

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

**ORIGINAL**

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |   |  |                      |   |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>435039</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                      | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>06/17/2015</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SOUTHRIDGE HEALTH CARE CENTER</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3600 SOUTH NORTON AVENUE<br/>SIOUX FALLS, SD 57105</b>   |                      |   |
| (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 |   |
| F 000  | INITIAL COMMENTS<br><br>Surveyor: 32333<br>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/8/15 through 6/11/15 and 6/16/15 through 6/17/15. Areas surveyed included quality of care and treatment, resident safety, falls, facility staffing, seclusion, resident neglect, improper infection control, unqualified personnel, resident assessment, and death. Southridge Health Care Center was found not in compliance with the following requirements: F223, F224, F226, F248, F278, F280, F309, F311, F314, F323, F325, F353, and F441.   | F 000   | <i>Addendums noted with an asterisk per 7/13/15 telephone to facility administrator and DON. sc/5006H/JS</i>   |                      |   |
| F 223<br>SS=G  | 483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION<br><br>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.<br><br>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 33265<br>Based on observation, interview, record review, and policy review, the provider failed to ensure freedom of movement for one of one sampled residents (10). Findings include:<br><br>1. Observation and interview on 6/10/15 from 12:40 p.m. to 1:00 p.m. in the East wing, far East hallway revealed: | F 223   | The door of resident #10 was adjusted and operates properly. Maintenance audited all doors of the facility on July 10, 2015 to ensure proper operation and ensure that the door doesn't stick to the frame. All doors are now open and close properly.<br><br>Involuntary seclusion could affect all residents. All staff will be educated on the facility's abuse and neglect policy including the different types of abuse including involuntary seclusion between July 14-15, 2015.<br><br>The Social Services department will ask every resident or resident representative by July 13, 2015 the questions listed on the Quality of Care rounds sheet which asks if the resident has ever experienced involuntary seclusion. | 7-16-15              |   |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

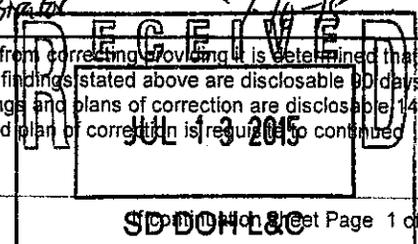
*Jeffrey Bergth*

TITLE

*Administrator*

(X6) DATE

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 required to continued program participation.



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| F 223   | <p>Continued From page 1</p> <p>*At 12:40 p.m. resident 10 was seated in his wheelchair, his knees were up against the bed, his head was down.</p> <p>*At 12:45 p.m. resident 10 put his call light on. It stayed on for several minutes, and then went into a faster beeping and flashing mode. The resident made his way into the hall with his wheelchair and stayed just outside of his doorway.</p> <p>*At 12:53 p.m. three certified nursing assistants (CNA) came to answer the call light. The resident was pushed back into his room, the television was turned on, and one CNA asked him if the channel was okay. I heard no response from the resident.</p> <p>*At 12:55 p.m. the resident turned his light on again and went out into the hallway in his wheelchair.</p> <p>*Two of the above three CNAs returned to his room, CNAs G and I pushed him backwards into his room. CNA G told him he needed to wait ten more minutes then they would move him into his recliner, then they closed the door to his room.</p> <p>*When the two CNAs were asked why the resident had to wait ten minutes. CNA G responded he wanted to know his weight, and they had not had time to get it.</p> <p>*This surveyor had previously identified the door to his room stuck and was difficult to open.</p> <p>*On previous random observations when the resident had been in his recliner and watching television, the door had been left open a few inches and the resident could have been seen in the recliner.</p> <p>After the CNAs had closed the resident's door and left the following occurred:</p> <p>*The resident was heard trying to open the door.</p> <p>*The door knob was moving, but it was not</p> | F 223  | <p>Responses that indicate a problem will be entered as a grievance or reported to the Department of Health if the criteria are met. The social services department will audit 10 random residents per month and ask if a staff member has involuntarily secluded them. Audit findings will be reported to the monthly QAPI meeting for 1 year by the Social Work Department and then as deemed necessary by the QAPI committee if no further patterns persist.</p> | 7/16/15   |

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| F 223  | Continued From page 2 opening.<br>*After knocking on the door, this surveyor opened it slowly to find the resident was right in front of the door.<br>*He motioned with his hands he wanted to move to the recliner.<br>-His call light was not seen.<br>*At 1:00 p.m. the resident's light was back on.<br>*The two CNAs returned with an EZ Stand (device to assist in lifting a person into the standing position) to move the resident.<br><br>Interview and record review including surveyor 32331 on 6/16/15 at 5:00 p.m. with the director of nursing (DON) and the administrator, revealed they were:<br>*Unaware of the event.<br>*Wanting to know if the event needed to be reported to the Department of Health office in Pierre at this time.<br><br>Review of the provider's June 2014 Reporting Abuse to Facility Management policy revealed:<br>*Involuntary seclusion was listed as a type of abuse.<br>*The definition for involuntary seclusion included a resident being confined to his room against his will.<br>*Employees, facility consultants, and or attending physicians were to report abuse or suspected abuse to the administrator or DON. | F 223   |   |                      |   |
| F 224<br>SS=E  | 483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.   | F 224   |   | 7-16-15              |   |

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| F 224  | <p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Surveyor: 32331</p> <p>Surveyor: 33265<br/>Based on observation, interview, record review, and policy review, the provider failed to identify, track, and investigate the loss of one of one sampled resident's (10) personal property. Findings include:</p> <p>1. Observation on 6/9/15 at 12:00 noon meal and at the evening meal on east wing in the dining room revealed resident 10 had not worn his dentures or hearing aides for either meal.</p> <p>Review of resident 10's complete medical record revealed:<br/>*The Inventory of Personal Effects form listed the following:<br/>-One pair of dentures, upper, and lower.<br/>-One pair of glasses - gold framed/brown in color.<br/>-One cell phone, black Samsung flip type.<br/>-One wallet with \$184.00, two blank checks, and a debit card.<br/>-One gold Timex watch.</p> <p>The Activities Evaluation form dated 2/12/15 revealed:<br/>*"Hearing aides needed from."<br/>*The check box for hearing aides was checked.</p> | F 224  | <p>The facility reported the missing items for resident #10 to the Dept of Health and the Sioux Falls Police Department on 6-16-15. The cell phone was found, is in operable condition and given to the family. Social worker and maintenance searched the room of resident #10 and located the hearing aide, 2 checkbooks and a signature stamper. All items were turned over to the family. Family advised that there was only 1 hearing aide (left ear) so that was given to the charge nurse to place in the locked medication room for resident #10 to use. The family reported that the debit card was canceled months ago. Social Services asked the resident and his son if any other items are missing on July 9, 2015.</p> <p>The Social Services department will ask every resident or resident representative by July 13, 2015 the questions listed on the Quality of Care rounds sheet which asks if the resident has any missing property. Responses that indicate a problem will be entered as a grievance or reported to the Department of Health if the criteria is met.</p> <p>The social services department will continue o maintain a Grievance Log in the Social Work office and follow the facility Grievance Policy and Procedure. All staff will be in-serviced on the Grievance Policy Procedure between July 14-15, 2015.</p> <p>The social services department will list all outstanding grievances during the daily stand-up meeting. The Administrator will audit each grievance on the Grievance Log on a</p> | 7-16-15   |

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| F 224   | <p>Continued From page 4</p> <p>-Further clarification of which side or sides the hearing aides were for was not checked.<br/>*Under adaptive equipment nothing was checked: no hearing aides, no glasses, and no dentures.</p> <p>The 2/12/15 Oral/Dental Status form stated "left dentures at (former facility)."</p> <p>The 5/6/15 Oral/Dental Status form had "dentures" written in.</p> <p>Interview on 6/10/15 at 8:15 a.m. with certified nursing assistant (CNA) E regarding resident 10 revealed:<br/>*She did not know about the resident's hearing aides.<br/>*She thought one had worked.<br/>*She usually worked evenings and had never seen a hearing aide belonging to him.<br/>*She searched for his dentures and located both upper and lower dentures in a dry cup without a lid.<br/>*When she offered him his dentures he declined.</p> <p>Further interview on 6/10/15 at 8:30 a.m. with CNA E regarding resident 10's hearing aide revealed she had asked her colleagues and they said there had been one hearing aide for the left ear.</p> <p>Further interview on 6/10/15 at 9:15 a.m. with CNA E regarding resident 10's hearing aide revealed she:<br/>*Had asked other staff members about the hearing aide.<br/>*Was told the hearing aide was not working and had been given to the family to take home. That date was not known.</p> | F 224  | <p>weekly basis to ensure timely follow-up on grievances.</p> <p>The Administrator will bring the results of the Grievance Log audit to the monthly QAPI meeting for 1 year and then as deemed necessary by the QAPI committee if no further patterns persist.</p> | 7-16-15   |

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| F 224  | <p>Continued From page 5</p> <p>Interview on 6/16/15 at 1:15 p.m. with the son of resident 10 revealed:</p> <ul style="list-style-type: none"> <li>*He had not been given the hearing aide to take home.</li> <li>*He had no idea where the hearing aide was and it had rarely been in his dad's ear.</li> <li>*It was very hard to communicate with his father without the hearing aide.</li> <li>*He understood the physician had written a notation to put his father's hearing aide in his ear every day.</li> <li>*He had no idea if the missing hearing aide had been reported to the State Department of Health.</li> </ul> <p>Surveyor 32331</p> <p>2. Interview and observation on 6/10/15 at 3:45 p.m. with the accounts receivable employee in the finance office regarding resident 10's resident trust account revealed:</p> <ul style="list-style-type: none"> <li>*He had opened a resident trust account on 5/1/15 with a balance of \$175.00.</li> <li>*He had used the account once since the above time on 5/4/15 for barber services with a withdrawal of \$15.00.</li> <li>*His current resident trust fund balance on 6/10/15 was \$160.00.</li> <li>*She showed this surveyor one legal-sized envelope that had been stored in the business office Sentry safe compartment that contained the following: <ul style="list-style-type: none"> <li>-One signed check blank by resident 10.</li> <li>*On the outside of that same above envelope there were handwritten notes with the following: <ul style="list-style-type: none"> <li>-The amount of \$184.00 had been underlined and scribbled out, and the amount of \$175.00 was written next to it.</li> <li>- "2 [two] check blanks."</li> <li>- An asterisk (*) with "took 1 chx (check) blank on 4/3/15" and initials of the accounts receivable</li> </ul> </li> </ul> </li> </ul> | F 224   |   | 7-16-15              |   |

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| F 224  | <p>Continued From page 6<br/>employee.<br/>-Resident 10's name.<br/>-Two more sets of initials.<br/>*She stated he had used one of the check blanks for a purchase on 4/3/15.<br/>*She stated when the envelope had been given to her to put in the business office's safe it had contained:<br/>-Two blank checks.<br/>-A total of \$175.00 in cash.<br/>*She stated there had not been a debit card in the above envelope when it had been given to her to put in the safe.<br/>*That above \$175.00 in cash had been placed in a resident trust account on 5/1/15.</p> <p>Surveyor 33265<br/>Review of resident 10's financial records revealed:<br/>*The resident trust fund account for resident 10 showed:<br/>-Deposit of \$175.00 on 5/1/15.<br/>-Withdrawal of \$15.00 for barber on 5/4/15.</p> <p>Interview on 6/16/15 at 10:55 a.m. with the son of resident 10 revealed:<br/>*He believed his father was transferred from the previous facility with the following belongings:<br/>-Wallet.<br/>-Watch.<br/>-Two blank checks.<br/>-One cell phone.<br/>-One shirt.<br/>-One pair of pajamas.<br/>*His father had been moved to this facility while he had been on a two week vacation. He brought his father the following items:<br/>-Two check books from different facilities.<br/>-Signature stamper for his use.</p> | F 224  |   | 7-16-15   |

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| F 224  | <p>Continued From page 7</p> <p>Further interview on 6/16/15 at 1:15 p.m. with the son revealed that:<br/>*The next time he visited his father he could not find the check books or the stamper.<br/>*At that time nothing was missing from either of the accounts.<br/>*He said there could have been a debit card, but he was not sure which financial institution it would have been from.<br/>*He had no idea if the provider reported missing items to the State Department of Health.</p> <p>Interview on 6/16/15 at 2:20 p.m. with the accounts receivable employee regarding resident 10's account revealed:<br/>*She remembered cash and two blank checks when he was admitted in February 2015.<br/>*The cash was left in the safe until 5/1/15 when it was transferred into the resident trust fund.<br/>*One check had been used. The one remaining blank check was still in the safe.</p> <p>3. Random observations between 6/9/15 and 6/11/15 in resident 10's room revealed no cell phone within sight in his room.</p> <p>Interviews on 6/16/15 at 10:55 a.m. and 1:15 p.m. with resident 10's son revealed:<br/>*His father had brought a cell phone with him from the previous facility.<br/>*The cell phone had been washed in the provider's laundry multiple times, and then went missing so was replaced by the son.<br/>*The second cell phone was reported as washed by the provider's laundry within three days of being delivered to his father. That too went on to be washed multiple times, then went missing, and was replaced by the son.</p> | F 224  |   | 7/16/15   |

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| F 224  | <p>Continued From page 8</p> <p>*The third cell phone had also gone missing. He had canceled the service between the first and second interviews today.</p> <p>*He had no idea if the provider had reported the missing items to the State Department of Health.</p> <p>4. Interview and record review on 6/16/15 at 2:15 p.m. with social worker designees (SSD) S and T concerning missing items revealed:</p> <p>*SSD S had only recently become resident 10's SSD.</p> <p>*SSD S had two cell phones that had been washed in the laundry sitting on his desk. He had no idea who they belonged to.</p> <p>*Neither one had known of resident 10's missing items.</p> <p>*SSD T remembered after reviewing records she had left eight or nine dollars in resident 10's wallet, and then put the rest in the safe. She was not sure about the debit card.</p> <p>*Both SSDs agreed when personal property was missing the routine was:</p> <p>-They would write a grievance .</p> <p>-If money was involved the police would be called and the State Department of Health would be notified.</p> <p>*If a cell phones was missing a grievance would have been written and the administrator was notified.</p> <p>*There were no grievances written for any missing items for resident 10.</p> <p>Interview and record review including surveyor 32331 on 6/16/15 at 5:00 p.m. with the DON and the administrator regarding the multiple missing items of resident 10 revealed:</p> <p>*Neither were aware of the personal items of his that were missing.</p> <p>*The administrator wanted to know if a report</p> | F 224   |   | 7-16-15              |   |

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FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>435039</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>06/17/2015</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SOUTHRIDGE HEALTH CARE CENTER</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3600 SOUTH NORTON AVENUE<br/>SIOUX FALLS, SD 57105</b>  |                      |   |
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| F 224  | Continued From page 9<br>needed to be filed with the State Department of Health at this time.<br><br>Review of provider's June 2014 Personal Property Policy revealed:<br>*Residents were encouraged to retain and use personal possessions as space permits.<br>*The residents' personal belongings and clothing would be inventoried and documented upon admission and as items are added.<br>*The facility would promptly investigate any complaints of misappropriation or mistreatment of resident property.  | F 224   |   |                      |   |
| F 226<br>SS=F  | 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 32333<br>A. Based on interview, record review, and policy review, the provider failed to ensure one of one suspected drug diversion with eight identified residents (34, 35, 36, 37, 38, 39, 40, 41) was reported and investigated in a timely manner. Findings include:<br><br>1. Review of the provider's twenty-four hour initial event report required by the South Dakota Department of Health received on 5/31/15 revealed on 5/27/15 it was discovered there was a possible diversion of controlled substances on | F 226   | Resident #11 resides in the facility. Employee QQ was terminated for neglect resulting from the interview and direct admission of the neglect action to the Administrator and DON. The incident was reported to the State Board of Nursing. There was no documented or suspected harm to these residents (6,8,47,48,49,50,51,52). After review of pain assessments, there was also no documented increased pain or complaints of not receiving appropriate medications requested for pain of these residents. Residents # 47,48,49,50 have discharged. Residents #6,8,51,52 have no further reports of drug diversion. Administrator now understands that drug diversions are required to be reported to the Department of Health and law enforcement immediately within twenty-four hours of the missing medications being noticed and will follow the provider's Resident Abuse/Neglect Policy and Procedure. | 7-16-15              |   |

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| F 226  | <p>Continued From page 10 the Warren rehabilitation wing.</p> <p>Interview on 6/1/15 at 4:55 p.m. with the administrator and registered nurse (RN) F revealed:</p> <ul style="list-style-type: none"> <li>*Medications were found to have disappeared on 5/12/15.</li> <li>*Sixty hydrocodone (controlled narcotic) were delivered from the pharmacy.</li> <li>*Thirty of those hydrocodone were missing.</li> <li>*Nursing staff discovered they were short twenty-two tramadol (controlled narcotic).</li> <li>*There were multiple other controlled medications missing.</li> <li>*They were in the process of their investigation.</li> <li>*They were unsure of the exact number of residents and medications the suspected diversion involved at this time.</li> <li>*They had not notified law enforcement until 5/31/15.</li> <li>*At the time they notified law enforcement they reported thirty missing hydrocodone tablets.</li> <li>*They had not reported any of the other missing medications.</li> <li>*They had not reported the suspected drug diversion, because they were unsure if it was a diversion.</li> </ul> <p>Review of the provider's final five-working day investigation report received on 6/5/15 into the South Dakota Department of Health revealed:</p> <ul style="list-style-type: none"> <li>*They determined eight residents had missing medications.</li> <li>*All medication documentation records, pain assessments, and controlled substances in the facility were reviewed.</li> <li>*The medications were found to have disappeared from 5/12/15 through 5/15/15 along with the sealed packaging they had arrived in or</li> </ul> | F 226  | <p>The consultant pharmacist explained to the Administrator that the diversion needed to be reported immediately. The Administrator did report the diversion on 5-31-15 after an email from with the consultant pharmacist. The Administrator and nursing team (DON was on vacation) did have a teleconference about the possible diversion with Pharmacy (consultant pharmacist not present) on the afternoon of 5-27-15 to come up with a plan to prevent further issues and to define if the diversion was actually a diversion. The drug diversion incident is still being investigated in cooperation with, Special Assistant Attorney General, Diversion Unit. The DON and/or designee will observe 5 random medication passes per month to ensure the six "Rs" are being conducted for medication administration.</p> <p>Resident #41 discharged from the facility on 2-20-15. Resident #42 discharged from the facility on 2-28-15.</p> <p>The Controlled Substance Policy and Procedure was reviewed on July 10, 2015 and will be included on the all staff in-service on July 14-15, 2015.</p> <p>All staff will be in-serviced on the facility abuse and neglect policy/procedure, Department of Health abuse/neglect reporting requirements and timelines, and the Controlled Substance Policy and Procedure by July 14-15, 2015.</p> | 7-16-15   |

*to include all shifts see 5000H/JJ*

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| F 226  | <p>Continued From page 11 were kept in.<br/>*They were continuing to investigate.</p> <p>Review of the undated amendment to the drug diversion report revealed:<br/>*Resident 36 had lorazepam 1 milligram (mg), two tablets missing.<br/>*Resident 37 had oxycodone 5 mg 4 tablets missing; hydrocodone/Tylenol (APAP) 5/325 mg 4 tablets missing; Tramadol 50 mg 30 tablets missing.<br/>*Resident 38 had morphine sulfate immediate release 15 mg 24 tablets missing.<br/>*Resident 39 had Tramadol 50 mg 29 tablets missing.<br/>*Resident 40 had hydrocodone/APAP 5/325 mg 4 tablets missing; Oxycodone 5 mg 30 tablets missing<br/>*Resident 34 had oxycodone/APAP 5/325 mg 3 tablets missing; tramadol 50 mg 2 tablets missing.<br/>*Resident 35 had hydrocodone/APAP 5/325 mg 3 tablets; tramadol 50 mg 2 tablets.<br/>*Resident 41 had Tramadol 50 mg 21 tablets missing.</p> <p>Interview on 6/16/15 at 2:25 p.m. with the director of nursing and the administrator revealed:<br/>*The administrator said he:<br/>-Had never had a drug diversion before.<br/>-Was unsure if the medications were misplaced or diverted.<br/>-The consultant pharmacist told him he needed to report the suspected drug diversion.<br/>-Should have notified the South Dakota Department of Health immediately within twenty-four hours of the missing medications being noticed.<br/>-Should have notified the police immediately</p> | F 226  | <p>The facility now utilizes a Controlled Substances Record Binder Book provided by Pharmacy to control and reduce the opportunities for a drug diversion to occur. The social services department developed a Resident Property Log on July 8, 2015 that will be used to log the resident name, room number, current date, type of item, final status, and date item given back to resident or resident representative.</p> <p>DON and/or designee will randomly audit 10 random residents in the facility each month that are listed in the Controlled Substances Record Book for 4 months to look for signs of possible drug diversion. The DON will in-service the Medication Aides and Nurses regarding the drug diversion and measures that the facility takes to reduce the opportunities for drug diversions between July 14-15, 2015.</p> <p>The Social Services department will ask a random sample of 10 residents or resident representatives each month for 4 months if the resident has any property that is missing. Responses that indicate a problem will be entered as a grievance or reported to the Department of Health if the criteria is met. The Social Services Department will audit the Resident Property Log each month to ensure timely follow-up on all entries during the month. The results of the Controlled Substances Record Binder Book audit will be brought to the monthly QAPI meeting by the Director of Nursing and/or designee for 4 months and then for 1 year until deemed necessary by the</p> | 7-16-15   |

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| F 226  | <p>Continued From page 12 within the same above stated time-frame.</p> <p>Review of the provider's revised June 2014 Resident Abuse/Neglect Policy and Procedure revealed "The administrator or designee will notify the Department of Social Services, the ombudsman, Department of Health and the residents attending physician immediately after being informed of the incident. (Immediately as defined as not longer than twenty-four (24) hours after being informed of the incident." Surveyor: 35625</p> <p>B. Based on record review, interview, and policy review, the provider failed to thoroughly investigate four of four sampled incident reports (1, 6, 11) to determine no abuse or neglect had occurred. Findings include:</p> <p>1a. Review of a grievance report dated 2/3/15 regarding resident 1 revealed:<br/>*The incident occurred on 1/30/15.<br/>*Her call light had been on for over an hour.<br/>*Social services designee S had been rude and disrespectful.<br/>*The facility ran a call light report for resident 1's room with a response time of no longer than twelve minutes for that date.<br/>*The resident was switched to social worker designee T.<br/>*There was no documentation interviews had been conducted or that a thorough investigation had been completed.<br/>*There was no documentation the provider had followed up with resident 1 regarding the grievance.</p> <p>b. Review of a grievance report dated 1/31/15 regarding resident 6 revealed:<br/>*A certified nursing assistant (CNA) had been</p> | F 226  | <p>QAPI committee if no further patterns persist. The Social Services Department audits of the Quality of Care tool and Resident Property Log will be given to the monthly QAPI meeting for 1 year and then as deemed necessary by the QAPI committee if no further patterns persist.</p> | 7-16-15   |

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| F 226   | <p>Continued From page 13</p> <p>rude and disrespectful during the previous night.<br/>*The resident and spouse were very upset regarding the matter.<br/>*An apology was offered to resident 6 and his spouse.<br/>*The CNA no longer worked at the facility.<br/>*The name of the CNA was not documented in the report.<br/>*No documentation was provided regarding the reason the CNA no longer worked at the facility.<br/>*No documentation was available regarding investigation of the CNA's behavior.</p> <p>c. Review of an event form submitted to the Department of Health (DOH) dated 5/7/15 for resident 11 revealed:<br/>*She had sustained a fall while attempting to transfer herself in the bathroom.<br/>*It had occurred on 4/30/15 at 4:00 a.m.<br/>*The CNA notified the nurse of the incident.<br/>*The nurse had left the building for a cigarette break and had not immediately assessed resident 11.<br/>*The nurse was terminated for neglect.<br/>*There was no documentation interviews had been conducted or that a thorough investigation had been completed.</p> <p>d. Interview on 6/1/15 at 9:30 a.m. with the local ombudsman prior to entering the facility regarding resident 11 revealed:<br/>*She had given the hearing aids to social services designee S to have repaired.<br/>*The hearing aids were not delivered in a timely manner to the repair shop.<br/>*Social services designee S had them in his car for an undetermined length of time.<br/>*The repair shop had not received payment for the repair of the hearing aids.</p> | F 226  |   | 7-16-15              |   |

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| F 226  | <p>Continued From page 14</p> <p>*No dates were provided in regards to the event.</p> <p>Review of a grievance report dated 6/5/15 for resident 11 revealed:</p> <p>*The facility had paid for the damaged hearing aids for resident 11 on 6/5/15.</p> <p>*A copy of the invoice and check was attached in the report.</p> <p>*No additional documentation was provided in the report.</p> <p>Interview on 6/16/15 at 10:00 a.m. with social services designee S revealed he:</p> <p>*Acknowledged the hearing aids were left in his car for an extended period of time.</p> <p>*Was not able to provide a date the hearing aids were given to him or when it was turned in to the repair shop.</p> <p>*Acknowledged he had no system in place for the documentation of items given to him by residents.</p> <p>e. Interview on 6/16/15 at 10:45 a.m. with the director of nursing and the administrator revealed:</p> <p>*Several staff members had visited with resident 1, but those interviews were not documented.</p> <p>*Acknowledged the report for resident 6 should have contained the name of the CNA involved in the incident and the reason she was no longer employed at the facility.</p> <p>*They were unable to provide documentation the nurse involved in the fall regarding resident 11 was reported to the South Dakota Board of Nursing.</p> <p>*Acknowledged the hearing aids for resident 11 had been left in social services designee S's car.</p> <p>-The administrator referred to that as an "outlying situation."</p> <p>-Was not aware social service designee S did not document receipt of items for the residents.</p> | F 226   |   | 7-16-15              |   |

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| F 226  | Continued From page 15<br>*Acknowledged the reviewed incidents did not contain thorough documentation of the evidence to determine if abuse, neglect, or misappropriation of property had occurred.<br><br>Review of the provider's June 2014 Resident Abuse/Neglect Policy and Procedures revealed:<br>*The completed report should have contained as many details as possible.<br>*All occurrences should have been reported to the administrator immediately.<br>*Social services personnel and nursing manager/designee were responsible for interviews of witnesses.<br>*Witness reports would be in writing with a signature and date.<br>*The administrator or designee would notify the Department of Social Services, the ombudsman, Department of Health, and attending physician immediately after being informed of the incident. | F 226   |   |                      |   |
| F 248<br>SS=E  | 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES<br><br>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 14477<br><br>Surveyor: 32333<br>Based on interview, record review, policy review, the provider failed to maintain an effective one-to-one activity program for 3 of 3 sampled  | F 248   | Review of the clinical records for Resident's 2 & 3 were reviewed on 7/6/15 and those residents were determined to have no negative outcomes related to F Tag 248. Reviewed resident's 2 & 3 along with all residents with activity staff. The Activity Director or designee will provide one on one's per what Individual Activities & Room Visits Program policy states. The Activity Staff will chart whether the resident was unavailable, out of building or refused if they could not or did not want to attend the activity. |                      | 7-16-15   |

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| F 248   | <p>Continued From page 16 residents (2, 3, and 18) that were unable to plan or attend activities on their own. Findings include:</p> <p>1. Review of resident 2's activities with the Staff Detail report from 5/1/15 through 6/8/15 revealed:<br/>*No activities were documented on 5/1/15.<br/>*There were two one-to-one activities documented.<br/>*There was one one-to-one activity documented as attempted.<br/>*No other documentation of one-to-one activities were documented during that time frame.</p> <p>Review of resident 2's 9/1/14 care plan for activities revealed no mention of how many times a week she would have been offered one-to-one activities by the staff.</p> <p>2. Review of resident 3's activities with the Staff Detail report form from 5/1/15 through 6/8/15 revealed:<br/>*No activities were documented from 5/1/15 through 5/3/15.<br/>*There were two one-to-one activities documented.<br/>*There was one one-to-one activity documented as attempted.<br/>*No other documentation of one-to-one activities were documented during that time frame.</p> <p>Review of resident 3's May 2015 care plan for activities revealed:<br/>*"Provide one-to-one services in my room . You can hold my hand, sensory, read to me and visit with me."<br/>*No mention of how many times a week one-to-one activities should have been offered per week.</p> | F 248  | <p>Review of the clinical records for Resident 18 was reviewed on 7/6/15 and that resident was determined to have no negative outcomes related to F Tag 248. Resident 18 review of the activity participation log shows that resident 18 attended activities 64% of the time from 10/7/14 till his discharge. The Activity Staff will chart whether the resident was unavailable, out of building or refused if they could not or did not want to attend the activity. Activity Staff will also chart how many attempts were made by the staff.</p> <p>Individual Activities &amp; Room Visit Program Policy was revised and changes were made to reflect current activities. In-service was held on 7/8/15 to go over new policies and new systems in place.</p> <p>The Activity Director or designee will randomly audit the participation records for 8 residents per week for 12 weeks and then 8 residents per month for 3 months, then quarterly on going. The audit reports on activity participation will be presented at the monthly QAPI committee by the Activity Director for 1 year and then the QAPI committee will determines otherwise.</p> | 7-16-15              |   |

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| F 248  | <p>Continued From page 17</p> <p>3. Review of the provider's list of residents that were on a one-to-one activity program revealed eighteen residents including resident 2 and 3.</p> <p>Interview on 6/16/15 at 1:15 p.m. with the activity director revealed:<br/>*They had 18 residents that were on a one-to-one activity program.<br/>*She would have liked each resident to at least have had three one-to-one activities a week.<br/>*They do not always have enough staff to work in activities.<br/>*The one-to-one activity program has not been developed as much as she would like it to be.</p> <p>Surveyor 14477</p> <p>4. Review of discharged resident 18's 7/14/14 care plan notes revealed he had wanted assistance to attend special music, watch TV, visit with people, participate in Bingo, and to help him outside when the weather was between 70-80 degrees. He also had wanted help turning on his room TV, and wanted to sit by the nurses station to visit with people who walked by.</p> <p>Review of resident 18's 10/7/14 care conference notes revealed his sister who had Durable Power of Attorney (DPOA) for him was upset he had been removed from activities because he was too loud. The provider had stated he was to have had more one-to-one activities and someone would have had to sit with him during a movie activity.</p> <p>Review of the 3/5/15 interview with the DPOA revealed the provider had been keeping resident 18 in his room and had not been offering or taking him to activities. The DPOA felt the lack of participation in activities had undone years of</p> | F 248  |   | 7-16-15   |

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

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>435039</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                      | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><br><b>06/17/2015</b> |
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| F 248  | Continued From page 18<br>behavior modification resident 18 had previously received.<br><br>Review of the closed medical record for resident 18 revealed there was no documentation of one-to-one activities or any other activity attendance.<br><br>Surveyor: 32333<br>Review of the provider's undated Individual Activities and Room visit program revealed "It is recommended that residents on a full room visit program receive, at a minimum, three room visits per week. Typically a room visit is ten to fifteen minutes in length."   | F 248   |  |                      |   |
| F 278<br>SS=E  | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>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 | F 278   | The facility will not utilize gerobics as a restorative option and only as an activity function.<br><br>The facility will maintain a one to four instructor to resident ratio for other restorative programs. All-staff will be in-serviced on the MDS assessment restorative program regarding the ratios on July 14-15, 2015.<br><br>The MDS Coordinator will pick 5 random residents on Restorative per week to audit for ensuring that the conditions for restorative program are being met.<br><br>The MDS Coordinator will bring the results of the audit to the monthly QAPI meeting for a period of 1 year and then as deemed necessary by the QAPI committee. |                      | 7-16-15   |

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

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| F 278  | <p>Continued From page 19</p> <p>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.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Surveyor: 32333<br/>Based on observation, interview, record review, and policy review, the provider failed to ensure the gerobics (geriatric aerobics) restorative program was coded accurately for 13 of 13 sampled residents (2, 7, 8, 9, 13, 16, 20, 21, 29, 31, 32, 33, and 42) who participated in the program. Findings include:</p> <p>1. Interview on 6/10/15 at 3:05 p.m. and on 6/16/15 at 1:15 p.m. with the activities director revealed:<br/>*There had been more than four residents in the gerobic program.<br/>*They had not maintained a one-to-four instructor to resident ratio.<br/>*They coded residents that were in there Minimum Data Set assessment look back period as being in a restorative program.<br/>*She was only able to code four residents in attendance each session of that restorative program.<br/>*She was not sure why she was only able to code four residents at a time.<br/>Refer to F311.</p> | F 278  |   | 7-16-15   |
| F 280<br>SS=E  | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  | F 280  |   |   |

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

PRINTED: 07/01/2015  
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OMB NO. 0938-0391

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| F 280  | <p>Continued From page 20</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Surveyor: 32333<br/><br/>Surveyor: 34030<br/><br/>Surveyor: 33265<br/>Surveyor: 34030<br/>Based on observation, interview, record review, and policy review, the provider failed to ensure care plans had been updated and revised to reflect the residents current needs for 5 of 16 sampled residents (2, 10, 11, 12, and 19).<br/>Findings include:</p> <p>1. Review of resident 11's complete medical</p> | F 280  | <p>The facility care plan policy was updated on July 8, 2015, which includes direction to ensure that care plans are updated regularly to ensure accurate and current information is available for staff to follow through with resident cares. Resident 19 was discharged from our facility. Care plans for residents #11, 2, 10 and 12 have been updated to include current and accurate information. Care plans for all other residents in the facility have been assessed to ensure they include accurate information as well.</p> <p>Education for all nursing staff on the revised care plan policy and procedure will be conducted by the DON and/or designee on July 14-15, 2015.</p> <p>Audits will be conducted weekly x 1 month and then monthly x 3 months to ensure that care plans for residents #11, 2, 10 and 12 include current and accurate information. 5 random care plan audits will be conducted weekly x 1 month and then monthly x 3 months to ensure that care plans are updated as needed to ensure they include current and accurate information for 5 random residents as well. The DON and/or designee will be responsible for conducting audits and for overall compliance. The DON and/or designee will report audit findings to QAPI meetings for 1 year and then as deemed necessary by the QAPI committee.</p> | 7-16-15              |

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

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| F 280   | <p>Continued From page 21 record revealed:<br/>*She was admitted on 4/22/14.<br/>*Her 4/8/15 Minimum Data Set (MDS) assessment revealed:<br/>-A Brief Interview for Mental Status assessment that showed her to be aware and able to make decisions.<br/>-She needed extensive assistance of one staff member to transfer out of bed and to the bathroom.<br/>*Her 4/12/15 comprehensive care plan stated she was unsteady, needed assistance with transfers and activities of daily living.</p> <p>Interview on 6/9/15 at 10:30 a.m. with certified nursing assistant (CNA)/ medication aide W revealed resident 11 transferred into the bathroom by herself. Staff did not assist her.</p> <p>Interview on 6/9/15 at 3:30 p.m. with resident 11 revealed she usually transferred herself to the bathroom.</p> <p>Review of the undated CNA pocket care plan for resident 11 revealed she needed the assistance of two staff to transfer her.</p> <p>Interview on 6/16/15 at 10:45 a.m. with MDS case manager X regarding resident 11 revealed:<br/>*She decided how to code resident care needs based on discussion with staff and reviewing Care Tracker (where the CNAs charted their care for a resident).<br/>*She coded based on how the activity was done the majority of time.<br/>*"Sometimes the resident transferred herself and sometimes she needed help."<br/>*She agreed the comprehensive care plan for resident 11 had not been updated to show she</p> | F 280  |   | 7-16-15              |   |

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

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FORM APPROVED  
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| F 280  | <p>Continued From page 22</p> <p>frequently transferred herself to the bathroom nor did the pocket care plan reflect that.</p> <p>Interview on 6/16/15 at 3:30 p.m. with the director of nursing (DON) and the administrator regarding resident 11 revealed they agreed her care plan had not been updated to reflect her current care.</p> <p>Surveyor 33265</p> <p>2a. Interviews with CNA E on 6/10/15 and with resident 10's son on 6/16/15 identified the resident had some lost personal items. Refer to F224 findings 1, 2, 3, and 4.</p> <p>b. Review of resident 10's complete medical record revealed:</p> <ul style="list-style-type: none"> <li>*He had been admitted on 2/12/15.</li> <li>*He weighed 205.6 pounds (lbs) on admission.</li> <li>*He weighed 177 lbs on 5/19/15, which was a loss of 28 lbs.</li> <li>*He had upper and lower dentures.</li> <li>*He was hard of hearing and used hearing aides. On 3/13/15 a hearing aide was documented as having been in his left ear.</li> <li>*He had a cell phone when he was admitted. The cell phone had gone through the washing machine in the laundry.</li> <li>*He wanted to be a full code (wanted CPR [cardiopulmonary resuscitation]), but was also listed as a "do not resuscitate" (DNR [do not do CPR]).</li> <li>*He was on honey thickened liquids (all liquids to drink were thickened to be like honey) since 6/4/15.</li> <li>*The undated care plan had documented: <ul style="list-style-type: none"> <li>-He used a hearing aid in his left ear and still had difficulty hearing. Resident 10 had not worn a hearing aide in either ear during the survey. Refer to F 224, Findings 1 and 4.</li> </ul> </li> </ul> | F 280  |   | 7-16-15   |

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

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FORM APPROVED  
OMB NO. 0938-0391

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| F 280  | <p>Continued From page 23</p> <ul style="list-style-type: none"> <li>-He needed nectar thickened liquids. That had not been updated to the change to honey thickened liquids.</li> <li>-Stated he wanted to be a full code and a DNR.</li> <li>-Had not included any update on weight loss.</li> <li>-Had not included when the resident was to be weighed.</li> <li>-Had not included the resident had not been using his dentures to eat.</li> <li>-Had not included any update as to the repeated washing and loss of three cell phones. Refer to F224, Findings 1, 3, and 4.</li> </ul> <p>Interview and record review including surveyor 32331 on 6/16/15 at 5:00 p.m. with the director of nursing (DON) and the administrator revealed the DON:</p> <ul style="list-style-type: none"> <li>*Thought the daily weights had been discontinued.</li> <li>*Would expect the care plan to be updated when changes occurred.</li> </ul> <p>Surveyor 33488</p> <p>3. Review of the medical record for resident 12 revealed:</p> <ul style="list-style-type: none"> <li>*He had a tunneled catheter (a special type of intravenous line that is placed into a large vein, the flexible line is placed under the skin and then into the vein) placed on 3/22/15.</li> <li>*His care plan documentation showed "Monitor my shunt dialysis fistula [surgically created access for dialysis, placed in arm or leg] for signs and symptoms of infection, and bruit [sound heard when assessing a dialysis fistula] for patency."</li> </ul> <p>Interview on 6/11/15 at 9:30 a.m. with MDS case manager X regarding resident 12's care plan documentation listed above revealed she:</p> | F 280   |   | 7-16-15   |

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

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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| F 280  | <p>Continued From page 24</p> <p>*Stated the resident had a fistula in his arm.<br/>*Was unaware of where the floor nursing staff documented on the assessment for the resident.</p> <p>Interview on 6/11/15 at 10:00 a.m. with the director of nursing regarding resident 12 revealed:<br/>*Nursing staff had not routinely documented bruit and thrill. They would only document if something was wrong or abnormal.<br/>*She was unsure where the fistula was located on the resident.<br/>*An unidentified staff nurse who was nearby remarked the resident had not had a fistula but had a tunneled catheter for dialysis access.</p> <p>Interview on 6/11/15 at 10:30 a.m. with resident 12 revealed he did not have a fistula. He had a tunneled catheter in his right upper chest.</p> <p>A tunneled catheter would be monitored for signs and symptoms of infection and whether or not the dressing was intact. The care plan was incorrect for resident 12 at the time of the survey.</p> <p>Surveyor 32333<br/>4. Review of resident 2's care plan revealed:<br/>*Two focus areas documented as pressure ulcers (injury to the skin from prolonged pressure).<br/>a.*One of the pressure ulcer focus areas updated on 3/12/15 included the following:<br/>-She was at risk for pressure ulcers, because she was frequently incontinent (loss of bladder control) of urine and she had edema (swelling).<br/>-During care they were to observe her skin and notify the nurse if there were any areas of concern.<br/>-Notify the nurse, family and doctor with any areas that are reddened, opened, or with any</p> | F 280   |   | 7/16/15              |   |

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

PRINTED: 07/01/2015  
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| F 280  | <p>Continued From page 25</p> <p>unexplained bruising.</p> <ul style="list-style-type: none"> <li>-Remind the resident to reposition when sitting or lying in one place.</li> <li>-On 3/12/15 her care plan was updated "Area to buttock [bottom] crease open again."</li> <li>-3/12/15 was the last time her care plan had been updated for that focus area.</li> </ul> <p>b. *The other focus area documented as pressure ulcers updated on May 2015 included the following:</p> <ul style="list-style-type: none"> <li>-"I have a pressure ulcer."</li> <li>-Progress toward the healing of the resident's pressure ulcer.</li> <li>-If there were no changes to wound in two weeks seek a different treatment.</li> <li>-If there were no changes in four weeks, seek a consultation to the wound clinic.</li> </ul> <p>c. *She had a focus area for pain with the following interventions:</p> <ul style="list-style-type: none"> <li>-Nursing should assess pain and document it.</li> <li>-Encourage the resident to change positions if she was in the same position for more than two hours.</li> </ul> <p>*Review of her care plan on 6/16/15 revealed it had not been updated to include her new skin concern noted on 6/10/15. Refer to F314.</p> <p>Review of resident 2's complete medical record revealed:</p> <ul style="list-style-type: none"> <li>*A 3/12/15 skin assessment report that stated she had a stage II pressure ulcer (open sore) to her buttock crease (no documentation as to the exact location).</li> <li>*A 3/12/15 fax to the physician with the concern of a new stage II pressure ulcer.</li> <li>*On 5/21/15 at 10:30 p.m. a nursing note: <ul style="list-style-type: none"> <li>-Her coccyx open to air.</li> <li>-DuoDerm (Type of wound dressing) discontinued and area healed.</li> </ul> </li> </ul> | F 280  |   | 7-16-15   |

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

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| F 280  | <p>Continued From page 26</p> <p>-No areas of concerns.</p> <p>*There was no mention of her pressure ulcer as being healed on her care plan.</p> <p>5. Review of resident 19's fall risk assessment revealed he scored a sixteen which indicated he was at high risk for falls.</p> <p>Review of resident 19's 2/16/15 nursing Kardex (temporary care plan) revealed no mention or interventions for falls.</p> <p>Review of resident 19's nursing notes revealed he had a fall resulting in a left hip fracture on 2/17/15. Refer to F323.</p> <p>6. Interview on 6/16/15 at 2:25 p.m. with the administrator and director of nursing revealed they would have expected care plans to have been complete and updated to reflect the residents' current status.</p> <p>Surveyor 33265</p> <p>Review of the provider's January 2009 Care Plans-Preliminary Policy and Procedure revealed a preliminary care plan was developed on admission to assure the resident's immediate care needs are met and maintained.</p> <p>Review of the provider's January 2009 Care Plans - Comprehensive Policy and Procedure revealed the comprehensive care plan:</p> <p>*Was to be developed within seven days of the completion of the resident's assessment or within twenty-one days after the resident's admission, whichever came first.</p> <p>*Was to include measurable goals and time tables to meet the resident's medical, nursing, and psychological needs.</p> | F 280  |   | 7-16-15   |

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

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>435039</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><br><b>06/17/2015</b> |
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| F 280  | Continued From page 27<br>*Was to be revised as changes in the resident's condition occurred.<br>*Had been designed to:<br>-Identify problem areas.<br>-Identify risk factors associated with the identified problem areas.<br>-Build on resident's strengths.<br>-Identify treatment goals in measurable terms.<br>-Prevent decline in the resident's abilities.<br>-Increase the resident's abilities to function by focusing on a rehabilitation program.   | F 280   |   |                      |   |
| F 309<br>SS=H  | <b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b><br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 32331<br><br>Surveyor: 32333<br><br>Surveyor: 32335<br><br>Surveyor: 34030<br><br>Surveyor: 33265<br>Surveyor: 32335<br>A. Based on observation, record review, interview, and policy review, the provider failed to perform tasks of daily living (toileting), implement | F 309   | The facility Pressure Ulcer/Skin Breakdown protocol was revised on 7-06-15. The new protocol will be implemented on residents #10 and #25 on 7-13-15. All other residents in the facility were assessed on 7-06-15 to ensure skin was intact and to begin the revised protocol on 7-13-15. All nursing staff will be inserviced on the revised Pressure Ulcer/Skin Breakdown protocol on July 14-15, 2015. The facility is actively setting up an outside wound care specialist to in-service the nursing staff regarding pressure ulcer/skin breakdown prevention within the next 30 days. Audits will be conducted weekly for 1 month and then monthly for 3 months on residents #10 and #25 and on all residents found to have skin issues on the facility wide assessment process to ensure skin protocol is being followed appropriately. A new skin integrity team has been created and meet weekly to assess, monitor and document all pressure related skin concerns. | 7-16-15              |   |

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

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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| F 309  | <p>Continued From page 28</p> <p>individualized interventions, and appropriately assess and document skin breakdown for three of three sampled cognitively impaired residents (10, 18, and 25) resulting in skin breakdown. Findings include:</p> <p>1. Interview on 6/10/15 between the timeframe of 2:30 p.m. and 3:30 p.m. with resident 25's daughter revealed she:</p> <ul style="list-style-type: none"> <li>*Visited almost everyday.</li> <li>*Felt her mother was taken to the bathroom too late sometimes.</li> <li>*Purposely did her mother's laundry to see how wet her clothes were from being incontinent.</li> <li>*Had a system where staff were to put wet clothes into one laundry bag and dry clothes into the other but staff had not followed it.</li> <li>*Stated the clothes were consistently very wet.</li> <li>*Stated her mother had skin breakdown on her bottom which healed about one month ago.</li> </ul> <p>Review of resident 25's skin assessment report revealed on 2/18/15 she had developed a superficial skin abrasion to her bottom. The contributing factor was incontinence.</p> <p>Review of resident 25's 4/30/15 Minimum Data Set (MDS) assessment revealed she was frequently incontinent of bladder (urine). She needed extensive assistance of two plus staff members for toileting. Her mental status score (thinking ability) was 0 meaning her thinking was severely impaired.</p> <p>Review of resident 25's 2/11/15 care plan revealed:</p> <ul style="list-style-type: none"> <li>*Urinary incontinence had been identified as a focus area on 8/26/14.</li> <li>*Interventions included:</li> </ul> | F 309  | <p>The DON and/or designee will be responsible for ensuring compliance and audit findings will be reported by the DON at the monthly QAPI meetings for 1 year and then as deemed necessary by the QAPI committee.</p> <p>The facility bathing policy and procedure was reviewed on 7-06-15. All nursing staff will be educated by the DON on the new bathing policy and procedure on July 14-15, 2015. Residents #3,29,36,38,53,54,55,56,57 and 58 records and all other residents in the facility were reviewed on July 9, 2015 to ensure that they had received a bath during the week. A daily bathing record was implemented to assist the assigned bath aide with documenting baths or showers appropriately. Caretracker charting has been modified to include scheduled baths.</p> <p><b>[REDACTED]</b> The Unit Coordinators and/or designee will be responsible for ensuring the bath aides get their daily baths completed and documented. Weekly audits will be conducted by the Unit Coordinators and/or designee weekly for one month and then monthly for 3 months on the residents listed above as being deficient during the survey and on 10 random residents in the facility to ensure compliance.</p> | 7/16/15   |

*or shower given as well as not given. If the residents preference for a bath or shower is not honored the reason will be documented on the Caretracker 5/5/2008 | JJ*

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

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FORM APPROVED  
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| F 309  | <p>Continued From page 29</p> <p>"Assist me to the toilet before and after meals, at bedtime, and every couple of hours at night."<br/>                     "If I am anxious, ask me if I need to use the toilet."<br/>                     -On 11/16/14 toilet every two hours while awake, at 12:01 a.m. and between 5:00 a.m. and 6:00 a.m. had been added.<br/>                     -On 11/19/14 "I want to be kept clean and dry throughout our next meeting" had been added.<br/>                     *There were no other interventions added for urinary incontinence after 11/19/14.<br/>                     *There had been no documentation on the care plan regarding the documented 2/18/15 skin abrasion.</p> <p>Interview on 6/10/15 between the timeframe of 2:30 p.m. and 3:30 p.m. with certified nursing assistant (CNA) G revealed some residents who needed assistance with toileting were "soaked" in the morning when she got to work. She defined "soaked" as meaning the bed and her clothes had been wet. She stated the overnight staff did not always toilet residents, especially those that may have behaviors or are more difficult.</p> <p>Interview on 6/16/15 at 2:30 p.m. with CNA H regarding resident 25 revealed:<br/>                     *The resident was dependent on staff for most care.<br/>                     *She was to have assistance from one staff person for toileting.<br/>                     *Sometimes when she arrived at work in the morning the resident was "really wet."<br/>                     -When asked to explain what really wet meant she replied, "The bed, her clothes, and everything."<br/>                     *She did not think the overnight staff always toileted her.<br/>                     *She felt they did not change her because they</p> | F 309   | <p>The DON and/or designee will be responsible for overall compliance and will present audit findings at the monthly QAPI meeting for 1 year. The facility hospice policy and procedure was revised on 7-06-15 to include how to incorporate the hospice agency care plans into the facility's care plans. All facility nursing and social service staff will be educated on this new policy and procedures on July 14-15, 2015 by the DON. Resident # 14 and 15 care plans have been updated to ensure they have been updated per the new facility policy. Care plans for all other residents in the facility on hospice have been updated to ensure they are in compliance with the new policy as well. Audits will be conducted weekly for 1 month and then monthly for 3 months on the hospice care plans for residents #14 and 15 and on five random hospice residents. These audits will be conducted by the DON and/or designee who will also be responsible for overall compliance. Audit findings will be reported at the monthly QAPI meetings by the DON and/or designee for 1 year.</p> | 7/16/15              |   |

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

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| F 309   | <p>Continued From page 30</p> <p>were short staffed or because sometimes the resident would fight with staff.</p> <p>Interview on 6/16/15 at 2:15 p.m. with the director of nursing revealed:<br/>*CNAs did not document every time they assisted the resident with toileting. They would document one time during their shift.<br/>*There was no documentation to verify staff had been toileting her "before and after meals, at bedtime, every couple of hours at night" or "every two hours while awake, at 12:01 a.m., and between 5:00 a.m. and 6:00 a.m."<br/>*There had been no updated interventions on the care plan.</p> <p>A toileting policy had been requested on 6/11/15 but had not been received by the time the survey team had exited on 6/17/15.</p> <p>Review of the provider's 11/13/14 Bowel and Bladder Assessment Policy revealed:<br/>*Residents would achieve their highest possible level of bowel and bladder function.<br/>*Each resident would be assessed for bowel and bladder incontinence upon admission, re-admission, annual review, and with significant changes.<br/>*The bladder screening sheet should have been completed by staff for three days to provide information on potential patterns of incontinence.<br/>*The nurse was to implement an individualized toileting plan based on the information obtained.<br/>*The care plan should have included goals and interventions.</p> <p>Surveyor 33265<br/>2. Observation and interview on 6/10/15 at 1:00 p.m. with CNA G during resident 10's care after</p> | F 309  |   | 7-16-15   |

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

PRINTED: 07/01/2015  
FORM APPROVED  
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| F 309   | <p>Continued From page 31</p> <p>toileting with assistance from CNAs G and I revealed:</p> <p>*Both sides of his buttocks were bright pink and dry with cracks in the skin at the outer edges of the bright pink area.</p> <p>*There was a small open area (top layer of skin was gone) on the upper right buttock.</p> <p>*There was an area the size of a quarter on the back side of the upper left thigh with small dark brown scabbed areas throughout.</p> <p>-CNA G stated she had not known of the scabbed area on the upper left thigh.</p> <p>*There were several small open areas on the back side of the scrotum. Those areas were open, red inside, and about half the size of a pencil eraser.</p> <p>-CNA G stated these were from his constant dribbling of urine.</p> <p>-He had dribbling of urine during the time of the assessment.</p> <p>*When asked how those areas were being cared for CNA G replied they were to use a cream on the scrotum and buttocks.</p> <p>-The Calmoseptine cream (a moisture barrier) that had been in the resident's room was applied in a thick layer over both sides of the buttocks, the back side of the upper left thigh, and the back side of the scrotum.</p> <p>Review of resident 10's complete medical record revealed:</p> <p>*From 2/28/15 to 4/11/15 the skin was documented as intact with no areas of concern.</p> <p>*On 4/13/15 the groin area was pink.</p> <p>*On 4/14/15 there was an open area on the right upper buttocks and the family and the physician were notified.</p> <p>-"Moisture cream applied to area."</p> <p>-No time was documented.</p> | F 309  |   | 7-16-15              |

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

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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| F 309   | <p>Continued From page 32</p> <p>*On 4/14/15 the Skin Assessment Report had documented an open area on the upper right buttocks with "sitting in urine" listed as a causal or contributing factor.</p> <p>-The diagram to identify the location of the skin concern had an "X" over the left groin.</p> <p>*On multiple dates the wound was tracked on a Non-Pressure Skin Condition Report form and was identified as a "skin tear".</p> <p>-The intervention started was listed as a "moisture barrier."</p> <p>*On 4/27/15 the left ischial crease (skin fold at bottom of buttocks and top part of thigh) was documented as a new area of concern.</p> <p>*On 4/27/15 the Skin Assessment Report identified friction from briefs as a causal or contributing factor.</p> <p>-Skin was described as sheared.</p> <p>*On 5/4/15 there were no new areas of concern noted; wounds to buttocks "not improving much".</p> <p>*No physician's order or nursing order for the use of the Calmoseptine cream was found.</p> <p>*Calmoseptine cream was not documented on the treatment administration record.</p> <p>Review of the undated manufacturer's instructions stated to apply Calmoseptine in a thin layer.</p> <p>Interview and record review including surveyor 32331 on 6/16/15 at 5:00 p.m. with the director of nursing (DON) and administrator revealed the DON:</p> <p>*Had not seen resident 10's open skin area.</p> <p>*Was not aware a barrier cream was being used on resident 10's open skin areas.</p> <p>Surveyor 14477<br/>3. Review of resident 18's closed medical record</p> | F 309  |   | 7-16-15   |

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

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FORM APPROVED  
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|  |  |   |   |                      |   |
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| F 309  | Continued From page 33<br>revealed an admission skin assessment had been completed on 7/3/14 with no skin concerns noted on buttocks, coccyx, or heels. Review of his 7/4/14 nursing note revealed he had been a total assist for all ADLs (activities of daily living), was incontinent of both bladder and bowel, and wore incontinent products. Further review of the Interdisciplinary Progress Notes revealed on:<br>*7/11/14 - Admission MDS (Minimum Data Set is an assessment tool) revealed a:<br>-Braden (a skin assessment tool) score of 13 (at risk for skin breakdown).<br>-Pressure reducing mattress was to have been on his bed at all times.<br>-Pressure reducing cushion was to have been in the wheelchair when he was in it.<br>*9/9/14- At 11:15 a.m. the nutrition documentation revealed "a Braden score of 13 and coccyx may be red." A nursing note on that same day at 5:16 p.m. stated a half-dollar size red area was noted on the lower coccyx, but was not open.<br>*9/24/14 - A nutrition note indicated his skin did not have a pressure ulcer per nurse and the skin team notes had been reviewed.<br>*10/7/14 - The care plan conference record revealed the family was concerned the resident was not getting a bath 3 times a week as expected.<br>*11/6/14 - A new skin concern of an open area 1 centimeter (cm) x 1 cm on the inner aspect of butt cheek had been documented. The physician was notified and an order received for Calmoseptine (moisture barrier ointment). The area was also documented on a non-pressure skin condition report and was noted as incontinence skin break down.<br>*11/7/14 - On a weekly pressure ulcer record the coccyx was noted to have been a stage II ulcer (an open sore in the top layer of the skin) | F 309   |   | 7/6/15               |   |

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

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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| F 309  | Continued From page 34<br>measuring 1.0 cm x 1.0 cm. Risk factors/cause were noted to have been diabetes and incontinence.<br>*11/14/14 - On the weekly pressure ulcer record the coccyx was noted to be a stage I (reddened area without being open) and was 0.5 cm x 0.5 cm.<br>*11/21/14 - The weekly pressure ulcer record stated the coccyx area was healed but a new area was observed. The non-pressure skin condition report stated the inner buttocks cheek area was healed.<br>*11/21/14 - The skin assessment revealed a new open area on the inner lower aspect of buttocks cheek measuring 2 cm x 2 cm. Incontinence had been listed as a causal or contributing factor.<br>*11/29/14 - The nutrition notes indicated nursing assessments had documented an open area from incontinence; the nutrition team discussed it was a closed area; but a voice mail message left for dietary by nursing stated it was an open area. There was no change regarding extra protein until clarification of the skin condition had been received. The resident's family had been made aware of the open areas.<br>*12/8/14 - Licensed Nurses Notes stated the DuoDerm (type of wound dressing) had been replaced on the coccyx when there was no documentation of a start date for the DuoDerm.<br>*12/21/14- Licensed Nurses Notes stated the DuoDerm dressing had been reapplied to the reddened coccyx.<br>*12/23/14 - The nutrition notes indicated the pressure area was healed.<br>*1/5/14 (should have been 2015) - Licensed Nurses Notes stated the coccyx area was pink and intact and DuoDerm had been used for protection of fragile skin. | F 309   |   | 7-16-15   |

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

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| F 309  | <p>Continued From page 35</p> <p>Surveyor 32333</p> <p>B. Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled residents (3), 1 randomly interviewed resident (29), and 8 randomly reviewed residents (9, 16, 22, 23, 24, 26, 28, and 30) that resided in Center hall had received scheduled baths/showers and accurate documentation was maintained for when baths/showers had been given.</p> <p>1. Review on 6/10/15 of resident 3's Bath Type Detail Report revealed she had not had a bath since 5/31/15.</p> <p>Review of resident 3's May 2015 care plan for activities of daily living function/incontinence revealed:<br/>*She is always incontinent of bowel and bladder.<br/>*She would like to be kept clean and dry.</p> <p>Interview on 6/10/15 at 9:45 a.m. with CNA J who is also a full-time bath-aide revealed:<br/>*There were usually three CNA's including the bath-aide that worked on Center Hall.<br/>*She would get pulled from giving baths to help the other CNA's<br/>*3 CNA's were not enough for this many residents.<br/>*There were more than forty residents on Center hall.<br/>*Sometimes there was only one CNA on night shift.<br/>*Baths do not get done everyday.<br/>*Some of yesterdays baths had not been done.<br/>*Last nights scheduled baths had not been done.<br/>*There were a lot of wet beds and urine soaked residents in the mornings.</p> | F 309   |   | 7-16-15              |   |

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

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| F 309   | <p>Continued From page 36</p> <p>Interview on 6/9/15 at 11:40 a.m. with CNA K revealed there were two to three CNA's during the day to approximately forty-seven residents. Sometimes baths did not get done and they got moved to the next day. They usually had nine baths on Mondays, and about twelve to thirteen on Wednesdays and Thursdays. Sometimes they would have to change three to four urine soaked beds in the mornings when they got to work.</p> <p>Interview on 6/10/15 at 1:55 p.m. with CNA K revealed the bath logs that were kept in the bath house were inaccurate. The bath log in the computer should have been more accurate. When a resident was given a bath even if it was after their scheduled bath day, they would still document that the bath was given on their scheduled day. Sometimes they would put the correct date of the bath behind the residents names on the bath logs that were kept in the bath house. There was not consistent documentation.</p> <p>Review of the Center bathing log from 6/8/15 through 6/11/15 revealed:<br/>*On 6/9/15 resident 22 was scheduled for bath.<br/>*Resident 22 was moved to the next day on 6/10/15.<br/>*On 6/9/15 resident 23 was scheduled for a bath.<br/>*There was no documentation for resident 23 on 6/9/15 they had received a bath.<br/>*On 6/10/15 resident 9 was moved to 6/11/15.</p> <p>Review of the Bath Type Detail Report from 6/8/15 through 6/11/15 revealed:<br/>-Resident 22:<br/>-On 6/9/15 at 10:16 a.m. it was documented she received a shower.<br/>-On 6/10/15 at 2:27 p.m. it was documented she received a whirlpool bath.</p> | F 309  |   | 7-16-15              |   |

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

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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| F 309  | Continued From page 37<br>*Resident 23:<br>-On 6/10/15 at 8:27 a.m. it was documented she received a shower.<br>-On 6/11/15 at 9:51 a.m. it was documented she received a whirlpool bath.<br>-On 6/11/15 at 10:28 a.m. it was documented she received a shower.<br>*Resident 24:<br>-On 6/11/15 at 10:01 a.m. it was documented he received a shower.<br>-On 6/11/15 at 11:18 a.m. it was documented he received a whirlpool bath.<br>*Resident 16:<br>-On 6/8/15 at 5:49 a.m. it was document he received a whirlpool bath.<br>-On 6/8/15 at 6:50 a.m. it was documented he received a shower.<br>*Resident 26:<br>-On 6/9/15 at 10:10 a.m. it was document he received a shower.<br>-On 6/10/15 at 2:27 p.m. it was documented he received a whirlpool bath.<br>*Resident 28:<br>-On 6/11/15 at was documented she received a shower at 9:06 a.m. and 9:46 a.m.<br>*Resident 30:<br>-On 6/9/15 at 10:15 a.m. it was documented she received a shower.<br>-On 6/10/15 at 2:27 p.m. it was documented she received a shower.<br><br>Surveyor: 33265<br>Interview on 6/11/15 at 9:00 a.m. with resident 29 revealed "there was no time for my shower this morning. Maybe I will get it this afternoon. Otherwise I will have to wait until tomorrow. That happens all the time."<br><br>Surveyor: 32333 | F 309   |   | 7-16-15              |   |

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

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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| F 309  | <p>Continued From page 38</p> <p>Interview on 6/16/15 at 9:05 a.m. with CNA J who was also a full-time bath aide, revealed:<br/>*The bath detail reports were not accurate.<br/>*Instead of just the bath aide documenting that a resident would get a bath or shower all the CNA's would document it.<br/>*The charting would be inaccurate.<br/>*There was no way to know from their documentation if or when a resident received a shower or whirlpool bath.<br/>*There was just not enough staff to get all the cares done.</p> <p>Interview on 6/16/15 at 2:25 p.m. with the director of nursing and administrator revealed:<br/>*They would have expected baths and showers to have been completed the day they were scheduled.<br/>*They would have expected documentation to have been accurate and timely.</p> <p>Review of the revised October 2010 Shower/Tub policy/procedure revealed:<br/>*"The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the residents skin."<br/>*The following information should have been recorded on the residents activities of daily living and/or in the medical record:<br/>-The date and time the shower/tub bath was performed.<br/>-The name and title of the individual who assisted the resident with the shower/tub bath.<br/>-All assessment data obtained during the shower/tub bath.<br/>-How the resident tolerated the shower/tub bath.<br/>-If the resident refused the shower/tub bath, the reason why, and the intervention taken.<br/>-The signature and title of the person recording</p> | F 309   |   | 7-16-15              |   |

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

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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| F 309 | <p>Continued From page 39 the data.<br/>-Notify the supervisor if the resident refuses the shower/tub bath.</p> <p>Surveyor 34030<br/>C. Based on record review, interview, and policy review, the provider failed to combine the hospice plan of care with the provider's plan of care to specify who was responsible for care for two of three sampled hospice residents (14 and 15). Findings include:</p> <p>1. Review of resident 14's medical record revealed an admission on 8/9/14. Hospice care had started 5/22/15.</p> <p>Review of resident 14's current 2/12/15 provider's care plan revealed:<br/>*It was located in a Care Plan binder with the hospice agency's care plan placed behind it.<br/>*No mention was made on the provider's care plan to show who was responsible for what care the resident was to receive.</p> <p>Interview on 6/16/15 at 3:30 p.m. with the DON and administrator revealed they were unaware of the need to specify provider and hospice care for residents. No hospice specific policy on resident care plans existed.</p> <p>Surveyor 32331<br/>2. Review of resident 15's medical record revealed:<br/>*She had been admitted on 6/4/15.<br/>*She was currently on hospice care and had been receiving hospice services at another facility.<br/>*A 6/3/15 physician's order for hospice care for "No change in level of care at this time only change of location."</p> | F 309 |  | 7/16/15 |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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| F 309  | <p>Continued From page 40</p> <p>Review of resident 15's undated care plan revealed:<br/>*No interventions that had included hospice care.<br/>*It had not:<br/>-Addressed why she was on hospice.<br/>-Identified the services and what care was to have been provided by the provider and by hospice.</p> <p>Interview on 6/10/15 at 2:40 p.m. with registered nurse (RN) A regarding resident 15 revealed:<br/>*The provider had not combined hospice care plans into her care plans.<br/>*She had been unaware the hospice care plans needed to have been combined into the provider's care plan.<br/>*She agreed the hospice care plan needed to have been combined into the provider's care plan.</p> <p>Interview on 6/10/15 at 2:55 p.m. with certified nursing assistant (CNA) B regarding resident 15 revealed:<br/>*She had been unaware she was on hospice.<br/>*She had not known what services hospice were to have provided.</p> <p>Interview on 6/10/15 at 3:00 p.m. with the director of clinical services at the hospice agency regarding resident 15 revealed:<br/>*They had not combined hospice care plans into the provider's care plans.<br/>*It was the responsibility of the provider to integrate the care plan provided by the hospice agency into the provider's care plan.<br/>*She stated there was a hospice plan of care for her, and that she would send it to the facility.<br/>*She agreed the plan of care needed to have been available and combined into the provider's</p> | F 309  |   | 7/6/15  |

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

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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| F 309 | <p>Continued From page 41 care plan.</p> <p>Interview on 6/10/15 at 4:10 p.m. with CNA Q regarding resident 15 revealed she:<br/>*Had been aware she was on hospice because she had assisted with her admission on 6/4/15.<br/>*Stated "It would have been nice" to have had more information regarding her hospice care.<br/>*She was not aware what services hospice was to have provided.</p> <p>Interview on 6/10/15 at 4:40 p.m. with the DON regarding resident 15 revealed she:<br/>*Agreed they did not have her facility care plan combined with the hospice one.<br/>*Confirmed the provider's care plan needed to have been combined with the hospice one and followed.</p> <p>3. Review of the provider's January 2009 Care Plans - Preliminary policy revealed to ensure the resident's immediate care needs were met and maintained a short-term care plan was to have been developed on admission.</p> <p>Review of the provider's January 2009 Care Plans-Comprehensive policy revealed:<br/>*The provider developed a comprehensive care plan for each resident to meet the resident's medical, nursing, and psychological needs.<br/>*The above comprehensive care plan had been designed to:<br/>-Incorporate identified problem areas.<br/>-Incorporate risk factors associated with identified problems.<br/>-Build on the resident's strengths.<br/>-Reflect treatment goals and objectives in measurable outcomes.<br/>-Identify the professional services responsible for</p> | F 309 |  | 7-16-15 |
|-------|---|-------|--|---------|

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

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FORM APPROVED  
OMB NO. 0938-0391

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|--------------------|--|---------------|---|----------------------|
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| F 309 | <p>Continued From page 42<br/>each element of care.<br/>-Prevent decline in the resident's functional status and levels (the measure and levels of a person's ability to perform activities of daily living independently).</p> <p>Review of the provider's revised 7/25/12 Agreement for Nursing Home Services revealed:<br/>*The provider and hospice were to have developed a combined care plan for each hospice resident.<br/>*Hospice was to have provided the facility with a copy of any existing care plan upon admission.<br/>*If a care plan had not been developed prior to that admission:<br/>-Hospice was to have prepared a care plan for that resident within two working days.<br/>-And have delivered a copy to the provider.<br/>*The provider and hospice were to have worked together to:<br/>-Facilitate cooperative efforts between the provider and hospice in providing appropriate care for residents admitted to hospice.<br/>-Ensure that care for hospice residents was in compliance with the hospice plan of care.</p> | F 309 |   |         |
| F 311 | <p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS</p> <p>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Surveyor: 32333<br/>Based on observation, interview, and record review the provider failed to maintain an effective</p>   | F 311 | <p>The facility will not utilize gerobics as a restorative option and only as an activity function.</p> <p>The facility will maintain a one to four instructor to resident ratio for other restorative programs. All-staff will be in-serviced on the MDS assessment restorative program regarding the ratios on July 14-15, 2015.</p> <p>The MDS Coordinator will pick 5 random residents on Restorative per week to audit for ensuring that the conditions for restorative program are being met.</p> | 7-16-15 |

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

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FORM APPROVED  
OMB NO. 0938-0391

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|--------------------|--|---------------|---|----------------------|
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| F 311 | <p>Continued From page 43</p> <p>restorative program for 13 of 13 sampled residents (2, 7, 8, 9, 13, 16, 20, 21, 29, 31, 32, 33, and 42) who participated in the gerobics (geriatric aerobics) program.</p> <p>Findings include:</p> <p>1. Review of the activities with staff detail report from 6/8/15 through 6/13/15 revealed there had been more than four residents in the gerobics program with only one instructor.</p> <p>Observation on 6/9/15 and on 6/10/15 of the gerobics program held in the center dining room revealed it had one instructor for more than four residents.</p> <p>Review of the activities for staff detail reports for gerobics revealed:<br/>*On 6/9/15 there were 15 residents in attendance.<br/>*On 6/10/15 there were 14 residents in attendance.</p> <p>Interview on 6/10/15 and on 6/16/15 at 3:05 p.m. with the activities director revealed:<br/>*There were fifteen residents that attended the gerobics program for restorative therapy.<br/>*Nine of those residents went to gerobics today.<br/>*She was only able to code four residents for restorative therapy although many more residents attended.<br/>*She was unsure why they were only able to code four residents.<br/>*They charted attendance in a restorative program for whoever happened to be in their Minimum Data Set (MDS) assessment look back period.<br/>*All of the residents were welcome to come to gerobics.<br/>*One or two staff usually instructed gerobics.</p> | F 311 | <p>The MDS Coordinator will bring the results of the audit to the monthly QAPI meeting for a period of 1 year and then as deemed necessary by the QAPI committee.</p> | 7-16-15 |
|-------|--|-------|---|---------|

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

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| F 311              | <p>Continued From page 44</p> <p>*The week of 6/8/15 through 6/13/15 there was only one staff member working to instruct gerobics.<br/>*On 6/16/15 she was the only instructor for gerobics.</p> <p>Review of the list of residents on the undated, unlabeled list of residents that attended the gerobics restorative care program included thirteen residents.</p> <p>Interview on 6/16/15 with the administrator and director of nursing revealed they agreed the gerobics program should have had a one-to-four instructor to resident ratio to be coded as a restorative program to ensure residents receive optimal care.</p> <p>Review of the provider's 5/21/14 Restorative Nursing Care policy revealed "The facility's rehabilitative nursing care program is designed to assist each resident to achieve and maintain an optimal level of self-care and independence."</p> | F 311         |   |                      |
| F 314<br>SS=G      | <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced</p>  | F 314         | <p>The facility pressure ulcer/skin breakdown policy and procedure was revised on 7-02-15. New skin protocol was implemented for resident #2 on 6/10/15. The resident received an overall skin assessment by unit nurse and Clinical Coordinator and was appropriately documented. Orders were obtained from the physician and a new treatment initiated on that day. All other residents in the facility were assessed on 7/6/15. To ensure skin is intact, new skin protocol was implemented on every resident that had skin issues.</p> <p>All CNAs/Medication Aides and nurses will be educated by the DON on the new skin policy on July 14-15, 2015. The facility toileting and</p> | 7-16-15              |

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

PRINTED: 07/01/2015  
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| F 314   | Continued From page 45<br>by:<br>Surveyor: 32333<br><br>Based on observation, interview, record review, plan of correction review from the survey on 9/11/14, job description review, and policy review, the provider failed to appropriately identify, notify, assess, provide treatment, and care plan a pressure ulcer for one of one sampled resident (2) who was at risk for pressure ulcers.<br>Findings include:<br><br>1. Review of resident 2's complete medical record revealed:<br>*She was admitted on 11/16/10.<br>*There was multiple documentation of pressure ulcers since her admit.<br>*There was multiple conflicting documentation of pressure ulcers on different areas of her body.<br>*Her most recent documented pressure ulcer had been identified on 3/12/15.<br>*On 5/21/15 there was a nursing note that the area was healed.<br>*There was no way to know if the resident had a pressure ulcer currently or not because of conflicting documentation.<br><br>Random observations on 6/9/15 of resident 2 from 8:45 a.m. through 10:33 a.m. while she was seated in the center dining room revealed:<br>*At 8:45 a.m. she was sitting in her wheelchair at the dining room table with her breakfast in front of her on the table.<br>*At 9:49 a.m. she was seated at the dining room table in her wheelchair with her head down.<br>*At 10:00 a.m. she called out "Someone help me please" several times with no staff response.<br>*At 10:10 a.m. she called out "I need to use the toilet" with no staff response. | F 314  | repositioning policies were revised on 7/6/15. All nursing staff will be educated on the new toileting and repositioning policy by the DON on July 14-15, 2015. Resident #2 was placed on the facility toileting/repositioning program on 6/10/2015. All other residents in the facility will be assessed to determine if they need to be placed on the facility toileting and repositioning program if deemed necessary. Weekly audits will be conducted on resident #2's toileting and repositioning program along with 10 other residents on the toileting and repositioning programs for one month and then monthly for 3 months. The assessments and audits will be conducted by the DON and/or designee. The DON and/or designee will report the audits to the monthly QAPI meetings for 1 year and then as deemed necessary by the QAPI committee.<br><br>All nursing staff will be educated by an outside wound care specialist on the skin policy on July 14-15, 2015. | 7-16-15              |   |

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

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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| F 314   | <p>Continued From page 46</p> <p>*At 10:33 a.m. she was still seated in her wheelchair at the dining room table with her head down.</p> <p>*Dietary staff had been in and out of the dining room while she was calling for help.</p> <p>*No nursing staff were present in the dining room.</p> <p>Observation on 6/9/15 at 10:45 a.m. of resident 2 in her room revealed certified nursing assistant (CNA) K and C were helping her use the toilet.</p> <p>Interview on 6/9/15 at 10:55 a.m. with resident 2 while she was in her recliner in her room revealed:</p> <p>*The questions asked were written due to her hearing impairment with some of her answers being verbal.</p> <p>*She stated "I have a sore on my bottom [left buttock] and it hurts."</p> <p>*When asked if she was toileted enough she wrote on a piece of paper "It depends on who is working."</p> <p>Interview on 6/9/15 at 11:15 a.m. with CNA K regarding resident 2 revealed:</p> <p>*After meals they were supposed to toilet the resident and lay her down.</p> <p>*She had a reddened area on her bottom, but it was not opened.</p> <p>*She complained her bottom was sore when she was toileted.</p> <p>Interview on 6/9/15 at 11:15 a.m. with CNA C regarding resident 2 revealed there was no reddened areas on her bottom.</p> <p>Interview on 6/9/15 at 11:20 a.m with registered nurse (RN) P revealed she had not heard that</p> | F 314  |   | 7-16-15   |

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

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

|   |  |  |   |   |
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| F 314   | <p>Continued From page 47</p> <p>resident 2 had a sore on her bottom nor had she heard of any reddened areas on her bottom.</p> <p>Review of resident 2's 6/7/15-6/9/15 bowel and bladder detail report revealed:<br/>*On 6/7/15 she was toileted at:<br/>-12:31 a.m.<br/>-10:18 a.m.<br/>-2:51 p.m.<br/>*On 6/8/15 she was toileted at:<br/>-12:48 a.m.<br/>-1:41 p.m.<br/>-8:48 p.m.<br/>*On 6/9/15 she was toileted at:<br/>-11:52 p.m.<br/>-9:47 a.m. (The observation of resident 2 being toileted was 10:45 a.m. on this date).<br/>-9:30 p.m.</p> <p>Record review on 6/10/15 of resident 2's medical record revealed no documentation regarding her 6/9/15 complaints of a sore on her bottom or a pain assessment.</p> <p>Observation and interview on 6/10/15 at 9:00 a.m. while CNA K toileted resident 2 revealed:<br/>*She had a reddened area on her left buttock (bottom).<br/>*The CNA stated she would notify the nurse on duty.</p> <p>Observation and interview on 6/10/15 at 11:00 a.m. with MDS case manager X and L of resident 2's left buttock revealed:<br/>*A reddened area with several pinpoint open areas.<br/>*A scant amount of blood was noted on her incontinence (loss of bowel and bladder control)</p> | F 314  |   | 7-16-15   |

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

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |   |
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| F 314 | <p>Continued From page 48 brief.</p> <p>*They stated they were unsure if it was a pressure ulcer or an incontinence ulcer.</p> <p>*The resident does sit in her chair a lot.</p> <p>Interview on 6/10/15 at 11:25 a.m. with the director of nursing (DON) and licensed practical nurse (LPN) O regarding resident 2's left buttock assessment revealed:</p> <p>*LPN O stated "Its just red" when asked if she had assessed the resident's bottom.</p> <p>*LPN O had not documented the assessment yet.</p> <p>*There was no wound care nurse at the facility, however MDS coordinator L used to be the wound care nurse.</p> <p>*LPN O had asked the CNAs to apply a barrier cream on her bottom.</p> <p>Review of the following documentation on 6/11/15 regarding resident 2 revealed:</p> <p>*A nursing note on 6/10/15 at 7:30 p.m. stated "New skin concern on bottom see NPSCR [Non-pressure skin condition report]."</p> <p>*NPSCR:</p> <ul style="list-style-type: none"> <li>-Left buttock redness.</li> <li>-The size was documented as pinpoint.</li> <li>-Provon (skin barrier cream) was placed.</li> </ul> <p>*Review of resident 2's 6/10/15 skin assessment report revealed:</p> <ul style="list-style-type: none"> <li>-The location of the new skin concern was on the left buttock.</li> <li>-The contributing factor was incontinence.</li> <li>-The skin concern was redness and a pinpoint area open.</li> </ul> <p>*Review of resident 2's 6/10/15 interdisciplinary progress (IDP) notes revealed "New skin concern found on left side of residents bottom. There is one pinpoint area on bottom that is open, the rest of her cheek is red with no other open areas</p> | F 314 |  | 7-16-15 |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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| F 314   | <p>Continued From page 49</p> <p>noted at this time. PCP [primary care provider] faxed r/t [related to] this reoccurring skin issue. Family notified of skin concern. CNA instructed to put on Provon for time being until PCP faxes back with treatment. No other skin concerns at this time. Call light within reach. Will continue to monitor."</p> <p>Interview on 6/10/15 at 3:55 p.m. with MDS coordinator L regarding the above noted IDP note revealed:<br/>*It was not how she would have documented the assessment of what she observed resident 2's skin concern.<br/>* She would have measured the reddened area.<br/>*Resident 2's "cheek [entire left buttocks]" was not all reddened.<br/>*LPN O should have assessed the resident for pain and documented it.<br/>*She confirmed the assessment was inaccurate.</p> <p>Review of resident 2's entire medical record revealed:<br/>*There was no documentation on 6/9/15 of her complaint of the sore on her bottom or her complaints of pain.<br/>*There had been no pain assessment documented.<br/>*There had been no accurate measurement of her reddened area on her left buttock.<br/>*The only documentation for measurement stated "pinpoint."</p> <p>Review of resident 2's skin assessment report faxed to the physician on 6/10/15 and then physician response on 6/11/15 revealed it was okay to start with barrier cream and to keep it as clean as possible.</p> | F 314  |   | 7-16-15   |

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

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| F 314   | <p>Continued From page 50</p> <p>Review of a fax sent to the physician on 6/11/15 to clarify the above order revealed:<br/>*RN Y asked the physician "Do you want the barrier cream as a PRN [as needed] order or daily? Please clarify."<br/>*The physicians response was "If incontinent daily."</p> <p>Review of resident 2's bowel and bladder detail report from 6/12/15 through 6/16/15 revealed she had been incontinent on:<br/>*6/12/15 at 12:51 p.m. and 7:54 p.m.<br/>*6/13/15 at 12:24 a.m. and 8:05 p.m.<br/>*6/14/15 at 12:19 a.m. and 4:40 p.m.<br/>*6/15/15 at 10:09 a.m. and 3:35 a.m.<br/>*6/16/15 at 12:44 a.m.</p> <p>Review on 6/16/15 of resident 2's June 2015 treatment administration record revealed:<br/>*6/12/15 Barrier cream to area on buttocks if incontinent daily.<br/>*The time listed to apply the barrier cream was "PRN."<br/>*There was no documentation that the barrier cream had been applied.</p> <p>Interview on 6/16/15 at 9:50 a.m. with RN Y regarding resident 2 revealed:<br/>*She was incontinent more than usual.<br/>*The nurse should have been putting on the barrier cream.</p> <p>Interview on 6/16/15 at 10:05 a.m. with CNAs M and N regarding resident 2 revealed:<br/>*She was always incontinent.<br/>*She had been incontinent that day at 9:45 a.m.</p> <p>Review of resident 2's care plan revealed:<br/>*Two focus areas documented as pressure</p> | F 314  |   | 7-16-15   |

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

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| F 314  | <p>Continued From page 51</p> <p>ulcers.</p> <p>*One of the pressure ulcer focus areas updated 3/12/15 was the following:</p> <ul style="list-style-type: none"> <li>-She was at risk for pressure ulcers, because she was frequently incontinent of urine and she had edema (swelling).</li> <li>-During care observe skin and notify the nurse if there were any areas of concern.</li> <li>-Notify the nurse, family and physician with any areas that were reddened, opened, or with any unexplained bruising.</li> <li>-Remind the resident to reposition when sitting or lying in one place.</li> <li>-On 3/12/15 her care plan was updated "Area to buttock crease open again."</li> <li>-3/12/15 was the last time her care plan had been updated.</li> </ul> <p>*Another focus area documented as pressure ulcers updated on May 2015 revealed the following:</p> <ul style="list-style-type: none"> <li>-"I have a pressure ulcer."</li> <li>-Progress toward the healing of the residents pressure ulcer.</li> <li>-If there were no changes to wound in two weeks seek a different treatment.</li> <li>-If there were no changes in four weeks, seek a consult to the wound clinic.</li> </ul> <p>*She had a focus area for pain with the following interventions:</p> <ul style="list-style-type: none"> <li>-Nursing should assess pain and document it.</li> <li>-Encourage the resident to change positions if she is in the same position for more than two hours.</li> </ul> <p>Her care plan had not been updated to reflect when her pressure ulcer identified on 3/12/14 was healed. Review of her care plan on 6/16/15 it had not been updated to include her new skin concern.</p> | F 314  |   | 7-16-15   |

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

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|  |   |  |   |
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| F 314 | <p>Continued From page 52</p> <ul style="list-style-type: none"> <li>* A May 2015 focus area of urinary incontinence.</li> <li>- "Please take me to the toilet when I get up in the morning, before and after meals, at bedtime and PRN."</li> <li>- "Please take me every couple hours at night as well."</li> <li>- "I take a diuretic that makes me have to go often."</li> </ul> <p>Review of resident 2's pocket care plan revealed CNAs were to check skin daily.</p> <p>Interview on 6/16/15 at 2:45 p.m. with the DON and administrator regarding resident 2 revealed:</p> <ul style="list-style-type: none"> <li>*The nursing staff should have assessed her for her complaints of a sore on her bottom and pain.</li> <li>*They would have expected the physician's orders to have been followed.</li> <li>*They would have expected the nurse to have done accurate measurements and accurate assessments of the resident's impaired skin integrity (skin break down).</li> <li>*They would have expected the resident's care plan to have been updated.</li> <li>*The DON would not expect toileting to be real time (actual time it was done).</li> <li>*The DON agreed there was no way to know when the resident was being toileted.</li> <li>*The administrator asked the DON during this interview to have nursing staff go do an accurate assessment to get a baseline of the resident's impaired skin integrity.</li> </ul> <p>Review on 6/17/15 of resident 2's requested by the administrator skin assessment revealed a stage II pressure ulcer (open sore) measuring 2 centimeters by 0.8 centimeters.</p> <p>Review of the provider's 9/11/14 last survey</p> | F 314 |  | 7/6/15 |
|-------|---|-------|--|--------|

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

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OMB NO. 0938-0391

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| F 314   | <p>Continued From page 53</p> <p>results revealed the provider failed to appropriately assess, intervene, and care plan for three of four residents with pressure ulcers.</p> <p>Review of the provider's plan of correction for their 9/11/14 recertification survey regarding pressure ulcers revealed:</p> <ul style="list-style-type: none"> <li>*All nursing staff would be re-educated on pressure ulcer prevention, care planning, and treatment including contributing factors.</li> <li>*A certified wound care nurse would be hired within the next sixty days.</li> <li>*A weekly wound care committee was started to include the MDS case managers, DON, the certified wound care nurse, and the consultant registered dietician to review all residents at risk for weight loss and or wound management needs.</li> <li>*At monthly quality assurance and performance improvement meetings, the certified wound care nurse would provide a report, on a continuous basis, on pressure ulcer incidence, and effectiveness of current treatments and prevention program.</li> </ul> <p>Surveyor: 33488<br/>Interview on 6/17/15 at 8:15 a.m. with the administrator regarding audits performed as part of the plan of correction from the 9/11/14 survey related to pressure ulcer prevention revealed:</p> <ul style="list-style-type: none"> <li>**A certified wound care nurse will be hired within the next sixty days."</li> <li>*There was no certified wound care nurse hired as directed.</li> <li>*He was unsure why that had not been done.</li> <li>*He agreed they had not followed the plan of correction as stated by hiring a certified wound care nurse.</li> </ul> | F 314  |   | 7-16-15   |

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

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>435039</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>06/17/2015</b> |
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| F 314 | <p>Continued From page 54<br/>Surveyor: 32333<br/>Review of the provider's revised March 2013 CNA's job description revealed:<br/>**"Provides, completes and documents, if applicable, resident care as assigned in a timely and accurate manner."<br/>*Examples of resident care included provides personal care in eating, dressing, hair and body care, communication, toileting, bathing, and oral care.<br/>**"Reports changes in resident's condition immediately to the Staff Nurse."<br/>**"Responds to request from residents for assistance in a respectful and timely fashion. Answers call lights promptly."<br/>**"Communicates suggestions or concerns from residents, other staff, visitors or others to the Staff Nurse in a timely, factual and accurate manner."</p> <p>Review of the provider's undated LPN job description revealed:<br/>**"Assesses, plans, implements, evaluates plan of care for residents."<br/>**"Make changes on the plan of care as necessary."</p> <p>Review of the provider's undated RN job description revealed "Assesses, plans, implements, evaluates plan of care for residents.</p> <p>Review of the provider's September 2011 Standard Operating Procedure Skin Assessments revealed:<br/>**"To monitor residents known to have history of or be at risk of pressure ulcers or have skin breakdown."<br/>**"All staff are aware of need to notify a nurse concerning any resident's skin concerns."</p> | F 314 |  | 7-16-15 |
|-------|---|-------|--|---------|

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

PRINTED: 07/01/2015  
FORM APPROVED  
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| F 314   | Continued From page 55<br>**Staff nurse will perform skin assessments with measurements on a weekly basis."  | F 314  |   |                      |   |
| F 323<br>SS=H   | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 32333<br>Based on observation, interview, record review, and policy review, the provider failed to ensure interventions and safety measures were in place for:<br>*Three of three sampled residents (17, 18, and 19) who had falls and had been discharged from the facility.<br>*Two of eight sampled residents (25 and 27) who had falls.<br>Findings include:<br><br>1. Review of resident 17's closed medical record with a 12/21/14 post fall risk assessment that was to be completed immediately after a fall revealed:<br>*She was in the bath chair in the bath house.<br>*As the nurse entered the room the resident lifted the arm of the chair and slid out onto the floor.<br>*She hit her head on the floor.<br>*The environmental factors that contributed to the fall were it was wet, and there was no safety belt on the chair. | F 323  | The facility fall policy and protocol was revised on 7/6/15. All CNAs/Medication Aides and nurses will be educated by the DON and/or designee on the new fall policy and protocol on July 14-15, 3015. Residents #17 and #19 have expired. Resident #18 was transferred to another facility. Residents #25 and #27 were assessed by the Fall Risk Team (cross section of various departments) on 7/9/15. Interventions were implemented for each of them during that meeting and updated to their care plan. The Fall Committee will meet weekly for one month, then monthly for three months to assess need for fall interventions on all residents in facility with identified fall risks from admission, quarterly, and annually. Interventions will be implemented and individualized if necessary for those residents as well. Audits will be conducted weekly for 1 month and then monthly for 3 months on residents #25 and #27 along with 10 random audits to monitor for fall intervention compliance. The DON and/or designee will be responsible for conducting assessment audits and for overall compliance. Audit findings will be reported by the DON and/or designee at the monthly QAPI meeting for 1 year as deemed necessary by the QAPI committee. | 7-16-15              |   |

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

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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| F 323   | Continued From page 56<br>*The resident's cognitive (mental) status was alert and confused.<br>*No available safety belt on the bath chair.<br><br>Review of resident 17's interdisciplinary progress notes revealed:<br>*A nursing note on 12/21/14 at 11:00 a.m. noted the following:<br>-The nurse was called into the bath house to do a skin assessment on the resident.<br>-Upon entering the room the resident lifted the side arm on the bath chair and fell out onto the floor landing face first.<br>-The resident was rolled to her back.<br>-Small amount of blood noted on her nose.<br>-Left eye was swollen and bruised.<br>-Bruising noted to right hand.<br>-No complaints of pain noted.<br>-Two staff returned the resident to bed.<br>*A post-fall nursing note on 12/22/14 at 2:00 p.m. noted:<br>-Vital signs (basic indicators of body function) and neurological (neuro) assessments noted to be completed.<br>-No change to left eye bruising, and no further injury noted.<br>-Will continue to monitor for any changes in level of consciousness (awareness) (LOC) or any further injuries.<br>*A post fall nursing note on 12/22/14 at 9:00 p.m. noted:<br>-Vital signs were taken and documented.<br>-Left eye was bruised, but no other injuries noted.<br>-Resident denied pain.<br>-Would continue to monitor for any changes in LOC.<br>*A post fall nursing note on 12/23/14 at 10:45 p.m. noted:<br>-Continued to have bruising to left eye and right | F 323  | All facility bath chairs were assessed on July 7, 2015 by the maintenance department to ensure they are in good repair and that they all have seat belts that are in good working order and are manufacturer recommended. DON and/or designee provided training to CNA's OO and GG on 6-12-15 during the survey. All nursing care staff will be educated regarding the required use of seat belts for bath chairs between July 14-15, 2015.<br>Each whirlpool tub chair will be included on the Monthly Preventative Maintenance Log to ensure the chairs have proper seat belts and are in operational condition. Five random audits will be conducted by the Clinical coordinators weekly for 1 month and monthly for 1 year for CNA's performing baths using the whirlpool tub chairs with proper usage of seat belts.<br>The DON and/or designee will bring the audits on a monthly basis to the QAPI committee meeting for a period of 1 year and then as deemed necessary by the QAPI committee. | 7-16-15              |   |

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

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FORM APPROVED  
OMB NO. 0938-0391

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| F 323  | <p>Continued From page 57 hand.</p> <p>- "PEARL [PERRLA (pupils equal, round, and reactive to light, accommodate)] neuro assessments WNL [within normal limits]."</p> <p>- Vital signs were taken and noted.</p> <p>*A nursing note on 12/24/14 at 9:46 a.m. noted:</p> <p>- The resident's lung sounds did not sound good.</p> <p>- A fax was sent to the doctor to see what he would like them to do.</p> <p>- The resident was on 2 liters of oxygen and a nebulizer treatment was completed with no change to lung sounds.</p> <p>*A nursing note on 12/24/14 at noon noted a fax received from the physician that it was ok to send the resident to the emergency room (ER).</p> <p>*A nursing note on 12/24/14 at 12:05 p.m. revealed Sioux Falls wheel chair express picked up the resident and took her to Avera ER.</p> <p>*A nursing note on 12/24/14 at 3:00 p.m. written by MDS care manager L noted:</p> <p>- She reviewed the resident's fall from 12/21/14.</p> <p>- The resident was in the shower room in the bath chair.</p> <p>- The resident lifted the side arm on the bath chair and fell out onto the floor.</p> <p>- The resident landed face first onto the floor.</p> <p>- Her left eye was bruised and swollen, and her right hand was bruised.</p> <p>- The resident was instructed not to lift the arm on the chair.</p> <p>- The staff were instructed not to leave the resident unattended during her bath.</p> <p>- After further review it was determined there was not evidence of abuse or neglect with the above fall.</p> <p>*A late entry nursing note on 12/26/14 at 10:00 p.m. revealed:</p> <p>- The resident was admitted to Avera.</p> <p>- Her diagnoses were multiple rib fractures and a</p> | F 323  |   | 7-16-15   |

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

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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| F 323  | <p>Continued From page 58</p> <p>left clavicle fracture.</p> <p>-She had a hospice consult on 12/26/14.</p> <p>*A nursing note on 12/26/14 at 12:35 p.m. noted:<br/>-"Two broken vertebrae [bones in the spine] that are old!"</p> <p>-"She stated she is not upset with anyone."</p> <p>*A readmission to the facility nursing note on 12/28/14 stated:<br/>-Readmission diagnoses were trauma, multiple rib fractures, and a clavicle (curved bone at the root of the neck) fracture.</p> <p>*A nursing note on 12/30/14: A fax was sent to the physician asking for a hospice order.</p> <p>*A nursing note from 1/1/15 stated the resident was found at 5:45 p.m. without vital signs.</p> <p>Review of Avera McKennan Hospital and University Center's medical records for resident 17 revealed:<br/>*Emergency room visit notes:<br/>-Date of service was 12/24/14.<br/>-Her chief complaint was difficulty breathing.<br/>-The report from her daughter was she was sitting after getting out of the shower, she slipped out of her chair, falling onto her left side.<br/>-That had happened four days ago.<br/>-The nursing home had noticed she has had breathing difficulty since then.<br/>-She did complain of pain to her left shoulder.<br/>*The emergency department course and plan:<br/>-She had a fall four days ago with now difficulty breathing and some significant chest wall tenderness.<br/>-An x-ray was obtained.<br/>-The resident was noted to have multiple left rib fractures.<br/>-She also had a clavicular fracture.<br/>*She was admitted on to the trauma service on 12/25/14.</p> | F 323   |   | 7/16/15              |   |

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

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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| F 323 | <p>Continued From page 59</p> <ul style="list-style-type: none"> <li>-She presented in the emergency department from the nursing home with shortness of breath and wheezing.</li> <li>-In the transfer information it did not mention anything about a recent fall.</li> <li>-Upon evaluation it was evident the resident had some sort of trauma with bruising to her left shoulder, chest, and eye.</li> <li>-Further discussion demonstrated was she might have fallen either yesterday versus three days ago.</li> <li>-Reports were inconsistent.</li> <li>-She described she felt very confused and that was not normal for her.</li> <li>-She described diffuse (widespread) pain.</li> <li>-The chest x-ray showed multiple displaced rib fractures on the left side, and the left clavicle fracture.</li> <li>-It was unclear of the events that lead up to this, with a left clavicle fracture, multiple left rib fractures, on 3 liters of oxygen, bruising to the left eye, and some pelvic tenderness.</li> <li>*On 12/25/14 diagnostic test results showed the left second, third, fourth, fifth, sixth, seventh, ninth, and tenth ribs were fractured both anteriorly and posteriorly forming a "flail segment."</li> <li>*She was discharged back to the nursing home on 12/28/14 with the following diagnoses that included but not limited to:             <ul style="list-style-type: none"> <li>-Fall from "standing height."</li> <li>-Multiple left rib fractures.</li> <li>-Left clavicle fracture.</li> <li>-Hypoxia (inadequate oxygen supply).</li> </ul> </li> </ul> <p>Review of resident 17's 7/3/14 care plan for falls/psychotropic (mind-altering) drug use revealed:<br/>*It had been updated on 12/21/14 with her fall from the bath chair.</p> | F 323 |  | 7-16-15 |
|-------|---|-------|--|---------|

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

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FORM APPROVED  
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| F 323  | <p>Continued From page 60</p> <p>*She was reminded not to lift her arm up while she was in the bath chair.</p> <p>*She was not to be left unattended while in the bath.</p> <p>*She had a history of falls and was taking psychotropic medication that increased her risk for falls.</p> <p>Observation and interview on 6/11/15 at 11:00 a.m. with CNA D who was the bath aide that day revealed:</p> <p>*She was not using a seat belt on the bath chair.</p> <p>*There was no seat belt for the bath chair, she did not use anything to secure the residents in the bath chair.</p> <p>*Most residents could support themselves in the bath chair.</p> <p>*She remembered there being a seat belt probably back in April 2015, but she had not used one since then.</p> <p>*She worked at the facility as needed.</p> <p>Interview on 6/11/15 at 12:05 p.m. with Minimum Data Set care manager L revealed she had not seen a seat belt for the bath chair.</p> <p>Interview on 6/11/15 at 12:35 p.m. with CNA J who usually worked full-time as a bath-aide (but not on 6/11/15) revealed she had been using a seat belt when she bathed residents. The seat belt was ordered because of resident 17's fall out of the bath chair.</p> <p>Review of the 12/30/14 Penner Patient Care, Incorporated invoice revealed a seat belt had been ordered for the bath chair.</p> <p>Review of the Penner Manufacturing Cascade Patient Transfer Lift System Safe Operations and</p> | F 323   |   | 7-16-15              |   |

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

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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| F 323 | <p>Continued From page 61</p> <p>Daily Maintenance Instructions revealed on page 9 for the bath chair "WARNING Failure to secure the resident properly with the seat belt could result in injury to the resident or operator."</p> <p>Review of the revised October 2010 Shower/Tub bath policy revealed:<br/>*Never leave the resident unattended in the tub or shower.<br/>*No mention of the use of the seat belt for the bath chair.</p> <p>Interview with the director of nursing and administrator on 6/16/15 at 2:25 p.m. revealed:<br/>*They had ordered a seat belt after resident 17's fall from the bath chair.<br/>*They would have expected the CNAs that were giving baths to have used the seat belt for all baths.</p> <p>Surveyor 32333<br/>2. Review of resident 19's complete medical record revealed:<br/>*He was admitted on 2/16/15.<br/>*He was at high risk for falls.<br/>*His fall risk assessment score was sixteen.<br/>*His fall risk assessment report stated any score ten or greater to initiate the following:<br/>-Initiate falling star program.<br/>-Write on nursing Kardex, care plan, and pocket care plan.<br/>-Initiate other safety measure as appropriate.<br/>*His 2/16/15 nursing Kardex revealed no mention of falls or interventions for falls.<br/>*On 2/17/15 he had a fall with the following noted:<br/>-Nursing heard someone yelling for help.<br/>-He was found on his floor by his bed.<br/>-He complained of left hip pain and was unable to move his left leg.</p> | F 323 |  | 7-16-15 |
|-------|---|-------|--|---------|

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

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| F 323  | <p>Continued From page 62</p> <p>-He was sent by ambulance to the emergency department.</p> <p>-He was admitted to the hospital with a left hip fracture.</p> <p>Review of the provider's addendum to their final report for resident 19's 2/17/15 event revealed on 2/24/15 staff noted an obituary for him. He had died on 2/21/15.</p> <p>Surveyor: 14477</p> <p>3. Review of resident 18's closed medical record revealed:</p> <p>*An admission date of 7/3/14 with diagnosis of cerebral palsy, mental retardation, diabetes, and several others.</p> <p>*The 7/3/14 Fall Risk Assessment showed a score of 12 (score greater than 10 = high risk for falls).</p> <p>*The 7/14/14 care plan stated he had used a wheel chair for mobility and wanted it tilted.</p> <p>*The 7/15/14 care conference note indicated the family was concerned the resident would slide out of the wheelchair. He had his own wheelchair with a seat belt. The "resident unable to release the seat belt and is thus considered a restraint."</p> <p>*A 7/15/14 faxed request from therapy to the resident's physician requested "OT, PT, and ST [Occupational Therapy, Physical Therapy, and Speech Therapy] evaluations and treatment orders to address seating safety..."</p> <p>*On 9/17/14 at 11:15 a.m. the Interdisciplinary Progress Notes stated the resident was found by a certified nursing assistant (CNA) "setting on floor in room in front of assistive chair - no injury noted on assessment. Assistive chair not tilted appropriately - res [resident] slid out of chair onto floor."</p> | F 323   |   | 7-16-15              |   |

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

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>435039</b>  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                               |   | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>06/17/2015</b> |
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| F 323  | <p>Continued From page 63</p> <p>*On 9/24/14 at 1:30 p.m. the Interdisciplinary Progress Notes stated the resident's fall of 9/17/14 had been reviewed. It was noted the assistive chair was not tilted appropriately. Staff were reminded to place the assistive chair in the appropriate position. "No injuries were noted and no evidence of abuse."</p> <p>*On 3/1/15 at 10:00 a.m. a fax was sent to the physician stating the resident had a scratch to the left side of his nose. An antibiotic ointment was ordered to use on the nose, and an antibiotic via the G-tube (a tube inserted directly into the stomach to provide nutrition) was also ordered.</p> <p>*On 3/1/15 at 1:00 p.m. on the Interdisciplinary Progress Notes by nursing stated "Resident's sister was here and noticed bridge of nose is swollen and left eye sclera [whites of eye] is red and yellow."</p> <p>*A 3/2/15 Sanford Hospital dictation stated the patient reported a fall with bleeding. "A large scratch across the left bridge of nose and a little bit of ecchymosis [reddening] right at the corner of his eye so it suggests that there was probably a fall or injury." An X-ray showed no fracture.</p> <p>*A documented interview on 3/5/15 with the resident's sister revealed the physician had stated the resident had facial trauma. When she had asked the provider what had happened to his face, the administrator and DON told her they did not know, and that they were short staffed.</p> <p>Surveyor: 32335<br/>4. Review of resident 25's 2/11/15 care plan revealed:<br/>*From 9/1/14 through 3/14/15 she had forty falls.<br/>*The following interventions had been implemented:<br/>-On 9/4/14 "Attempt to engage in activities when up", and they had obtained a floor mat to place</p> | F 323  |   | 7-16-15   |

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

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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| F 323   | <p>Continued From page 64<br/>beside her bed.<br/>-On 9/8/14 "Will do frequent observations."<br/>-On 9/21/14 "Let resident wake up on own accord in AM."<br/>-On 9/29/14 "Offer food monitor freq [frequently]."<br/>-On 10/1/14 "keep around nurse's station when out of room for easier observation, and toileting every 2 hours while awake and prn."<br/>-On 10/10/14 "Will ambulate with restorative [therapy to help restore function] daily."<br/>-On 10/23/14 "Toilet between 0500-0600 [5:00 a.m.-6:00 a.m.] Q [every] AM."<br/>-On 10/29/14 "New cushion for w/c [wheelchair] per O.T. [occupational therapy]."<br/>-On 11/5/14 "Will add toilet at 0001 [12:01 a.m.]. Ambulate at least two times per day and prn [as needed]."<br/>-On 11/15/14 "Will start toileting program."<br/>-On 11/17/14 "Start falling stars program and toileting program. Monitor every 15 minutes."<br/>-On 11/20/14 "Trial of new voice activated bed/chair alarm."<br/>-On 1/7/15 "Pommel cushion (helps prevent forward sliding) applied to chair."<br/>-On 1/8/15 "Try music therapy with headphones."<br/>-No other interventions had been documented after 1/8/15.</p> <p>Interviews and record review revealed resident 25 had skin breakdown to her bottom due to incontinence. There was no documentation the toileting interventions above had been followed. Refer to F309, finding A1.</p> <p>Interview on 6/17/15 at 8:15 a.m. with the director of nursing revealed she did not know resident 25 and directed me to speak with Minimum Data Set (MDS) case manager X. MDS case manager X stated they put several interventions in place and</p> | F 323  |   | 7/16/15              |   |

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

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |   |   |   |
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| F 323  | Continued From page 65<br>referred to the care plan. All of the documentation regarding the fall interventions was requested.<br><br>Interview and record review on 6/17/15 at 10:20 a.m. with the director of nursing after she had brought the above requested information revealed:<br>*The activities documentation for resident 25 had only included information from 3/17/15 through 6/16/15.<br>*There was no documentation regarding the frequent observations and monitoring every fifteen minutes.<br>*There were no other interventions put in place.<br><br>Surveyor: 35625<br>5. Record review of resident 27's medical record revealed:<br>*He had a Brief Interview for Mental Status (BIMS) assessment score of fifteen out of fifteen indicating no cognitive impairment.<br>*Three falls had been documented since November 2014.<br>*A fall occurred on 11/5/14 with the following noted:<br>-Resident found on floor<br>-He had leaned over to reach for an object and slid out of the wheelchair.<br>-He was not injured in the fall.<br>-Staff encouraged him to use the call light when he needed assistance.<br>-No documentation was provided that indicated additional interventions were put into place to prevent future falls.<br>*A fall occurred on 1/18/15 and noted:<br>-The resident used the call light to request staff assistance after he had fallen.<br>-He attempted to transfer himself from the wheelchair to bed with no staff assistance. | F 323   |   | 7-16-15   |

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

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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| F 323 | <p>Continued From page 66</p> <ul style="list-style-type: none"> <li>-He was not injured in the fall.</li> <li>-Staff encouraged the resident to ask for assistance and use the call light.</li> <li>-Follow-up documentation stated the resident would like to have physical and occupational therapy reevaluate him.</li> <li>-There was no documentation a physical or occupational therapy consultation had been ordered after it was requested.</li> <li>-No additional documentation was provided up to the end of survey that indicated additional interventions were put into place to prevent future falls.</li> <li>*A fall occurred on 4/28/15 and noted:             <ul style="list-style-type: none"> <li>-Resident was found on the floor</li> <li>-He had slid out of his wheelchair while trying to place his urinal on a table.</li> <li>-He was not injured in the fall.</li> <li>-Education was provided regarding the use of the call light for assistance.</li> <li>-No documentation was provided up to the end of the survey that indicated additional interventions were put into place to prevent future falls.</li> </ul> </li> <li>Interview on 6/16/15 at 3:50 p.m. with resident 27 regarding the above falls revealed:             <ul style="list-style-type: none"> <li>*He acknowledged he "wasn't thinking" prior to each of the falls.</li> <li>*Staff frequently reminded him to use the seatbelt on his motorized scooter.</li> <li>-He demonstrated he was able to unbuckle the belt without assistance.</li> <li>-Verbalized he had been using the seatbelt for approximately one month.</li> <li>*He had a tool that allowed him to grasp objects that were out of arms reach.</li> <li>-The facility had replaced the tool sometime during the winter, because the old one was broken.</li> </ul> </li> </ul> | F 323 |  | 7-16-15 |
|-------|---|-------|--|---------|

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

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

|   |  |  |   |                      |   |
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| F 323   | Continued From page 67<br>*Staff frequently reminded him to use his call light when he needed assistance while in his room.<br><br>Interview on 6/16/15 at 4:15 p.m. with registered nurse (RN) Y revealed:<br>*Staff had been instructed to keep items including his call light within reach.<br>*Safety was reinforced with the resident after each fall.<br>*Staff observed the resident more often and estimated it was at an interval of approximately every hour.<br>*No documentation was provided to support the statement the resident had been observed at regular intervals.<br><br>6. Review of the provider's 2001 Falls and Fall Risk, Managing policy revealed:<br>*Initial approaches could have included exercise or balance training, rearrangement of room furniture, or medication adjustments.<br>*If falling reoccurred despite initial interventions staff should have implemented additional or different interventions, or indicated why the current approach remained relevant.<br><br>Review of the provider's revised December 2007 Falls and Fall Risk, Managing policy revealed "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling." | F 323  |   | 7-16-15              |   |
| F 325<br>SS=E   | 483.25(j) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE<br><br>Based on a resident's comprehensive assessment, the facility must ensure that a  | F 325  |   |                      |   |

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| F 325   | Continued From page 68<br>resident -<br>(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<br>(2) Receives a therapeutic diet when there is a nutritional problem.<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 14477<br><br>Surveyor: 33265<br>Surveyor 14477<br>Based on observation, interview, and record review, the provider failed to ensure accurate weights were consistently monitored and recorded in a central document and the dietary team was notified of significant weight changes for 2 of 2 sampled residents (1 and 10) with weight concerns.<br><br>1. Review of resident 1's entire medical record revealed:<br>*An admission date of 5/19/15.<br>* He was receiving tube feedings (receiving nutrition directly through a tube inserted into the stomach).<br>*Was NPO (nothing by mouth).<br><br>Review of his weight logs revealed his weight in pounds:<br>*May 2015:<br>-140.6 on 5/20 (day after admission)<br>-150.2 on 5/26<br>-149.6 on 5/27 | F 325  | The facility policy for weighing and measuring a resident was updated on July 8, 2015 to include communication of weight variances to the nurse, dietitian, physician and family to ensure proper follow-up and/or further evaluation. Education for all nursing staff regarding this new policy and procedure for weighing will be done by the DON and/or designee on July 14, 2015.<br>Resident #1 has expired. Resident #10's treatment record has been updated to include the daily weight section to ensure the nurse verifies that #10's daily weight has been obtained and assessed by the nurse.<br>All other residents in the facility on daily weights will have this category added to their treatment records by July 14, 2015.<br>For residents on weekly weights, a new facility bathing/weight sheet has been created to ensure that the weekly weights are obtained, recorded, and compared to the previous weight. The weight is also documented in Caretracker. Audits will be conducted weekly x 1 month and then monthly x 3 months to ensure that resident #10 and #5 random residents on daily weights have had their daily weights taken and documented. Audits will be conducted weekly x 1 month and then monthly x 3 months on 5 random residents on weekly weights to ensure that their weekly weights have been taken and documented appropriately.<br>The DON and/or designee will be responsible for conducting audits and for overall compliance. The DON and/or designee will report audit finding to QAPI meetings for one year and as deemed necessary by QAPI committee. | 7-16-15              |   |

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

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

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| F 325   | <p>Continued From page 69</p> <p>-151.8 on 5/30<br/>*June 2015:<br/>-152.7 on 6/1<br/>-153.8 on 6/2<br/>-154.1 on 6/3<br/>-154.6 on 6/4<br/>-156.2 on 6/5<br/>-155.2 on 6/6<br/>-156.2 on 6/7<br/>-157.4 on 6/8</p> <p>Observation on 6/9/15 at 9:50 a.m. of resident 1 being weighed revealed his weight in his wheelchair with peddles on was 218.4 pounds. The weight sheet indicated the wheelchair weight was 61.2 pounds with peddles on. The recorded weight was 156 pounds on the weight log sheet. The correct weight on the log sheet should have been 157.2 pounds.</p> <p>Review of resident 1's 6/9/15 swallow study revealed he had been allowed to start taking foods by mouth that day. His weights following that study were:<br/>*159.2 on 6/10<br/>*160.0 on 6/11<br/>*161.0 on 6/12<br/>* No weight had been documented on 6/13<br/>*168.0 on 6/14<br/>*172.4 on 6/15<br/>*178.4 on 6/16</p> <p>Review of the weight log sheet instructions stated "if the weight differs by 5# [pounds], please re-weigh."</p> <p>Review of the provider's policy entitled "Tracking Weight Changes" revealed under Procedure #5: "The RD (registered dietician) or designee will be</p> | F 325  |   | 7-16-15              |   |

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

PRINTED: 07/01/2015  
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OMB NO. 0938-0391

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| F 325 | <p>Continued From page 70</p> <p>notified of any individual with an unplanned significant weight change of 5% [percent] in one month, 7.5% in three months, or 10% in six months."</p> <p>Review of resident 1's weight records revealed he had a greater than 10% weight gain in 28 days. No documentation was found regarding:<br/>*Any reweights done for differing weights of greater than five pounds.<br/>*If the RD had been notified of the 6/9/15 change from NPO to eating by mouth in addition to the tube feeding.</p> <p>Surveyor: 33265<br/>2. Review of resident 10's complete medical record revealed:<br/>*Four different documents on which weights were to have been recorded.<br/>-Daily weights were to have been written in by hand for a month at a time.<br/>-Weekly weights were to have been written in by hand for an entire year.<br/>-Monthly weights were to have been written in by for a two year period. The day of the month the weight was to have been done was not recorded.<br/>-A computer print out form of weights had been entered into the computer documentation system.<br/>*The resident had weights recorded on all four types of weight records. None of the forms were complete.<br/>*On the daily weight form for February 2015 there was notation the resident was to "start daily weights on 2/13/15."<br/>-There were 3 daily weights missing for that month.<br/>*The daily weight form for March 2015 had not had the month or year filled in. There were:<br/>-Three weights documented for the entire month</p> | F 325 |  | 7-16-15 |
|-------|--|-------|--|---------|

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

PRINTED: 07/01/2015  
FORM APPROVED  
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| F 325         | <p>Continued From page 71 and twenty-eight daily weights missing.<br/>*The daily weight form for April 2015 also had "daily wts" (weights) written in on the form.<br/>-Seven days had no weight recorded.<br/>*The daily weight form for May 2015 had seven daily weights missing for the month.<br/>*Daily weights were listed on the June 2015 Treatment Administration Record. The first two days of the month were blank.</p> <p>Interview and record review including surveyor 32331 on 6/16/15 at 5:00 p.m. with the director of nursing (DON) and the administrator revealed the DON:<br/>*Believed the daily weights had been discontinued.<br/>*Stated she had not known of the existence of one of the four different weight documents.</p> <p>Continued review of the weight documentation revealed:<br/>*There was a ten pound weight loss between 3/24/15 and 4/2/15. No re-weight was noted.<br/>*There was an eight pound weight loss between 5/15/15 and 5/16/15 with the note "reweigh" written after the 5/16/15 weight. No weight was done for the next two days.</p> <p>Review of the provider's 11/10/09 Weight and Height Policy and Procedure revealed a reweigh was to be done for any five pound weight change from previous weight.</p> | F 325 |  | 7-16-15 |
| F 353<br>SS=H | <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental,</p>  | F 353 |  |         |

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

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| F 353 | <p>Continued From page 72 and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>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:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Surveyor: 32331<br/>Surveyor: 32333<br/>Surveyor: 32335<br/>Based on observation, interview, record review, job description review, and policy review, the provider failed to ensure sufficient nursing services were provided to meet all aspects of resident care needs. Findings include:<br/>Surveyor: 32333<br/>1. Group interview on 6/9/15 at 3:15 p.m. with fifteen residents in attendance revealed it was a group consensus:<br/>*They were short staffed.<br/>*The staffing shortage was mostly in the evenings</p> | F 353 | <p>The call light time log for the bed and toilet will be pulled for resident #24 and all other residents on a weekly basis by the Administrator. Results to be given to the DON and Clinical coordinators for trend analysis. The call light monitoring device is operational and has been adjusted to prevent turning the device off.</p> <p>A username and password of the EMR was given to Dr V on 6-23-15 by the Administrator when Dr. V requested it on 6-23-15 to the Director of Medical Records.</p> <p>The greatest identified need of staffing was identified as 6 AM – 10 AM and 4 PM-9PM shift for CNAs. The facility continues to offer very competitive wages for CNAs and nurses. The facility continues to recruit on Indeed.com, Keloland.com and speak at the CNA and nurse classes at Southeast Votech and North American University. The facility instituted the use of an online scheduling program called "Schedule Anywhere" to enable all nursing staff to view their schedule online, pick up open shifts, etc.</p> <p>The facility is in the process of starting a CNA preceptor program under the direction of the DON and/or designee with the goal of retaining new hires. The facility will ask 3 nursing staff employees per month to attend the monthly QAPI meeting to solicit their assistance in identifying trends and participate in subcommittees to ask for their ideas for solutions to those trends.</p> | 7-16-15 |
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| F 353  | <p>Continued From page 73 and overnights.</p> <p>*Sometimes there was only one CNA on duty in a wing to answer the call lights.</p> <p>*Sometimes there was only one nurse for center hall and east hall.</p> <p>*It had taken an hour or an hour and a half to answer call lights.</p> <p>*Resident 24 said he has had to lay in bed and wait to get up in the mornings because there was not enough staff to assist him.</p> <p>Surveyor: 32335<br/>2. Interview on 6/16/15 at 1:15 p.m. with the administrator revealed they were unable to provide call light logs from 5/13/15 to the present. The computer that had the call light software installed on it had been accidentally turned off. He had been getting an error message for approximately the past 3 weeks and was unable to get any reports. They had realized it had been turned off after this surveyor had requested the data earlier that morning.</p> <p>Surveyor:33488<br/>3. Interview on 6/9/15 at 9:20 a.m. with Dr. V revealed:<br/>*He had no access to the electronic medical record (EMR) nursing notes or dietary notes.<br/>*He had been waiting "a long time for my access" from the facility.<br/>*He had to "hunt down a nurse if I want to know about my residents."<br/>*No nurse was available to assist him when he made rounds.<br/>*He would "have to do my best" with the information he had received.<br/>*"They don't have enough staff for that." in regards to sending a nurse with him when he visited residents.</p> | F 353   | <p>The call light time log for the bed and toilet will be pulled weekly for all residents by the Administrator and/or designee. Results to be given to the DON and Clinical coordinators for trend analysis to indicate halls that need additional staffing. The results of the weekly call light times will be provided by the Administrator to the monthly QAPI meeting for 1 year and then as deemed necessary by the committee.</p> <p>The administrator will give a job satisfaction survey to 10 random employees per month to look for trends. The results will be shared with the Monthly QAPI meeting for 1 year and then as deemed necessary by the committee.</p> | 7-16-15              |   |

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

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| F 353 | <p>Continued From page 74</p> <p>"I will be here until 12:30 I bet. It is slow without a nurse."</p> <p>4. Interview on 6/16/15 at 9:38 a.m. and at 2:35 p.m. with the staff coordinator revealed:<br/>*She was responsible for coordinating the nursing staff schedule.<br/>*She prepared a new nursing schedule every six weeks.<br/>-There were many changes to that above schedule after it had been posted.<br/>*The day of each week that had been the hardest to fill was on Sunday.<br/>*The evening shift from 2:00 p.m. until 6:30 p.m. and until 10:30 p.m. were the more difficult ones to have filled.<br/>*There were many changes to the schedule after it had been posted.<br/>*She stated there were challenges with the staffing schedule.</p> <p>Interview on 6/16/15 at 5:15 p.m. with the administrator and the director of nursing revealed they both agreed there were challenges with the staffing schedule.</p> <p>Surveyor: 32335</p> <p>5. Review of the provider's April 2013 director of nursing (DON) job description revealed she:<br/>*"Monitors the nursing staff to maintain sufficient staff to provide quality care for the residents."<br/>*Was "Responsible for making sure that there is adequate staff in number and ability to maintain the highest practicable level of physical, mental, and psychosocial well-being for each resident that meets the state and federal regulations."</p> <p>6. Interviews, observations, record review, and policy review throughout the course of the survey</p> | F 353 |  | 7-16-15 |
|-------|---|-------|--|---------|

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

PRINTED: 07/01/2015  
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| <p>F 353</p> <p>F 441<br/>SS=F</p>                                       | <p>Continued From page 75<br/>from 6/8/15 through 6/11/15 and from 6/16/15 through 6/17/15 revealed the provider failed to ensure resident needs were met. Refer to F309, F314, F323, F325, and F441.</p> <p><b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b></p> <p>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.</p> <p>(a) Infection Control Program<br/>The facility must establish an Infection Control Program under which it -<br/>(1) Investigates, controls, and prevents infections in the facility;<br/>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br/>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection<br/>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br/>(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.<br/>(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.</p> <p>(c) Linens</p> | <p>F 353</p> <p>F 441</p>  | <p>The QAPI policy and procedure reviewed and revised to include monthly and more in-depth meetings on 7-09-15.</p> <p>The facility's Infection Control Nurse began her duties on 7-9-2015. She was given a copy of the facility's updated Infection Control Manual to review on 7-9-2015. Employee C is the designated infection control nurse and will train with the Infection Control Nurse of a sister facility on July 15, 2015. The Infection Control Nurse will conduct surveillance, prevention, control, and reporting as necessary. This will include random audits of the components of Infection Control. The Infection Control Nurse will participate in continued education of Infection Control programs and policies.</p> <p>The DON will educate all staff between July 14-15, 2015 as to where the Infection Control Manual is located on the facility and on what type of material is included in it.</p> <p>The facility's "Cleaning and Disinfecting Equipment" policy was revised on July 8, 2015, to include the proper cleaning of the blood Glucometer machines between residents.</p> | <p>7-16-15</p>  |

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

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| F 441 | <p>Continued From page 76</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Surveyor: 34030</p> <p>Surveyor: 14477</p> <p>Surveyor: 33265<br/>Surveyor 33265</p> <p>A. Based on observation, interview, record review, and policy review the provider failed to implement and promote consistent adherence to infection control practices by having a functioning Infection Control Program with appropriate oversight. Findings include:</p> <p>1. Interview and record review on 6/10/15 at 2:25 p.m. to 2:55 p.m. with infection control nurse revealed:<br/>*She had accepted the position of infection control nurse one month ago.<br/>*She had no specialized training or additional training for infection control.<br/>*The interim director of nursing was here at that time and was going to assist in her training, but that had not happened.<br/>*There had been no infection control report at the last QA (quality assurance) meeting as she had not been trained on the task.<br/>*She was not aware of or involved in any training on infection control for new employees.<br/>*She was not aware of any training on infection</p> | F 441 | <p>All of the facility Blood Glucometer machines are cleaned according to manufacturer's instructions. Audits will be conducted weekly x 1 month and monthly x 3 months on resident #59 and #10. Audits will also be performed on 5 other random residents who require the use of Blood Glucometers by the DON and/or designee. The DON and/or designee will be responsible for conducting the audits and for overall compliance. The DON will report audit findings to monthly QAPI meetings for one year.</p> <p>The facility Shower/Tub and Bath policy was revised on 7-8-2015 to include the instructions for cleaning and disinfecting the facility tubs and showers and the disinfecting procedure for each whirlpool tub will be located in each tub or shower area.</p> <p>C.N.A.'s OO and Q were educated on the proper tub and shower cleaning and disinfection procedure on 6-12-15 during the survey. All other facility staff will be educated on the tub and shower disinfection process and revised policy for each by the DON on between July 14-15, 2015. Audits will be conducted on C.N.A.'s OO and Q along with 10 other random C.N.A.'s weekly x 1 month and monthly x 3 months. Audits will be conducted by the DON and/or designee who will also be responsible for overall compliance.</p> | 7/6-15 |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

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| F 441   | <p>Continued From page 77</p> <p>control since the training that had been required due to last survey in September 2014.</p> <p>*She was not aware of any monitoring or auditing of infection control practices since completion of the monitoring/auditing required from the last survey in September 2014.</p> <p>*She agreed there was no current infection control program.</p> <p>*Her role included many other tasks besides infection control.</p> <p>*She resigned her position as infection control nurse earlier that week.</p> <p>Review of the provider's April 2013 Policies and Procedures - Infection Control document revealed:</p> <p>* The Quality Assurance Performance Improvement committee was to have been overseeing the implementation of infection control policies and practices.</p> <p>*All personnel were to have been trained on the infection control policies and practices upon their hire and periodically.</p> <p>-The amount of the employee training was to have been dependent on the time spent on direct resident contact and job responsibilities.</p> <p>*The administrator or governing board, through the QAPI committee, had adopted the policies and practices needed to prevent transmission of infections and communicable diseases.</p> <p>Interview and record review including surveyor 32331 on 6/16/15 at 5:00 p.m. with the director of nursing (DON) and administrator concerning above observations and interviews revealed the infection control nurse had resigned her position after one month.</p> <p>B. Based on observation, interview, record</p> | F 441  | <p>The DON and/or designee will be responsible for reporting audit findings at monthly QAPI meetings for one year.</p> <p>The facility policies – "Dressing Dry Clean and Dressings Soiled" – were revised on 7-8-2015. The entire nursing staff will be educated by the DON on July 14-15,2015 on these procedures. RN BB will be educated on 7-14-2015 by the DON on the proper dressing policy and procedure.</p> <p>Audits will be conducted weekly x 1 month and monthly x 3 months on RN BB and 10 other random RN's or LPN's on dressing changes. Audits will be conducted by the DON and/or designee who will also be responsible for overall compliance.</p> <p>The DON will report audit findings at monthly QAPI meetings for 1 year and then as deemed necessary by the QAPI committee.</p> <p>The facility's Shower, Tub and Bath policy was reviewed and revised on 7-6-15 to include where the cleaning and disinfection procedures will be located within the bathing and shower areas. The manufacture guidelines of disinfecting each whirlpool will be posted in each whirlpool room. CNAs OO and Q were educated on the proper procedure for cleaning and disinfection of the tubs and shower areas on 6/15/15. The entire nursing staff will be educated by the DON on July 14-15,2015 on these procedures. Audits will be conducted on CNAs OO and Q along with 5 other random audits weekly for 1 month and monthly for 1 year.</p> <p style="text-align: right;">7-16-15</p> |

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| F 441   | <p>Continued From page 78</p> <p>review, and policy review, the provider failed to follow infection control practices for the following:</p> <ul style="list-style-type: none"> <li>*Two of two randomly observed disinfections of the glucometer (a device used to measure blood sugar) in between resident use.</li> <li>*Two of two whirlpool tub disinfection procedures and one random shower disinfection procedures after resident use.</li> <li>*Two of three sampled residents (9 and 30) observed dressing changes.</li> <li>*One of one randomly observed hand hygiene practice.</li> <li>*One of one randomly observed resident ice water distribution.</li> </ul> <p>Findings include:</p> <p>Surveyor 14477</p> <p>1. Observation and interview on 6/9/15 at 11:48 a.m. revealed staff nurse D was taking resident 59's blood sugar test by doing a fingerstick and then used an Element Compact Blood Glucose Monitoring System (glucometer). After the completion of the test, staff D returned to the medication cart with the glucometer. She then:</p> <ul style="list-style-type: none"> <li>*Laid the glucometer on the top of the medication cart.</li> <li>*Stated she was putting on gloves because she couldn't stand the smell of the glucometer cleaner.</li> <li>*Put on those gloves and removed a sanitizing wipe from container.</li> <li>*Wiped the the glucometer with the sanitizing wipe for fifteen seconds.</li> <li>*Discarded the wipe and her gloves and replaced the glucometer back in the top drawer of the medication cart. A second glucometer was also in that top drawer. There were no names on either of the glucometers, and they were co-mingled in the drawer.</li> </ul> | F 441  | <p>The DON and/or designee will be responsible for conducting audits and for overall compliance. Audit findings will be reported by the DON and/or designee for 1 year and then as deemed necessary by the QAPI committee. Nurse BB will be educated on proper procedure for changing a suprapubic catheter, to include proper hand hygiene on July 14, 2015. Hand hygiene and suprapubic catheter care policies were reviewed on 7/9/15, and found to be current and accurate. All other nursing staff will be educated on these policies during the July 14-15, 2015 in-service. Dietary Aide R was educated by the CDM on 6/9/15 on facility policy for water pass. The CDM or designee will randomly monitor Dietary Staff R weekly x 4 weeks for compliance. A directed in-service was completed by the Registered Dietitian (RD) on 7/10/15 for all dietary staff with review of example and current facility policy and procedure on Resident Water Pass. A competency checklist has been completed by the CDM or designee between 7/7/15 and 7/10/15 for each dietary staff, and will be completed by the CDM annually for all dietary staff. Records to be kept in the CDM office. The Certified Dietary Manager (CDM) or designee will complete random audits will be completed weekly x 12 weeks and monthly thereafter for 9 months for continued compliance. Results to be reported by the CDM or designee monthly at the QAPI Meeting for 1 year and then until deemed by the QAPI committee for 1 year and then until deemed by the QAPI</p> | 7-16-15   |

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| F 441   | <p>Continued From page 79</p> <p>Review of the manufacturer's instruction manual in the glucometer box revealed under "Intended Use: The system is intended for self testing by persons at home, is for single patient use only, and should not be shared."</p> <p>Interview on 6/16/15 at 10:40 a.m. with RN M and unlicensed assistive personnel (UAP) W confirmed those glucometers were being used for multiple residents and were not designated for single person use.</p> <p>Review of the sanitizing germicidal disposable wipe at the above time revealed it was a premoistened wipe with a stabilized bleach solution (equivalent to a 1:10 dilution). The instructions stated it killed bacteria, fungi, and viruses. It was to have maintained a wet contact time of four minutes.</p> <p>Review of the provider's 6/20/11 "Multiple Use Glucometer Cleaning" policy and procedure revealed:<br/>           **Policy: To provide a healthful environment by reducing soil/contamination on equipment. In accordance with the CDC, Infection Control practices and manufacturer's guidelines, all multiple use Glucometer machines will be disinfected between each patient use."<br/>           ***Procedure: Disinfecting between patient use:<br/>           -After each patient use, the nurse and/or designee will disinfect the Glucometer machine with a 1:10 bleach solution wipe.<br/>           -Take extreme care not to get any liquid in the test strip and key code port of the meter.<br/>           -The glucometer should be allowed to air dry for 2 minutes prior to using again."</p> | F 441  | <p>committee. Dietary Aide R was educated by the CDM on 6/9/15 on facility policy for hand sanitation practices for dietary. The CDM or designee will randomly monitor Dietary Staff R weekly x 4 weeks for compliance.</p> <p>A directed in-service was completed by the Registered Dietitian (RD) on 7/10/15 for all dietary staff with review of example and current facility policy and procedure on Handwashing. A competency checklist has been completed by the CDM or designee between 7/7/15 and 7/10/15 for each dietary staff, and will be completed by the CDM annually for all dietary staff. Records to be kept in the CDM office. The Certified Dietary Manager (CDM) or designee will complete random audits will be completed weekly x 12 weeks and monthly thereafter for 9 months for continued compliance. Results to be reported by the CDM or designee monthly at the QAPI Meeting for 1 year and then until deemed by the QAPI committee.</p> | 7-16-15              |   |

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

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| F 441   | <p>Continued From page 80<br/>Surveyor 34030</p> <p>2. Observation on 6/9/15 at 11:05 a.m. of certified nursing assistant (CNA)/medication tech (MT) Z using the glucometer during the medication pass on the East wing revealed:<br/>*She took the glucometer into a residents room to check his blood sugar.<br/>-She stated she would use the same glucometer to check multiple residents.<br/>*After use wiped it clean with a Sani-Cloth with bleach and let it air dry.<br/>*Review of the package instructions revealed it required a contact time of four minutes to kill germs, which required the cloth to be wrapped around the glucometer to ensure contact time.</p> <p>3. Observation and interview on 6/16/15 with CNA/MT U on the East hallway medication cart revealed:<br/>*The Sani-Cloths with bleach were outdated in April 2015.<br/>*She usually used alcohol wipes to clean the glucometer as they did not always have Sani-Cloths.</p> <p>4. Observation and interview on 6/16/15 at 10:10 a.m. with RN Y on the Center hallway medication cart revealed:<br/>*The Sani-Cloths with bleach were outdated in April 2015.<br/>*She used either the Sani-Cloths or hydrogen peroxide wipes to clean the glucometer.</p> <p>5. Interview on 6/16/15 at 3:30 p.m. with the DON and administrator revealed they were unaware of what was being done to clean the glucometers but would look into it.</p> <p>Surveyor 33265</p> | F 441  |   | 7-16-15              |   |

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

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| F 441  | <p>Continued From page 81</p> <p>6. Observation and interview on 6/10/15 at 2:05 p.m. of the cleaning and the disinfection of the Center wing whirlpool tub by CNA J revealed she:</p> <ul style="list-style-type: none"> <li>*Used her bare hands.</li> <li>*Sprayed the seat of the transfer lift system with the 3M Neutral Quart (disinfectant) spray. A different cleaner was used to clean the rest of the whirlpool tub.</li> <li>*Added Penner whirlpool disinfectant cleaner solution into the bottom of the tub.</li> <li>*Used a long handled brush to scrub surfaces inside of tub with disinfectant.</li> <li>*Pulled the plug to drain out the disinfectant solution.</li> <li>*Rinsed off the long handled brush and tub immediately.</li> <li>*Wiped off seat with a dry towel.</li> <li>*The entire cleaning and disinfection of the whirlpool tub and transfer lift system took less less than three minutes.</li> <li>*CNA J stated this was how she was taught to clean and disinfect the whirlpool tub between residents use.</li> </ul> <p>Surveyor 14477</p> <p>7. Observation on 6/17/15 at 8:10 a.m. in the Warren Wing whirlpool tub room revealed a document entitled: "Warren Wing Spa/Whirlpool Disinfecting procedure." Review of those instructions revealed:</p> <ul style="list-style-type: none"> <li>**Close and lock the tub door.</li> <li>*Rinse the inside tub surfaces with the shower sprayer.</li> <li>*Spray the entire tub inside surface, including the lift chair, with an EPA [Environmental Protection Agency] approved/recommended disinfectant.</li> <li>*Using a long-handled brush, thoroughly scrub all interior surfaces of the tub and chair with the disinfectant. Let disinfectant stay on surface for</li> </ul> | F 441   |   | 7-16-15              |   |

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

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FORM APPROVED  
OMB NO. 0938-0391

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| F 441  | <p>Continued From page 82</p> <p>10 minutes (or, as recommended by the instructions on the disinfectant container).<br/>*With the shower spray, rinse the interior surfaces of the tub and lift chair thoroughly.<br/>*Visibly check that the tub was effectively cleaned during the disinfecting procedure. If not, repeat the procedure.<br/>*After the last bath of the shift, use a towel to wipe down the door and around the seal. Leave the tub door open."</p> <p>8. Observation and interview on 6/17/15 at 8:30 a.m. with certified nursing assistant (CNA) Q revealed she:<br/>*Sprayed Quat (a type of disinfectant) in each of the jets.<br/>*Sprayed the entire tub surfaces, added hot water, and waited for 10 minutes before draining the tub. Interview at that time regarding the manufacturer's direction for cleaning the whirlpool tub confirmed she was not taking each jet assembly apart for cleaning after every bath.</p> <p>Surveyor 33265</p> <p>9. Observation and interview on 6/10/15 at 4:48 p.m. on East wing in the shower room on cleaning and disinfection of the shower area after resident use with CNA Q revealed she:<br/>*Used Clorox Germicidal Bleach Spray in a spray bottle.<br/>*Sprayed the walls, the shower chair, and the floor of shower area with the bleach spray.<br/>*Used a long handled brush to go over the shower chair and the middle sections of wall surfaces.<br/>*Immediately rinsed off the walls, the shower chair, and the floor with water from the hand held shower wand.<br/>*CNA Q stated this was how she was taught to</p> | F 441   |   | 7-15-15              |   |

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

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| F 441  | <p>Continued From page 83</p> <p>clean and disinfect the shower area between resident use. She added that she would try to let it air dry before the next use if there was time.<br/>*Entire cleaning, disinfecting and rinsing off of bleach spray was completed in 3 minutes.</p> <p>Interview and record review including surveyor 32331 on 6/16/15 at 5:00 p.m. with the director of nursing (DON) and administrator concerning above observations and interviews revealed the:<br/>*DON was not aware the staff were not following the policies/procedures for cleaning of the whirlpool tubs and shower areas.<br/>*DON was not sure why two different disinfectant/cleaner solutions were used in the Center wing whirlpool tub procedure observed.</p> <p>Review of undated manufacturer's instructions for use of Clorox Bleach Germicidal Cleaners listed a five minute contact time was needed to kill all the germs listed on the label.</p> <p>Review of the provider's 10/23/12 Whirlpool/Shower Bathing Policy and Procedure revealed they were to disinfect the shower chair and the floor after each use following the manufacturer's disinfecting recommendations.</p> <p>Review of the manufacturer's instructions undated instructions on Penner Whirlpool Disinfectant Cleaner label revealed there was a ten minutes contact time (time needed for the disinfectant to kill germs) needed on nonporous (hard) surfaces of whirlpool tubs.</p> <p>Review of the 2012 manufacturer's instructions on the 3M Neutral Quat Disinfectant Cleaner label revealed:<br/>*There was a ten minutes contact time needed to</p> | F 441  |   | 7-16-15   |

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

PRINTED: 07/01/2015  
FORM APPROVED  
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| F 441 | <p>Continued From page 84</p> <p>kill the majority of germs on surfaces.<br/>*It may cause skin irritation; should avoid prolonged skin contact.</p> <p>Review of the manufacturer's 11/07/12 Cascade Aqua -Aire Whirlpool tub Instruction Manual revealed the disinfectant solution should have remained on the surfaces for ten minutes or as disinfectant manufacturer instructed on container label.</p> <p>Review of the provider's undated Cleaning of the Tub policy revealed the disinfectant Provon was to be used and only this cleaner.</p> <p>Review of the provider's 10/23/12 Whirlpool/Shower Bathing Policy and Procedure revealed:<br/>*The whirlpool tub was to have been disinfected after every use.<br/>*Staff were to follow whirlpool disinfecting procedure posted in the whirlpool room.</p> <p>Review of the provider's undated Whirlpool Disinfecting Procedure posted in the Center wing whirlpool tub room revealed the disinfectant spray was to stay on the surfaces for ten minutes or as recommended by the instructions on the disinfectant concentrate container.</p> <p>Review of undated manufacturer's instructions for use of Clorox Bleach Germicidal Cleaners listed a five minute contact time was needed to kill all the germs listed on the label.</p> <p>Review of the provider's 10/23/12 Whirlpool/Shower Bathing Policy and Procedure revealed they were to disinfect the shower chair and the floor after each use following the</p> | F 441 |  | 7-16-15 |
|-------|---|-------|--|---------|

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

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| F 441  | <p>Continued From page 85<br/>manufacturer's disinfecting recommendations.</p> <p>Surveyor 34030<br/>10. Observation and interview on 6/9/15 at 9:30 a.m. of a random resident dressing change (30) with RN P revealed:<br/>*Dressing changes were being done to sores on the resident's lower legs.<br/>*RN P placed all the supplies for the dressing change on the bare floor of the resident's room in front of the resident in her wheelchair. These supplies included:<br/>-The scissors used to cut the gauze dressings.<br/>-Ace wraps used to go over the gauze dressings to hold them in place.<br/>-A tube of ointment.<br/>-Sterile gauze dressings taken out of the package and were placed on top of the package on the floor.<br/>-A package of tube grip (netting used to keep gauze dressings in place).<br/>*She proceeded to do the dressing change and took the tube of ointment to place some on the sterile gauze, then placed the tube back on the bare floor.<br/>*After the dressing change she:<br/>-Placed the ointment into a plastic bag.<br/>-Put the scissors into her pocket.<br/>-Picked up the remainder of the unused tube grip and placed it, the scissors, and the ointment into the medication cart.<br/>*No barrier had been used between the supplies and the floor to keep them clean.<br/>*When this surveyor spoke to RN P about the above dressing change she replied she had put her supplies on the floor because there was no table in the resident's room to use and she had not thought to ask for one.</p> | F 441  |   | 7-16-15   |

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

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| F 441 | <p>Continued From page 86</p> <p>Interview on 6/16/15 at 3:30 p.m. with the DON and administrator regarding the above dressing change revealed the DON agreed this had not been done in a sanitary manner.</p> <p>Review of the provider's August 2011 Dressing Change (Routine) Policy and Procedure revealed:<br/>*"Place a barrier (towel/paper towel) between supplies and area placed on."<br/>*"Open dressings, etc remembering to keep barrier between supplies and area supplies are placed</p> <p>Surveyor 33265<br/>11. Observation and interview on 6/9/15 at 1:25 p.m. with registered nurse (RN) P during a suprapubic catheter (tube to drain urine from bladder out through lower abdominal) dressing change on resident 9 revealed she:<br/>*Washed her hands at the sink for five seconds.<br/>*Wiped off the area next to the sink with a paper towel.<br/>*Placed a paper towel on the counter next to the sink.<br/>*Removed supplies from her jacket pocket.<br/>*Opened the supplies onto a paper towel.<br/>*Put on gloves.<br/>*Removed the soiled dressing from the suprapubic site and threw it into the trash.<br/>*Poured sterile water on a gauze pad and wiped off the suprapubic site and down the catheter tubing.<br/>*Removed the gloves and discarded them into the trash.<br/>*Washed her hands at the sink for three seconds.<br/>*Put on new gloves.<br/>*Took tape out of her pocket, tore off a piece a few inches long and placed it on the wheelchair handle.</p> | F 441 |  | 7/16/15 |
|-------|---|-------|--|---------|

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| F 441  | <p>Continued From page 87</p> <ul style="list-style-type: none"> <li>*Took a tube of mupirocin cream (antibiotic) and applied it directly to suprapubic site from tube.</li> <li>*Placed a piece of new gauze over the site.</li> <li>*Pulled the tape off of the wheelchair handle and placed it over the new gauze.</li> <li>*Removed pen from pocket and documented the date on the tape and the sterile water bottle.</li> <li>*Placed the pen back in her pocket.</li> <li>*Took off the soiled gloves and discarded them into the trash.</li> <li>*She pulled the full trash bag out of the trash container and made a knot to seal it.</li> <li>*Washed her hands at the sink for three seconds.</li> <li>*Confirmed that was her routine for dressing changes.</li> </ul> <p>Review of the provider's August 2011 Dressing Change (Routine) policy and procedure revealed:</p> <ul style="list-style-type: none"> <li>*Were to gather supplies and then place on barrier, not put in pocket.</li> <li>*Were to wash hands and put on gloves after supplies were placed on barrier.</li> <li>*Were to open supplies after old dressing and used gloves was removed and thrown away and hands washed.</li> </ul> <p>Review of the provider's June 2014 Hand Washing/Hand Hygiene policy revealed:</p> <ul style="list-style-type: none"> <li>*Employees must wash their hands for at least fifteen (15-20) seconds using antimicrobial or non-antimicrobial soap and water:</li> <li>-Before and after direct resident contact.</li> <li>-Before and after handling invasive (go into body) devices.</li> <li>-Before and after changing a dressing.</li> <li>-After removing gloves.</li> </ul> <p>12. Observation and interview on 6/9/15 at 3:35 p.m. in the Center wing hallway of dietary aide R</p> | F 441  |   | 7/16-15   |

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

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| F 441  | <p>Continued From page 88</p> <p>revealed:</p> <ul style="list-style-type: none"> <li>*She had an ice chest with ice in it and had been going to each resident room.</li> <li>*Without wearing gloves she: <ul style="list-style-type: none"> <li>-Went into residents' rooms, pushing on doors or handling door knobs/ handles.</li> <li>-Picked up a resident's water mug.</li> <li>-Opened the mug and discarded ice or water into the sink in the room.</li> <li>-Returned to the hall and the ice chest with the resident's water mug.</li> <li>-Opened the ice chest and dug for scoop in the ice.</li> <li>-Filled the mug with ice using the scoop.</li> <li>-Dropped the scoop back into the ice in the chest and closed the lid.</li> <li>-Filled the mug with water in the resident's room.</li> <li>-Replaced the lid on the mug and placed the mug for resident use.</li> </ul> </li> <li>*Dietary aide R had not responded when asked by the surveyor if she had done the ice water pass task daily.</li> <li>*Dietary aide R confirmed it had been her "first time" for the ice water pass task.</li> <li>*She was asked if she was taught to handle the ice scoop as I had observed her. She said "yes".</li> </ul> <p>Interview on 6/9/15 at 3:42 p.m. with the dietary manager revealed:</p> <ul style="list-style-type: none"> <li>*She agreed the scoop should not have dropped into the ice after use, but should have been put back into the scoop drawer.</li> <li>*The dietary department had taken over refilling of the resident water mugs last week.</li> <li>*She confirmed that it had been dietary aide R's first time doing the task.</li> <li>*The staff had been instructed on how to do that task last week, but she was unsure if it had been on Thursday or Friday.</li> </ul> | F 441  |   | 7-16-15              |

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:<br><br><b>435039</b>  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                     |   | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>06/17/2015</b> |
|--|--|--|---|---|
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| F 441  | <p>Continued From page 89</p> <ul style="list-style-type: none"> <li>*The training for the ice water pass task had consisted of reviewing the policy.</li> <li>*She had been unsure if there was a return demonstration of the task when staff were instructed.</li> <li>*She had not provided any documentation of training that had been done regarding that task.</li> <li>*The ice chest and scoop should have been retrieved, cleaned and disinfected.</li> <li>*She had twenty-one days to change an employee's habits and had not agreed there was a need to re-educate the staff on the handling of ice at that time.</li> </ul> <p>Review of the provider's April 2011 Ice procedure revealed:</p> <ul style="list-style-type: none"> <li>*Ice was to have been maintained and served to residents in a sanitary manner.</li> <li>*Ice was to have been handled, transported, and stored in such a manner as to have been protected against contamination.</li> <li>*Scoops were to have been stored and handled in a sanitary manner.</li> </ul> <p>Review of provider's undated Ice policy revealed ice was not to be handled with bare hands.</p> <p>Review of provider's April 2012 Ice Machines and Ice Storage Chests Policy revealed:</p> <ul style="list-style-type: none"> <li>* Ice was not to have been handled by hand.</li> <li>*The scoop used in ice chests was to have been kept in a covered container when not in use.</li> </ul> <p>13. Observation on 6/9/15 at 11:55 a.m. in East wing dining room regarding dietary aide R revealed:</p> <ul style="list-style-type: none"> <li>*She sat down at one of the tables where residents needed assistance with eating.</li> <li>*She reached for and used the hand sanitizer on</li> </ul> | F 441  |   | 7-16-15   |

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| F 441  | <p>Continued From page 90</p> <p>the table.</p> <p>*After rubbing her hands together for ten seconds she stopped, looked at the palms of her hands and then wiped both of her hands down the top of her pant legs several times.</p> <p>*She then waited for the food to arrive.</p> <p>Review of the provider's June 2014 Hand Washing/Hand Hygiene policy revealed:</p> <p>*Employees must wash their hands for at least fifteen (15-20) seconds before and after assisting a resident with meals.</p> <p>*Alcohol based hand sanitizers were not to be used before and after assisting residents with meals.</p> <p>Interview and record review including surveyor 32331 on 6/16/15 at 5:00 p.m. with the director of nursing (DON) and administrator concerning above observations and interviews revealed the DON was not aware the staff were not following the policies/procedures for dressing changes, handling of ice, and hand hygiene.</p> | F 441   |   | 7-16-15              |   |