

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

ORIGINAL

PRINTED: 02/25/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/12/2015
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NAME OF PROVIDER OR SUPPLIER JENKINS LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201
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F 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 27473 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/11/15 through 2/12/15. Areas surveyed included timely resident checks by staff, safety, and death reporting. Jenkins Living Center was found not in compliance with the following requirement: F514. 483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 27473 Based on record review, review of Physician Protocol, and interview, the provider failed to ensure: *Complete and accurate documentation to reflect ongoing resident status was maintained for four of four sampled residents (1, 2, 3, and 4). *Documentation reflected an assessment was provided and relayed to the physician in their</p>	F 000	<p>No corrective action is indicated for Resident #1, 2, 3, or 4 because the facility is unable to change past events.</p> <p>All residents in the facility could potentially be affected by this deficiency.</p> <p>The Administrator, Director of Nursing, and interdisciplinary team reviewed and revised the policy and procedure regarding documenting resident incidents to ensure complete and accurate documentation to reflect ongoing resident status. The Administrator, Director of Nursing, and interdisciplinary team reviewed and revised the Nurse's Post-mortem Care Procedure to ensure documentation reflects an assessment is provided and relayed to the physician to enable them to pronounce death. All staff responsible for documenting these issues in the resident record will be re-educated by the Director of Nursing at a directed inservice training session on March 10, 2015.</p> <p>The Director of Nursing, or her designee, will perform audits of 4 incidents weekly for a period of 4 weeks, and then monthly for a period of 3 months, to ensure documentation is complete</p>	3-10-15
F 514 SS=F		F 514		

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

[Handwritten Signature]

TITLE
Pres/CEO

(X6) DATE

3-6-15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 10 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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If continuation sheet Page 1 of 11

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F 514	Continued From page 1 absence to enable them to pronounce death for three of four sampled residents (1, 2, and 3). Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed: *All documentation entries were time stamped with military time. *She was admitted on 01/13/15 and passed away on 01/19/15. *On 01/13/15 between 1:51 p.m. and 11:10 p.m. with multiple single item entries her record reflected: -She was admitted from the acute care hospital by ambulance per stretcher and was to be on hospice care, -She was on oxygen and a continuous positive airway pressure (C-PAP) machine. -She received her tuberculosis skin test. -She denied chest pain and was experiencing shortness of breath with exertion. -She was alert and oriented. -She refused three medications and one medication was not available from the pharmacy. -She had numerous bruises on her hands and forearms. -She was seen at 4:00 p.m. by the hospice nurse for admission to hospice. The narrative note reflected a diagnosis of End Stage chronic obstructive pulmonary disease (COPD), overall head-to-toe status, as well as "...Pt is struggling to adjust to her end stage COPD diagnosis, and nursing home placement. Husband visiting, and mother-in-law and sister-in-law at bedside...." *On 01/14/15 between 2:04 a.m. and 8:53 p.m. with multiple single items entries her record reflected: -Her blood pressure, temperature, pulse, and oxygen saturation had been taken and recorded	F 514	and accurate. The Director of Nursing, or her designee, will perform audits of any resident deaths weekly for a period of 4 weeks, and then monthly for a period of 3 months, to ensure physician contact is made to pronounce death and orders given to release the body to the mortuary. Results of the audits will be reported by the D.O.N. at monthly QAPI meetings for a period of 3 months, with additional follow-up as recommended by the Committee.		

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F 514	<p>Continued From page 2</p> <p>twice,</p> <ul style="list-style-type: none"> -She refused seven medications. -Her blood glucose was 221 at 8:09 a.m. -Her blood glucose was 555 at 4:55 p.m. -She had received a flu shot in 2014 and a pneumovax in 2009. -She was seen at 10:45 a.m. by the hospice nurse. The narrative note reflected over view of status as well as "... states I like to feel sleepy, but they [staff] keep waking me up. Asked if she wanted a sign on door for do not disturb if sleeping and she said No." Note continued "...Asked how I could help her and she states set up my room like home, talked with staff and will get a card table to set up crafts." Note continued "...Pt [patient/resident] is continuing to struggle with terminal diagnosis and nursing home placement, will continue to give comfort and emotional cares..." *On 01/15/15 between 5:52 a.m. and 10:12 p.m. with multiple single item entries her record reflected: <ul style="list-style-type: none"> -She refused eleven medications. -Her blood glucose was 296 at 8:06 a.m. -Her blood glucose was 358 at 5:55 p.m. -She was seen at 10:13 a.m. by the hospice nurse. The narrative note reflected "pt having a respiratory crisis this am, has been bleeped [pain medication self-accessed by resident per an infusion pump] total of 43 bleeps over the past 24h, saO2 [saturated oxygen blood level] low into 50's, fluctuates, temp [temperature].8, pulse 105, resp [respirations] 24, occ [occasional] weak cough, non-productive,..." Note continued with assessment and over all status as well as indicated the syringe medication had leaked last night and had been addressed. - She had two medications held after 10:00 p.m. as "unable to take unable to awaken. 	F 514		

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F 514	<p>Continued From page 3</p> <p>*On 01/16/15 between 3:31 a.m. and 11:52 p.m. with multiple single item entries her record reflected: -She had eight medications held "d/t [do to] asleep. -Her blood glucose was 300 at 8:40 a.m. -Her blood glucose was 213 at 4:19 p.m. *On 01/17/15 between 1:05 a.m. and 10:20 p.m. with single item entries her record reflected: -At 7:44 a.m. "5 cc [cubic centimeter, a liquid measurement] in syringe driver at 2245 [10:45 p.m.] when checked at 0615 [6:15 a.m.] husband also stated she was restless - see resident lying on left side with mouth open, flat affect and not moving" -Her blood glucose was 63 at 8:43 a.m. -Her blood glucose was 211 at 4:25 p.m. -She had refused and/or eleven medications were held. *On 01/18/15 between 12:58 a.m. and 7:26 p.m. with multiple single item entries her record reflected: -She had refused and/or seven medications were held. -Her daughter called at 10:45 a.m. and expressed worry about her mother stating she had not heard from her since "the other day" and requested the Skype be opened. Staff accommodated. -At 6:24 p.m. "Resident has slept all afternoon. Very difficult to arouse her. Nursing has not bleeped syringe driver since it was changed this AM. No supper intake - resident clamped lips shut and turned head away. She is breathing evenly and non-labored..." -At 7:26:06 p.m. "Spoke with name of registered nurse [RN] hospice nurse regarding insulin orders. Discussed the decrease in her intake and the current insulin order. I will give the lantus insulin this evening (as it is long acting</p>	F 514		

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F 514	<p>Continued From page 4</p> <p>medication) and I will fax physician regarding my concerns. Hospice will address the orders with physician tomorrow."</p> <p>*On 01/19/15 there are ten entries beginning at 12:39:18 a.m. that are out of order for timeline. Eight of the entries were ahead of the entry that reflected:</p> <p>-At 8:45:47 a.m."Respirations, heart rate and B/P [blood pressure] not present @ [at] 0545 [5:45 a.m.] Resident found on floor with no Vitals [pulse, respirations, and blood pressure] present. Physician notified Via Fax Dr _____. Family notified: Tried repeatedly to contact husband on MB [mobile phone] and Home phone with no success. Body readied for release Funeral home was not contacted at this time due to the fact family unable to contact prior."</p> <p>-At 8:55:27 a.m. documentation included the "INCIDENT TYPE: found on the floor," ... "MENTAL STATUS: normal for resident," ... "ACTIVITY AT TIME: unknown," ... "INJURY: no apparent injury," ... "ANATOMICAL LOCATION: laying on side" and reflected a repeat of the narrative documented at 8:45:47 a.m.</p> <p>Review of the provider's 8/25/13 Physician's Protocol revealed under the heading DEATH: "If uneventful death after clinic hours: notify DR. on call for orders to release the body to the morgue, meds [medications] to pharmacy (as permitted) and remove all tubing from body. Notify the attending [physician] by fax during next available clinic hours."</p> <p>Interview on 2/11/15 at 4:45 p.m. with the director of nurses (DON) revealed: *There was no policy about do not disturb; it was "more informal." -At times there had been requests by residents or</p>	F 514			

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F 514	<p>Continued From page 5</p> <p>family to not disturb when sleeping. -At times hospice had asked if residents wanted to have posting about do not disturb. -Her expectations were staff would respect a resident's request to not be repeatedly awakened. They would check in as often as was necessary to ensure the resident was resting but not awaken them.</p> <p>Interview on 2/11/15 at 6:20 p.m. with licensed practical nurse (LPN) A revealed she had worked the evening of 1/18/15 and recalled resident 1 was "very lethargic." *She had slept all afternoon and was difficult to arouse. *She had not done much with her but was aware certified nurse assistant (CNA) B had gotten her up on the commode. *She recalled the Skype needed to be opened for her daughter to communicate. *Her oxygen saturation had fluctuated. *She had checked with hospice about the Lantus insulin and after the discussion gave the insulin. She had sent a fax to the physician about concerns with her not eating. Hospice was going to follow up in the morning with the physician. *She had checked in on her when she was leaving her shift, and "she was resting quietly."</p> <p>Interview on 2/11/15 at 11:50 p.m. with CNA B revealed she had worked the evening of 1/18/15 providing care for resident 1. She recalled: *She had refused to take very much of evening meal, "took a few sips of milk and then refused to take anymore." She was aware the resident had diabetes and had informed the nurse of the food refusal. *She had gotten her up on the commode and had changed her underwear.</p>	F 514		

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F 514	<p>Continued From page 6</p> <p>*She had logged off Skype when resident 1 went to sleep;"she was asleep when I left my shift." *When asked about how she received information about the residents in her care she reported the CNAs received report from the nurses and they had information sheets. They did some charting and could access the information needed on the EMR.</p> <p>Interview on 2/12/15 at 12:05 a.m. with CNA C revealed she had worked the night shift that had started on 1/18/15 at 11:00 p.m. She had not gone into resident 1's room that night. She had several other residents she provided care to. She recalled LPN D cared for resident 1 that night.</p> <p>Interview on 2/12/15 at 12:20 a.m. with LPN D revealed: *She had worked the night of 1/18/15. *Resident 1 had refused her treatment around midnight. Her oxygen saturation was lower. *She had checked in a couple of times after that, and she was resting, no specific time was recalled. * When she had started her morning meds, she went into resident 1's room at 5:45 a.m. and discovered her on the floor. She knew "she was gone." -She was lying on the floor facing the bed. -She was lying with her head at the foot of the bed and her feet at the head. She "was warm and not stiff." -Another resident's family member had stopped in the door way to ask a question, she sent them on, and returned to resident 1. -She used the vital signs machine and was unable to to obtain blood pressure, pulse, and respirations. No reading for oxygen saturation. *She did not attempt to contact the physician as</p>	F 514		

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F 514	<p>Continued From page 7</p> <p>"we fax them." She had difficulty reaching resident 1's family.</p> <p>*She charted like everyone else did related to a death, "we're not supposed to pronounce death and I understand." She had worked as an emergency medical technician (EMT) and would have preferred to chart things like falls and death in the manner taught as the EMT. "You can explain things better." The electronic record was "more fill in the blank."</p> <p>*She could not explain why she had indicated "normal for resident" when "MENTAL STATE" area prompted in the incident report of the EMR. "Sometimes it would be easier to just chart."</p> <p>*She could not recall the date but one night when she worked resident 1 "had a good night and had talked a lot about how much she had enjoyed art and crafts." There was nothing of that reflected in the EMR.</p> <p>2. Review of resident 2's EMR revealed:</p> <p>*All documentation entries were time stamped with military time.</p> <p>*He was admitted on 01/13/15 at 4:20 p.m. and passed away on 01/25/15.</p> <p>*He was unable to walk due to a history of polio.</p> <p>*He had a Cardioverter Defibrillator (surgically placed internal cardiopulmonary device that would "shock" the heart).</p> <p>*He had a peripherally inserted central catheter (PICC) a form intravenous (vein) access.</p> <p>*He was discharged on 01/20/15 at 11:30 a.m. the acute care hospital for "hypotension [low blood pressure] and continued cellulitis [n infection of the skin]of left hand."</p> <p>*He was re-admitted on 01/22/15.</p> <p>*The remainder of the record was daily multiple single line item entries.</p> <p>*On 01/25/15 between 3:49 a.m. and 5:49 p.m.</p>	F 514		

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F 514	<p>Continued From page 8</p> <p>multiple single item entries with record reflecting at 2:19 p.m."Respirations, heart rate and B/P not present. @ 1330 [1:30 p.m.]</p> <p>-NOTIFICATION: Family notified @ bedside</p> <p>-NOTIFICATION: Dr [initial name] on call to release body.</p> <p>-ACTIONS: Body readied for release.</p> <p>-NOTIFICATION: coroner notified by family [Name Funeral Home].</p> <p>*On 1/25/2015 at 3:03 p.m. record reflects "Held - ([Augmentin])Amoxicillin-Pot [potassium] Clavulanate 875MG [milligrams]-125MG Tablet, Cavedilol 3.125 MG Tablet</p> <p>-MED(S) HELD: held</p> <p>-REASON: other (describe) Resident passed away 1330."</p> <p>*On 1/25/2015 at 5:49:29 p.m. record reflects "Held - Albuterol Sulfate (2.5MG/3ML[millileters]) 0.083%[percent] Nebulization Solution ([Tylenol PM Extra Strength]) Diphenhydramine-APAP (sleep) 500MG-25MG Tablet</p> <p>-MEDS(S) HELD: held</p> <p>-REASON: other (describe) Resident passed away 1330 [1:30 p.m.].</p> <p>3. Review of resident 3's EMR revealed:</p> <p>*All documentation entries were time stamped with military time.</p> <p>*She was admitted on 01/16/15 at 1:04 p.m. following hospitalization for a "severe hemorrhagic stroke with left hemiparesis [weakness of the entire left side of the body] and passed away on 1/22/15.</p> <p>*She was admitted to hospice care for comfort.</p> <p>*She responded "to stimuli but sleeps mostly" with few verbalizations.</p> <p>*She had a syringe driver for pain and comfort.</p> <p>*Her family was very actively involved in her care.</p> <p>*Hospice made seven narrative entries that</p>	F 514		

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F 514	<p>Continued From page 9</p> <p>detailed her admission and progression of dying. *The remainder of the record was daily multiple single line item entries. *On 01/22/15 the record reflected: -"06:32:47[6:32:47 a.m.] PRN[as needed] MED GIVEN: Acetaminophen 650MG Suppository given for temp of 101.9 tymp [temperature]. Follow up after 1 hour. 01/22/2015 07:32" -"09:32:50 [9:32:59 a.m.] Mortuary [NAME], [NAME] Comes, [NAME] here to get Body." -"13:05:13[1:05:13 p.m.] Late Entry for: 01/22/2015 0823 No Pulse, No Bp [blood pressure], No resp. [respirations]" *There was no notification made to the physician with an assessment of apparent death and physician acknowledgement pronouncing death prior to releasing resident 3's body.</p> <p>4. Review of resident 4's EMR revealed: *All documentation entries were time stamped with military time. *On 01/31/15 from 10:17:53 [10:17:53 a.m.] through 17:15:08 [5:15:08 p.m.] there were multiple single line item entries that reflected she had her blood pressure, temperature, pulse, respirations, and oxygen saturation taken and recorded. -She had denied pain, had no edema (swelling in extremities), was drowsy, experienced fatigue, and nausea. -She was transferred to the emergency room at the acute care hospital. -There was no documentation to reflect when she returned to the nursing home. *On 02/01/15 from 05:57:41 [5:57:41 a.m.] through 14:41:37 [2:41:37 p.m.] there were multiple single line item entries that reflected: -Her daughter had communicated with the facility main phone line requesting someone go to her</p>	F 514		

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NAME OF PROVIDER OR SUPPLIER JENKINS LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 215 SOUTH MAPLE STREET WATERTOWN, SD 57201		
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F 514	<p>Continued From page 10</p> <p>room as she "...was stuck in her chair and she was not able to reach her call light." When staff responded, "Resident found sitting in her recliner, call light was pinned to the side of the chair with in reach of the resident. Control to the chair was in the chair with the resident and chair was in proper working condition." -She was transferred to the emergency room at 1:43 p.m. by car with nursing home staff. *There was no documentation to reflect she did not return to the nursing home but had passed away at the hospital.</p> <p>5. Interview and record review of resident's 1, 2, 3, and 4, on 2/12/15 at 10:00 a.m. with the administrator, DON, and assistant DON revealed: *The DON had felt the EMR had good prompts for the nurses for documentation. -She had been concerned about ensuring the nurses did not go beyond their scope of practice and pronounce death. *The assistant DON had worked with LPN D the morning resident 1 had passed away. She had asked her before leaving her shift to write a summary separate from the record of her finding resident 1 on the floor. -That summary still had not included detail LPN D had revealed in her 2/12/15 interview with this surveyor. *The administrator had been of the understanding from the insurance carriers it was not good to have too much discoverable information in the record. *The DON was able to make modifications to the EMR context without going through their vendor. She could make it possible for the nurses to document more narratively.</p>	F 514		