of unnecessary drugs Resident # 10 has had drug regimen reviewed by the pharmacy consultant and in collaboration with physician revisions to regimen have been made as appropriate. Resident #14 has been discharged. Residents residing in the facility who are administered antipsychotic medications have the potential to be affected in a similar manner Residents who are currently receiving antipsychotic medications have had their regime reviewed by the pharmacy consultant and in collaboration with physician revisions to regimen have been made as appropriate. The Director of Nursing, Pharmacy Consultant and Medical Director has reviewed the Golden Living Antipsychotic monitoring policy.	* 7/31/15 XG/SDDCH/JT	

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F 329	<p>Continued From page 57</p> <p>review, the provider failed to have an appropriate diagnosis for two of seven sampled residents (10 and 14) who had been given multiple medication doses of antipsychotics and an antidepressant. Findings include:</p> <p>Surveyor: 26180</p> <p>1. Observation and interview on 7/2/15 at 10:00 a.m. with resident 10 revealed:</p> <p>"Everything had gone pretty good here until recently." "She got mad a little while back and was upset, because her brother-in-law had died. So you know how that can stress you out?"</p> <p>*She used to be able to go outside and have a cigarette. Now she needed a supervisor with her if she wanted to go out and have a cigarette. That was new.</p> <p>*She just wanted to go out and talk with people the way she used to.</p> <p>*She was stressed and could not get a supervisor to go out with her. She got angry. "Talk about acting like a 10 year old. I was real angry."</p> <p>-So she went out and was in the parking lot, then when she had to come back in, she got so mad she pulled the fire alarm.</p> <p>*"That was when they stuck me. They gave me a shot and told me it was to make me sleep. I don't take meds [medications] that I don't know what they are for.</p> <p>-They did that to me four or five times. It didn't make me sleep. It made me angry.</p> <p>-They should put a picture of a dog on my door that says "Beware of Dog." That is how I feel.</p> <p>*She thought a couple of the nurses are bull dogs. They were the ones that gave her the shots. They said I was combative. I was not combative."</p> <p>*Now they wanted her to move to another facility "because I am combative."</p>	F 329	<p>Licensed Nursing staff has been reeducated on the Golden Living Antipsychotic monitoring policy.</p> <p>Director of Nursing or designee will complete 5 random audits weekly x 4 weeks then monthly x 2 months to ensure the Golden Living Antipsychotic monitoring policy is being followed. Results will be reviewed at monthly QAPI meetings for further recommendations.</p> <p><i>and report to QAPI monthly. KG/SDDoH/JJ</i></p>	
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F 329	<p>Continued From page 58</p> <p>*She relayed that one certified nursing assistant (CNA) who was holding her when they gave her the shot, the resident used her long fingernails to get the CNA and pointed to her neck were she had "gotten" the CNA.</p> <p>*A new resident had come in on 7/1/15, and that resident also smoked. When the staff saw her warning this new resident about not being able to smoke they moved resident 10 to a different table away from the new resident.</p> <p>Surveyor: 26632 Review of resident 10's interdisciplinary progress notes from 6/7/15 through 7/1/15 revealed: *On 6/7/15 at 6:45 a.m. "Resident is alert with confusion and able to make all needs know to staff using call light." *On 6/14/15 at 6:55 p.m. "Resident is alert and oriented with confusion at times." "Always ask staff to go out and smoke." *On 6/16/15 at 9:16 a.m. "Resident is alert and can be confused at times." "She requires assistance to go out to smoke. She cannot pass the smoking assessment." *On 6/22/15 at 9:39 p.m. the following documentation revealed: -"Situation: At about 1900, [7:00 p.m.] resident was reported to be in the middle of the facility parking lot and stating she was going to leave. Resident hit a parked car of another family member's and scratching it with her WC [wheelchair] and attempting to leave. -Background: History of UTI [urinary tract infection], altered mental status [not thinking clearly], dementia [decreased thought process]. -Assessment: Resident refused any and all cares and vital signs [blood pressure, pulse, and breathing per minute] but is noted to be confused and combative towards staff. Resident trying to</p>	F 329			

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F 329	<p>Continued From page 59</p> <p>stand and get out of chair while WC is being pushed by staff and grabbing staff's hands. -Response: Resident was assisted by staff back onto the sidewalk and back into facility. Resident's sister called as requested. Once sister arrive, resident was assisted down to her room. At 1955 [7:55 p.m.] on call MD [medical doctor] was paged. At 2030 [8:30 p.m.] MD paged again. At 2120, [9:20 p.m.] call from _____ [MDs name] received with orders noted." *On 6/23/15 at 2:54 a.m. "St. [straight] cath [catheterization (tube to drain urine) of urinary bladder] done as ordered. Resident tolerated well. Results pending." *On 6/23/15 at 1:38 p.m. "Received UA [urinalysis] [urine test results] and faxed to _____ [MDs name]." *On 6/23/15 at 8:25 p.m. a note by the social services (SS) worker revealed: "Earlier a mood assessment was completed with resident. She scored 5 for mild depression. She answered yes to thoughts that she would be better off dead and that she has had thoughts in the past of hurting herself but not at the time. As SS was leaving for home this evening found resident in the street trying to leave. Brought her back to facility and she refused to come in. She continued to try to leave and 4 times almost tipped chair over going down the sloping drive and off the curb. She made comments that hurting her self would be ok and being better off dead. These comments were made a few times. She is refusing to come into facility. She states that her behavior is ok and disagrees that being in the road is a safety risk." *On 6/23/15 at 9:00 p.m. the following documentation revealed: -"Situation: At 1900, [7:00 p.m.] facility SS worker found resident in the street trying to leave facility. SS brought her back to facility and resident</p>	F 329		
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F 329	<p>Continued From page 60</p> <p>refused to come in. Resident continue to try and leave 4 times and almost tipped her w/c [wheelchair] over while going down the sloping driveway and off the curb.</p> <p>-Background: Hx [history] of altered mental status, UTI.</p> <p>-Assessment: Resident apparently disoriented and confused. Resident is not thinking clearly and cognitive [thinking; reasoning] status is severely altered. Resident refuses any care from any and all staff.</p> <p>-Response: Resident was brought back several times for safety purposes. One on one and at times two staff to 1 for safety and monitoring. PRN [as needed] medication administration attempted and refused. Call to her niece made. Niece arrived to assist in reassuring resident but resident continued to be agitated and attempt to elope. Call to MD at 2025 [8:25 p.m.] with order to send to _____ [name of hospital] for psych [psychiatric] eval [evaluation] via [by] ambulance. Ambulance on scene and here to transport resident at 2035 [8:35 p.m.]. At 2040, [8:40 p.m.] report called to _____ [name of registered nurse at hospital]. Awaiting update at this time."</p> <p>*On 6/24/15 at 1:44 a.m. "At 2330, [11:30 p.m.] call received from _____ [name of hospital] ER [emergency room] that resident is being sent back to facility. Resident verbalized no intentions to harm self in ER and displayed no behaviors while in the ER. Resident returned at 0030, [12:30 a.m.] with new orders for antibiotics for present UTI as well as progress notes regarding medications administered while in the ER. Resident assisted to bed with no concerns noted at this time. Will continue to monitor."</p> <p>*On 6/24/15 at 6:43 p.m. "Received orders for Ativan [anti-anxiety medication] solution 2 mg [milligram] per ml [milliliter] injection et [and] for a</p>	F 329			

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F 329	<p>Continued From page 61</p> <p>wanderguard [personal alarm device] R/T [related to] recent attempts to leave."</p> <p>*On 6/24/15 at 9:30 p.m. Medication administration of 1 mg of Haldol (antipsychotic medication) intramuscularly (IM). "Resident is exit seeking and combative to staff."</p> <p>*On 6/24/15 at 10: 43 p.m. the following documentation revealed:</p> <p>-Situation: "Resident is repeatedly attempting to elope from facility. Has opened exit doors at least x [times] 3 starting at 1930 [7:30 p.m.] exiting x 2. Resident hitting at staff and grabbing door handles and side rails and attempting to stand when wheel chair is in motion.</p> <p>-Background: Present UTI-currently on antibiotics therapy. Eloping and combative behaviors noted previous two days.</p> <p>-Assessment: Resident is noted to be confused, combative, and danger to self at this time.</p> <p>-Response: Earlier this shift, order was received for IM Ativan. Pharmacy called for medication. Medication unavailable at this time and not in our medication dispensing unit. Pharmacy continued with communications with MD for alternative medication. New order received. During this time, resident was supervised 1 on 1 [one staff person for one resident] at nurse's station by staff to prevent elopement. PRN oral medication administration attempted without success. IM injection of Haldol given as ordered. Family was notified and came to facility to help facilitate ADLs [activities of daily living that includes dressing, toileting, eating and personal care] with success. Family appreciative towards staff. Will continue to monitor and assess."</p> <p>*On 6/25/15 at 4:58 p.m. "Haldol 2 mg IM given. Resident left building three times. On third time, resident became combative with staff, attempting to hit staff, swinging at CNA [certified nursing</p>	F 329		

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F 329	Continued From page 62 assistant], nurse, et management. Resident re-directed for brief time et [and] brought into the hallway, where she then pulled the fire-alarm." *On 6/25/15 at 5:19 p.m. "Resident left building three times, stating that she was 'leaving this damn place'. Resident was stopped by nurse et CNA and explained to her why she needs to stay here for her safety. Resident re-directed back into building. A different resident left the building to leave with her son et this resident attempted to leave with the other resident. Nursing was able to re-direct resident, but she became combative, swinging to hit staff et kicking at nurse. Resident brought back into building et re-directed for a short time. Resident went down the hallway et pulled the fire-alarm, after being asked not to by nurse. Nurse assigned CNA to do one-on-one with resident; PRN dose of IM Haldol given per MAR [medication administration record]." *On 6/26/15 at 8:44 p.m. a late entry "Resident was trying to get out of the facility, and telling everyone that she will pull the fire alarm. Resident was stopped by nurse et CNA and explained to her why she needs to stay here for her safety. Nursing was able to re-direct but she's trying to hit staff. Given PRN dose of IM Haldol given per eMAR [electronic medication administration record]. She tries to kick staff while given the injection. After that she pours water on the laptop and still mad because she wants to go out." *On 6/28/15 at 8:19 p.m. "Haldol 2 mg IM given. Resident was trying to go out of the facility, and was very agitated." *On 6/28/15 at 9:49 p.m. "Resident was trying to get out the facility again at 2000, [8:00 p.m.] and she want [wanted] to go out and smoke. She was confused, she stated that she want to talk to the doctor on what's going on. Explained to the resident that she's living here and needs to stay	F 329			

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F 329	<p>Continued From page 63</p> <p>here for her safety. Give PRN dose of IM Haldol given per eMAR. Resident is still agitated called her sister and they came to help calm her down. Resident sister help her to bed and finally goes to sleep."</p> <p>*On 6/30/15 at 9:09 p.m. "Haldol 2 mg IM given."</p> <p>*On 6/30/15 at 10:03 p.m. "Resident with increased agitation, admin [administered] one IM shot of Haldol and called family to come up to see res.[resident] Res. then called 911 and police officer showed up, explained situation to police without any issues. res is resting in bed at this time, family just left. will cont [continue] to monitor."</p> <p>*On 7/1/15 at 12:43 p.m. a note by the SS worker. "Faxed _____ [MD] regarding resident behaviors. Family member is concerned about the behavior and said they have a Dr appt [appointment] schedule with _____ [MD] on 7/10/15. Discussed that we have request bed on 2nd fl [floor] _____ [another facility] for her safety."</p> <p>Interview on 7/1/15 at 5:30 p.m. with registered nurse O and licensed practical nurse N revealed:</p> <p>*Resident 10 had been having multiple episodes of trying to elope from the building.</p> <p>*She had been combative towards staff and had required one-on-one staff supervision.</p> <p>*They had not known why she had kept on trying to leave.</p> <p>*Agreed she was a smoker and had been assessed as unsafe to smoke alone on 4/27/15.</p> <p>*The provider's policy was only residents that did not have to be supervised to smoke could smoke.</p> <p>*Agreed staff had been supervising her since then for smoking.</p> <p>*Had not thought the Haldol she had received was a chemical restraint.</p>	F 329		
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F 329	<p>Continued From page 64</p> <p>*It had only been used to control her behaviors.</p> <p>Surveyor: 26180</p> <p>2. Review of resident 14's 5/8/15 physician's orders revealed:</p> <p>*He was admitted on 5/8/15 and discharged on 6/18/15.</p> <p>*His diagnoses included:</p> <ul style="list-style-type: none"> -A traumatic brain injury (TBI). -Mild cognitive impairment. <p>*The following psychotropic (medications effecting mood and behavior) had been ordered:</p> <ul style="list-style-type: none"> -Haldol (treatment for psychosis/severe mental disorder) inject 2 milligram (mg) intramuscularly (IM) PRN (as needed) every eight hours for severe agitation. Start date 5/10/15. There was no time limit on the use of that medication. -Risperidone (treatment for psychosis/severe mental disorder) tablet - 0.25 mg per PEG Tube (tube placed into the stomach for nutrition and medication) three times a day related to mild cognitive impairment. Start date 5/14/15. -Seroquel (for psychosis) tablet 25 mg per PEG tube every four hours as needed for severe agitation. -Trazodone (depression) HCL (hydrochloride) tablet 25 mg every six hours as needed for ABS (agitated behavior scale) greater than 27. Start date 5/8/15. -Trazodone HCL tablet 50 mg every 6 hours as needed for ABS greater than 27. Start date 5/8/15. <p>Review of resident 14's 6/1/15 physician's orders revealed:</p> <p>*His diagnoses remained unchanged from 5/8/15.</p> <p>*The following psychotropic had been ordered:</p> <ul style="list-style-type: none"> -Haldol inject 2 milligram (mg) intramuscularly every eight hours for severe agitation. Start date 	F 329		
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F 329	<p>Continued From page 65 5/10/15.</p> <ul style="list-style-type: none"> -Resperidone - 0.25 mg by mouth three times a day related to mild cognitive impairment. Start date 5/14/15 -Seroquel tablet 25 mg by mouth every four hours as needed for severe agitation. -Trazodone HCL 25 mg every six hours as needed for ABS greater than 27. Start date 5/8/15. -Trazodone HCL 50 mg every six hours as needed for ABS greater than 27. Start date 5/8/15. <p>Review of nurses progress notes and the Medication Administration Record from 5/8/15 through 6/18/15 revealed he received the Haldol 2 mg IM on 5/20/15 for severe agitation.</p> <p>Review of resident 14's behavior log revealed: *On 5/20/15 he exhibited verbal behavior one time. *From 5/8/15 through 6/18/15 he exhibited behaviors thirteen times. *Those behaviors included: -Rejecting care four times. -Wandering four times, -Verbal behavior twice. -Physical behavior twice. -Other behavior once.</p> <p>Interview on 7/2/15 at 10:40 a.m. with the director of nurses regarding resident 14 revealed: *He was very confused and restless. *He was assigned a one-on-one staffing ratio to monitor him. *He was constantly wanting to leave the building and was a fall risk. *The ABS scale (measured agitation) was a scale the TBI unit he had come from used.</p>	F 329		

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F 329	<p>Continued From page 66</p> <ul style="list-style-type: none"> -They did not have a copy of that scale and had not used it. -The nurses should have addressed that when they got the order for the medication using the ABS scale. *She agreed the diagnoses of mild cognitive impairment and severe agitation were not appropriate indicators for the use of an antipsychotic. *Not all behaviors had been documented. *She confirmed the nurses should have addressed those diagnoses with the admitting physician. <p>Review of the provider's 5/4/15 Antipsychotic Medication Review policy revealed:</p> <ul style="list-style-type: none"> *The procedure was to "Ensure that the Medical Record of any Resident who receives antipsychotic medication contains documentation supporting the appropriateness and necessity for the use of the drug. *Antipsychotics are a class of psychiatric medication primarily used to manage psychosis (including delusions, hallucinations, or disordered thought) particularly in schizophrenia and bipolar disorder, and is increasingly being used in the management of non-psychotic disorders. *The Assessment of Psychotropic medications was a part of the policy. -That document was not found completed in resident 14's medical records. *Review to ensure that a consent form or documentation noting the risks and benefits for the use of an antipsychotic medication had been discussed with the resident and/or responsible party. -That had not been noted for resident 10. <p>Review of the provider's 2/12/15 Behavior</p>	F 329		
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F 329	Continued From page 67 Management Guideline policy revealed: *"The use of any medication to control behaviors should always be considered a last resort to assist with managing a patient's/resident's behavior. *Antipsychotic drugs would not be used unless the clinical record documents that the patient/resident has one or more of the following "specific conditions", as dictated and documented by the physician: *A. Conditions other than Dementia"- This included a list of twelve diagnoses and had not included: -Mild Cognitive Impairment. -Severe agitation. *Criteria: "All of the above highlight conditions/diagnosis where antipsychotic medications may possible be appropriate, but diagnosis alone do not warrant the use of an antipsychotic unless the following criteria are also met: -The behavioral symptoms present a danger to the patient/resident or others AND one or both of the following: -The symptoms are identified as being due to mania or psychosis (such as auditory, visual or other hallucinations; delusions, paranoia, or grandiosity); OR -Behavioral interventions have been attempted and included in the plan of care, except in an emergency." *"When an antipsychotic medication is being initiated or used to treat an emergency situation related to one or more of the aforementioned conditions/diagnosis, the use must meet the above criteria and all of the following additional requirements: -1. The acute treatment period is limited to seven days or less;	F 329			

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F 329	Continued From page 68 -2. A clinician in conjunction with the interdisciplinary team must evaluate and document the situation within 7 days to identify and address and contributing and underlying causes of the acute condition and verify the continuing need for an antipsychotic medications."	F 329			
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Surveyor: 26180	F 353	F353F Sufficient 24 hour Nursing Staff per care plans Unable to correct past nursing staffing Residents residing in the facility have the potential to be affected in a similar manner. Staffing levels have been reviewed and meet the resident's needs Executive Director or designee will monitor results of all plan of correction audits weekly x 4 weeks then monthly x 2 months to ensure they are reflective of needs of residents are being met. Results will be reviewed at monthly QAPI meetings for further recommendations.	* 7/31/15 KG15000H/ST	

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F 353	<p>Continued From page 69</p> <p>Based on observation, record review, interview, and policy review, the provider failed to maintain adequate staff to prevent resident's care issues and meet basic care needs for:</p> <ul style="list-style-type: none"> *One of one sampled resident (2) had a change of condition. *One of two observed residents (4) during a dressing change to ensure privacy was maintained. *One of one resident group (Resident Council) and three of four confidential resident interviews regarding call lights not being answered in a timely manner. *One of ten randomly observed residents (16) had been assessed for the capability to self-administer medications after set-up. *One of one sampled resident (14) using a seat belt that had been assessed. *Two of seven sampled residents (10 and 14) who had received chemical restraints for the management of behaviors. *One of one resident (10) who had eloped and one of one resident (2) with an incident involving missing property. *One of thirteen sampled residents (2) who did not receive activities based on their assessed interests and needs. *Four of thirteen sampled residents (1, 2, 9, and 10) had medically related social services provided. *One of one sampled resident (18) with methicillin resistant staphylococcus aureus and continued diarrhea had a thorough temporary care plan regarding infection control developed. *Nine of thirteen sampled residents (1, 2, 3, 4, 5, 8, 9, 10, and 11) care plans had been reviewed and revised as the resident's care needs had changed. *One of one sampled resident (2) whose 	F 353		
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F 353	<p>Continued From page 70</p> <p>medication was held and one of two sampled residents (1) with a pressure ulcer had physicians' orders that had been followed.</p> <p>*Two of three sampled residents (1 and 8) who had developed pressure ulcers (open areas on skin caused by unrelieved pressure that resulted in damage to the tissue) after admission into the facility.</p> <p>*One of one sampled resident (2) at nutritional risk received care to ensure no further weight loss or nutritional concerns had occurred.</p> <p>*One of forty medications administered to resident (8) had been correctly labeled.</p> <p>*Three of fourteen sampled residents (1, 2, and 9) had accurate medical records.</p> <p>*Two of two sampled residents (4 and 18) who were identified with contagious multidrug-resistant organism (MDRO) (infections that are hard to treat because they do not respond to most antibiotics) and clostridium difficile (C-diff) (contagious bacterial infection) had an effective infection control measures was implemented, monitored, and maintained through an infection control program.</p> <p>Findings include:</p> <p>1. Interview on 7/2/15 at 9:00 a.m. with the administrator and director of nursing revealed:</p> <p>*The provider's budget had been decreased for this fiscal year.</p> <p>*Staffing was not done according to how much care residents required.</p> <p>*They had not been aware the Minimum Data Set coordinator, infection control nurse, and the social services designee had not been able to complete their duties as assigned due to the work load.</p> <p>Refer to F157, F164, F166, F176, F221, F222, F226, F248, F250, F278, F279, F280, F281, F314, F319, F325, F329, F353, F431, F441, and</p>	F 353			

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F 353	Continued From page 71 F514.	F 353			
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F441F Infection Control/Prevent Spread Resident #4 medical record has been reviewed related to infection control concerns and plan of care has been revised as appropriate. Resident #18 has been discharged Residents residing in the facility have the potential to be affected in a similar manner. Residents residing in the facility with known multidrug resistant organisms (MRDO) have been reviewed and care plans have been revised as appropriate. Executive Director, Director of Nursing and Interdisciplinary team have reviewed the Golden Living Policies and Practices related to Infection Control Staff has been reeducated on Golden Living Policies and Practices related to Infection Control	*7/31/15 K6/S000H/SD	

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F 441	Continued From page 72 This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Surveyor: 32355 A. Based on observation, record review, guideline review, interview, and policy review, the provider failed to ensure an effective infection control program was implemented, monitored, and maintained that addressed two of two sampled residents (4 and 18) who were identified with contagious multidrug-resistant organism (MDRO) (infections that are hard to treat because they do not respond to most antibiotics) and clostridium difficile (C-Diff) (contagious bacterial infection). Findings include: 1. Observation on 6/29/15 at 6:00 p.m. of resident 4 revealed she had been sitting in her wheelchair (w/c) in the dining room. Her feet had been resting on the foot pedals of the w/c and were supported by Prevalon boots (type of pressure relieving device). Review of resident 4's medical record revealed: *An admission date of 12/7/11. *Diagnoses of Type II diabetes (uncontrollable blood sugar levels), pain, depression, and diabetic ulcers (wounds; open areas on skin) to her legs due to poor circulation (blood supply). *Currently had three diabetic ulcers with one on her right calf, one on the left great toe, and one on the left heel. *She had been on comfort measures and under the support of hospice care since 3/4/15. *The diabetic ulcer on her left heel had tested	F 441	Director of Nursing or designee will complete 5 random audits weekly x 4 weeks then monthly x 2 months to ensure the Golden Living Policies and Practices related to Infection Control are being followed. Results will be reviewed at monthly QAPI meetings for further recommendations. and report to QAPI monthly. KG/SDDH/JJ to include: • residents with infections to ensure precautions are in place and followed. • dressing changes to ensure proper technique is used. • resident cares to ensure hand washing / glove use is correct. KG/SDDH/JJ		

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F 441	<p>Continued From page 73</p> <p>positive for methicillin resistant staphylococcus aureus (MRSA) (bacterial infection that is resistant to many antibiotics and highly contagious[easily spread to others]) in February of 2015.</p> <p>*She had required the left heel ulcer dressing to be changed twice a day. Those dressing changes were done by the nursing staff.</p> <p>*She had required staff support with transfers, bed mobility, dressing, personal hygiene, and toileting.</p> <p>*She had been at risk for skin breakdown and required the use of Prevalon boots for her legs and feet.</p> <p>Random observations from 6/29/15 through 7/2/15 of resident 4 revealed:</p> <p>*She had worn the Prevalon boots at all times.</p> <p>*No identifiable precautionary directions for the MRSA infection had been posted on her door, in her room for visitors, or for staff to follow.</p> <p>Interview on 6/30/15 at 5:20 p.m. with the infection control nurse revealed:</p> <p>*She had:</p> <ul style="list-style-type: none"> -Been aware of the MRSA in resident 4's left heel. -Considered the MRSA to be contained (no drainage going through the gauze dressing) since it was in one area and covered with a dressing. To her knowledge there had not been any drainage from the wound on the outside of the dressing. -Instructed the staff to follow standard precautions when providing personal care for the resident. Standard precautions had included gloves and good hand hygiene. <p>*Educated the staff on 2/17/15 regarding the MRSA in the resident's left heel and the precautions required to take care of her. She had</p>	F 441		

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F 441	<p>Continued From page 74</p> <p>recommended standard precautions with good handwashing.</p> <p>Review of resident 4's hospice notes from 5/6/15 through 6/15/15 revealed: *There had been drainage from the left heel wound. *The drainage amount had been large to moderate. *The drainage had been serosanguineous in color (reddish and yellow). *At times the drainage had a foul odor.</p> <p>Review of resident 4's undated Minimum Data Set Kardex report revealed: *She had a skin and ulcer treatment with a "dressing to her feet." *It had failed to identify: -The MRSA infection to her left heel and any precautionary interventions that should have been used by the staff when assisting her with dressing changes and activities of daily living (ADLs) (personal care including mobility).</p> <p>Review of resident 4's undated resident care sheet revealed: *It had failed to identify: -The diabetic ulcers to her left foot and right calf. -The MRSA infection in her left heel and any precautionary interventions that should have been used by the staff assisting her.</p> <p>Review of the provider's 6/29/15 daily stand-up information revealed it had not identified resident 4's MRSA infection to her left heel. Nor did it identify any precautionary interventions that should have been followed by the staff.</p> <p>Review of resident 4's 6/16/15 revised care plan</p>	F 441			

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F 441	<p>Continued From page 75</p> <p>revealed: *Failed to identify: -The MRSA infection in her left heel until 6/23/15. No precautionary interventions had been in place for the staff to follow when assisting her with ADLs or dressing changes.</p> <p>Observation on 7/1/15 at 10:25 a.m. licensed practical nurse (LPN) B and hospice LPN D during a dressing change for resident 4 revealed: *The resident had been laying in her bed with the Prevaion boots on. *LPN D had: -Brought a plastic bag full of dressing supplies from her personal car for the staff to change the resident's dressing. -Laid that plastic bag on top of the resident's bedside table. -Put on a pair of clean gloves, opened the bag, and started to get dressing supplies from that bag. -Placed some of those dressing supplies directly on top of the resident's roommate's dresser. -Put all of the dressing supplies in the resident's closet in the appropriate boxes. All of resident 4's dressing supplies had been in cardboard boxes that sat directly on the closet floor. -Retrieved the appropriate supplies necessary to change the dressing on the resident's left foot. -Placed all of those dressing supplies directly on top of the plastic bag she had brought in from her personal car. -Retrieved a box of gloves from the resident's closet and sat the box on top of the roommate's dresser. -Washed her hands, put on clean gloves, and put on a gown to cover her clothes. *LPN B: -Entered the room and retrieved a pair of gloves</p>	F 441		

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PRINTED: 07/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/02/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - BLACK HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 NORTH 7TH STREET RAPID CITY, SD 57701
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F 441	<p>Continued From page 76 from the box.</p> <ul style="list-style-type: none"> -Laid those gloves directly on top of the roommate's dresser. -Washed her hands, put on a gown, and those gloves that had been sitting on the top of the roommate's dresser. -Removed the resident's Prevaion boots and rested her feet directly on top of the bed covers. *There had been a large yellowish and reddish stain on the left Prevaion boot. That stain had been located where the left heel would have been placed. *The observation of the gauze dressing to the resident's left foot revealed a large amount of yellow and reddish colored drainage from the heel area. *LPN D continued with the dressing change while LPN B supported the resident's leg. She had: <ul style="list-style-type: none"> -Removed the dressing and disposed of it into a small trash can placed up against the roommate's dresser. -Removed her gloves and placed them in the small trash can. - Washed her hands and put on clean gloves. *With those clean gloves LPN D had: <ul style="list-style-type: none"> -Opened up a blue disposable soaker pad and placed it underneath of the resident's feet. -Retrieved a package that had been sitting on top of the plastic bag, opened it, and took out the gauze. -Opened a new bottle of saline that had been sitting on the roommate's dresser and wet the gauze. -Cleaned the wound and placed the soiled gauze in the small trash can. The trash can had been full and the soiled supplies had started to touch the roommate's dresser drawers. *LPN D removed those soiled gloves. She had: <ul style="list-style-type: none"> -Retrieved a package from the resident's closet 	F 441		
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F 441	<p>Continued From page 77</p> <p>without washing or sanitizing her hands. -Placed that package on top of the roommate's dresser. -Retrieved a pair of gloves and placed them on top of the roommate's dresser. -Washed her hands and put on the gloves that had been placed on top of the roommate's dresser. -Applied the medication to the wound bed and wrapped the left heel with a gauze dressing. *LPN D and LPN B removed their gloves and gowns. They had disposed of them into the trash can next to the roommate's dresser.</p> <p>Interview on 7/1/15 with LPN D and B after the above dressing change observation revealed: *They had been aware of the MRSA in the left heel. *They had agreed: -The MRSA had not been contained due to the amount of drainage that had been observed on the outside of the dressing and in the Prevalon boot. -The Prevalon boot needed to be washed or replaced. -The staff should have recognized the Prevalon boot was soiled and taken it to laundry for washing. -The plastic bag had not created a clean area for the dressing supplies. -The staff would have had to open the roommate's dresser drawers to obtain items when providing care for her. -They should not have placed any of the supplies or gloves on top of the roommate's dresser. -The above process had placed the roommate and other residents at risk for acquiring the infection. -They did not recognize the dressing change</p>	F 441			

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F 441	<p>Continued From page 78</p> <p>process had not been done in a sanitary manner.</p> <ul style="list-style-type: none"> -The resident should have been placed on contact precautions. -There should have been proper disposable garbage waste containers and supplies accessible for the staff when they provided care for her. *There should have been precautionary instructions available for all visitors. *The LPN D had asked the facility multiple times to get a shelf for the resident's closet to put the dressing supplies on. She had informed the provider the boxes should not have been sitting directly on the floor. <p>Interview on 7/1/15 at 11:10 a.m. with the director of nursing and the infection control nurse revealed:</p> <ul style="list-style-type: none"> *The infection control nurse had: <ul style="list-style-type: none"> -Not been aware the resident's left heel wound had any drainage seeping through to the outside of the dressing. -Not done any visual assessments of the wound or dressing. -Relied upon the nursing staff to inform her on the condition of the wound. They had informed her that the MRSA was contained and standard precautions had been sufficient. -Not reviewed any of the hospice notes and assessments on any of the resident's diabetic ulcers. -Not monitored and watched the nursing staff or hospice nurse during a dressing change to ensure sanitary conditions had been maintained. *They agreed: <ul style="list-style-type: none"> -The resident should have been monitored to ensure standard precautions for the MRSA had been appropriate. -The dressing change had not been done in a 	F 441		
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F 441	<p>Continued From page 79</p> <p>sanitary manner. That had created the potential for the roommate and other residents in the facility to acquire the infection.</p> <p>*The staff had been responsible to ensure any soiled linens were given to the laundry department to wash.</p> <p>*They had not been aware:</p> <ul style="list-style-type: none"> -All of the resident's dressing supplies had been sitting directly on her closet floor. -The hospice nurse had requested a shelf for those dressing supplies. <p>*They agreed the dressing supplies should not have been sitting on the floor.</p> <p>Surveyor: 26632</p> <p>2. Review of resident 18's admission face sheet revealed:</p> <ul style="list-style-type: none"> *He had been admitted on 6/25/15 from another skilled nursing facility. *He had diagnoses that included MRSA in his urine. <p>Review of resident 18's history and physical completed 7/1/15 by his primary physician revealed:</p> <ul style="list-style-type: none"> *He had been hospitalized for MRSA with urosepsis and treated with intravenous antibiotics at the other skilled nursing facility. *He has had chronic loose stools (bowel movements). *Resident 18 had stated to the physician he had "Between 5 -15 loose watery stools per day" *He has had problems with urinary retention and has a urinary catheter in place. *Discussion notes by the physician included: <ul style="list-style-type: none"> -Chronic diarrhea, history of microscopic colitis (inflammation of the colon). -Would plan for test of his stool for clostridium difficile (contagious infection of the intestine) due 	F 441		

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F 441	<p>Continued From page 80 to his recent antibiotic therapy.</p> <p>Review of resident 18's nurse's noted revealed: *On 6/15/15 at 5:58 p.m. an admission note. That admission note had not mentioned his previous MRSA infection diagnosis in his urine. *On 7/1/15 at 10:36 p.m. Resident went to physician appointment at 3:00 p.m. and was back at 5:02 p.m. *Has a diagnosis of diarrhea. Has new orders that included to get a stool sample for C. difficile (clostridium difficile).</p> <p>Interview on 7/2/15 at 9:55 a.m. with licensed practical nurse N and registered nurse O revealed: *They had not been aware that resident 18 had a previous diagnosis of MRSA in his urine. *They confirmed no infection control precautions had been put in place while both the MRSA in urine urine and the possibility of C.Diff had been ruled out.</p> <p>Surveyor: 32355 Review of the provider's 1/6/15 MRSA guideline revealed: *Description "In healthcare facilities, the main mode of transmission to other patients is through human hands." *Precautions: -"LTCHs (long-term care facilities) should make a decision on a case by case basis whether contact precautions are needed." -"Risk of transmission increases in the following situations and therefore, contact precautions should be considered with a heavy draining wound." *Room considerations "Infected or colonized residents should be placed in private room or cohorted (someone with the same infection)."</p>	F 441		
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F 441	<p>Continued From page 81</p> <p>Review of the provider's August 2012 Isolation - Categories of Transmission-Based Precautions policy revealed:</p> <ul style="list-style-type: none"> **Standard precautions shall be used when caring for residents at all times regardless of their suspected or confirmed infection status." **Transmission-Based Precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others." *Examples of infections requiring contact precautions include, but are not limited to: <ul style="list-style-type: none"> - "Infections with MDRO" - "Heavily draining wounds with noncontained drainage" *Resident placement "Place the individual in a private room if possible." *Gloves and gowns should be worn upon entering the resident's room and disposed of prior to leaving the room. **The facility will implement a system to alert staff to the type of precaution resident requires." **When transmission-based precautions are implemented the infection preventionist or designee shall: <ul style="list-style-type: none"> - Ensure that protective equipment (i.e., gloves, gowns, masks, etc.) is maintained outside of the resident's room so that everyone entering the room can access what they need. - Post the appropriate notice on the room entrance door, so that all personnel and staff will be aware of precautions, or be aware that they must first see a nurse to obtain additional information. - Ensure that an appropriate linen barrel/hamper and waste container, with appropriate liner, are placed in or near the resident's room." <p>Surveyor: 26632</p>	F 441		
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F 441	<p>Continued From page 82</p> <p>3. Review of the provider's 12/18/14 Infection Control Policy revealed the objectives of our infection control policies and practices were to:</p> <ul style="list-style-type: none"> *Prevent, detect, investigate, and control infections in the facility. *Maintain a safe, sanitary, and comfortable environment. *Establish guidelines for implementing isolation precautions. *Establish guidelines for the availability and accessibility of supplies and equipment necessary for standard and transmission based precautions. *Maintain records of incidents and corrective actions related to infections. <p>Interview on 7/2/15 at 9:55 a.m. with the infection control nurse revealed:</p> <ul style="list-style-type: none"> *She kept track of residents who were using and had used antibiotics. *She used the Beer's list to indicate if the resident was appropriate for the use of the antibiotic. *She checked for cultures and what organism had been present. *She checked if the appropriate antibiotic had been used according to the sensitivity test. *She did not complete any monitoring of staff infection control practices. *She presented an annual skills fair for the licensed nurses and medication aides that included handwashing and glove use. <p>Surveyor: 32355</p> <p>Review of the provider's unsigned and undated Infection Control Nurse job description revealed:</p> <ul style="list-style-type: none"> *General purpose: -"Eliminating infection risks to residents and personnel through surveillance of multiple activities and practice. 	F 441		

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F 441	<p>Continued From page 83</p> <p>-Teaching information pertinent to infection control and isolation to all involved employees.</p> <p>-Implementing monitoring and surveillance programs in an effort to identify and reduce infection hazards in the facility."</p> <p>Surveyor: 28057</p> <p>B. Based on observation, interview, and policy review, the provider failed to ensure infection control processes were followed for:</p> <ul style="list-style-type: none"> *Two of three observed residents (1 and 8) during dressing changes. *Hand washing and glove use during one of three observed resident's (9) personal cares by certified nursing assistant (CNA) (I). <p>Findings include:</p> <ol style="list-style-type: none"> 1. Observation on 6/30/15 at 2:30 p.m. during a dressing change for resident 8 revealed registered nurse (RN) M: <ul style="list-style-type: none"> *Washed her hands and put clean gloves on her hands. *She then washed the pressure ulcer on the resident's ischium (bottom). *She then applied ointment to the ulcer and placed a clean dressing over the ulcer. *She dated the dressing on the outside. *She then removed her gloves and washed her hands. *She stated that had been her usual procedure. <p>Interview on 7/1/15 at 2:55 p.m. with the director of nursing confirmed she would have expected RN M to have changed her gloves and washed her hands after cleansing the wound and before she had applied the ointment and clean dressing to the pressure ulcer.</p>	F 441		
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F 441	<p>Continued From page 84</p> <p>Review of the provider's revised August 2014 Handwashing/Hand Hygiene policy revealed hands were to be cleaned before and after handling clean or soiled dressings.</p> <p>Surveyor: 26632</p> <p>2. Observation on 6/29/15 from 3:45 p.m. through 4:00 p.m. of CNA I during personal care for resident 9 revealed:</p> <ul style="list-style-type: none"> *Put clean gloves on without washing her hands. *Touched multiple surfaces in the room. *Put a gait belt on resident 9 and assisted her to stand, pivot (rotate), and sit on a bedside commode (portable toilet). *While resident 9 was standing she pulled down her pants and incontinent brief. *When she was done using the commode CNA I took personal wipes from a drawer and cleansed her bottom. *Helped her stand, pulled up her incontinent brief and pants, pivoted, and sit down in her wheelchair. *CNA then emptied the commode in the toilet, rinsed the commode in the hand sink, and emptied the commode again into the toilet. *When she emptied the commode she touched the inside part of it. *CNA then put the commode in the closet and shut the closet door. *She took her gloves off , gathered the garbage, and then washed her hands. *Took the garbage to the soiled utility room and used hand sanitizer. <p>Interview on 6/29/15 at 4:00 p.m. with CNA I confirmed that was her usual routine when she provided personal care to residents. She agreed she had contaminated many surfaces with her gloves.</p>	F 441		
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F 441	<p>Continued From page 85</p> <p>Surveyor: 26632 3. Observation on 6/30/15 from 10:19 a.m. through 10:40 a.m. of a dressing change for resident 1 revealed: *Physical therapy assistant (PTA) J put on gloves without washing her hands. *PTA J then: -Assisted licensed practical nurse (LPN) P with repositioning resident 1 onto her right side. -Touched resident 1's buttocks (bottom) to assist LPN P with seeing the wound. -Touched the bedding and the incontinent brief when LPN P changed it and cleansed resident 1's bottom. -Without removing or changing her gloves reached into her pocket three times to check her cell phone.</p> <p>Surveyor: 32355 C. Based on observation, interview, and policy review, the provider failed to ensure infection control processes were followed or developed for: *Resident care supplies stored on the floor in two of two observed areas (medical storage room and medical record room). *Five of five randomly observed oxygen concentrator filters being currently used by residents. *One of one randomly observed nebulizer for one of one observed resident (8) treatment by one of one registered nurse (RN) (A). *One of one observed housekeeping office with no soap or towel dispenser at the handwashing sink. *One of one observed beauty salon sink that was not disinfected between each resident's use. Findings include:</p>	F 441		
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F 441	<p>Continued From page 86</p> <p>Surveyor: 26632</p> <p>1. Observation on 6/29/15 at 4:30 p.m. and again on 6/30/15 at 10:00 a.m. revealed boxes of resident care supplies in the medical records office. Those boxes were stored directly on the floor. In the medical supply room there was two boxes of medical supplies also stored directly on the floor. Interview on 6/30/15 at 10:00 a.m. with the medical records staff person revealed she was aware supplies should have not been stored directly on the floor. The supplies that were in her office had been stored there as they did not fit in the medical supply room. That had been ongoing for a few months.</p> <p>Review of the provider's 2/12/15 Safety and Disaster Management policy revealed to store supplies on well-constructed shelves and racks.</p> <p>Surveyor: 32355</p> <p>2. Random observations from 6/29/15 through 7/1/15 throughout the facility revealed:</p> <ul style="list-style-type: none"> *Five residents' oxygen concentrators were in use. *The oxygen concentrator filters had been dusty with a whitish powder noted on them. *Some nebulizer sets had not been taken apart, and the nebulizer apparatus had been attached to the machine. <p>Interview on 7/1/15 at 7:35 a.m. with LPN B regarding the cleaning of the resident's oxygen concentrator filters revealed:</p> <ul style="list-style-type: none"> *The maintenance supervisor was responsible for the cleaning and upkeep of the oxygen concentrator filters. *She had been unsure of his schedule for the cleaning of the filters. 	F 441		

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F 441	<p>Continued From page 87</p> <p>Interview on 7/1/15 at 7:40 a.m. with the DON regarding the cleaning of the residents' oxygen concentrator filters revealed:</p> <ul style="list-style-type: none"> *The nursing staff had been responsible for the cleaning of the oxygen concentrator filters. *They should have been cleaned every Sunday by the nursing staff. *She had not been aware the oxygen concentrator filters were dirty. *There was no documentation process in place to ensure the filters had been cleaned every Sunday. *The provider did not have a policy and procedure in place for the cleaning of the residents' oxygen concentrator filters. <p>3. Observation on 6/30/15 at 11:45 a.m. of RN A revealed:</p> <p>*She:</p> <ul style="list-style-type: none"> -Had prepared and set-up resident 8 to do a nebulizer treatment (medication to improve breathing). -Entered the room and retrieved the nebulizer apparatus. The entire apparatus had not been taken apart and was attached to the machine. -Had taken apart the apparatus and went into the bathroom and rinsed out the medication chamber. -Placed the medication in the chamber and attached it to the rest of the apparatus. *After the resident had completed the nebulizer treatment she attached the apparatus to the nebulizer machine. <p>Interview on 6/30/15 with RN A at the time of the above observation revealed that had been her usual process to clean the nebulizer apparatus.</p> <p>Interview on 7/1/15 at 7:40 a.m. with LPN B</p>	F 441		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/02/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - BLACK HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 NORTH 7TH STREET RAPID CITY, SD 57701
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F 441	<p>Continued From page 88</p> <p>revealed:</p> <p>*She would have wiped the nebulizer mask with an alcohol wipe and rinsed the chamber out with water.</p> <p>*She would have put the apparatus back together and and attached it to the machine.</p> <p>Interview on 7/1/15 at 7:45 a.m. with the DON revealed:</p> <p>*The nursing staff should have rinsed out the chambers with water everyday.</p> <p>*She had not monitored the staff administering the nebulizer treatments to ensure they were following the provider's policy and procedure.</p> <p>Review of the provider's May 2012 Oral Inhalation Administration policy revealed:</p> <p>***"When treatment is complete, turn off nebulizer and disconnect T-piece, mouth piece, and medication cup."</p> <p>***"Rinse and disinfect the nebulizer equipment according to manufacturer's recommendations, or wash pieces (except tubing) with warm, soapy water daily. Rinse with hot water. Allow to air dry completely on paper towel."</p> <p>***"Once a week/three times a week/daily disinfect the equipment by using a microsteam bag in the microwave for time recommended on bag or soaking for 5 minutes in 70% (percent) isopropyl alcohol and then rinse with sterile water."</p> <p>***"When equipment is completely dry, store in a plastic bag with the resident's name and the date on it."</p> <p>Surveyor: 26632</p> <p>4. Observation on 6/30/15 at 8:45 a.m. of the housekeeping office revealed a handwashing sink. No handsoap dispenser or paper towel dispenser was present. Interview with the</p>	F 441		

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F 441	Continued From page 89 housekeeping supervisor at that time confirmed that. She also stated the housekeepers would use that sink to wash their hands. 5. Interview on 6/30/15 at 8:20 a.m. with the beautician revealed she did not sanitize the hair washing sink between residents. She stated she only rinsed the sink with water and was not aware she should have sanitized it.	F 441		