

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435118</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/21/2015</b>
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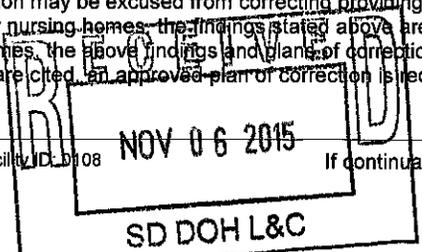
NAME OF PROVIDER OR SUPPLIER  <b>PRAIRIE VIEW CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>401 SOUTH FIRST AVENUE POST OFFICE BOX 68 WOONSOCKET, SD 57385</b>
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F 000	<p><i>*Addendums noted with an asterisk per 11/13/15 per telephone with facility administrator. LA/SDDOH/EL</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 32572</p> <p>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 10/19/15 through 10/21/15. Areas surveyed included staffing and quality of care. Prarie View Care Center was found not in compliance with the following requirements: F223, F224, F226, F241, F278, F280, F314, F353, F490, and F520.</p>	F 000	<p>Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.</p>	
F 223 SS=H	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32573</p> <p>Surveyor: 32572 Based on observation, interview, record review, and policy review, the provider failed to ensure five of eight interviewed sampled residents (1, 2, 3, 5, and 7) were free from verbal, emotional, and physical abuse, related to: *Staffing concerns. *Activities of Daily Living (ADLs) (toileting, dressing, bathing, moving from one surface to another). *Pressure (injury to skin usually from pressure and over a bony area) ulcers.</p>	F 223	<p><b>F223</b></p> <p>1. Resident 1 does not wear incontinent briefs due to allergy and is toileted per her plan of care. Resident 3 is toileted per his plan of care and not left on the commode for extended periods. Resident 5 is toileted per her plan of care. No immediate correction action could be taken for past alleged abuse for Residents 1, 2, 3, 5 and 7. The daily staffing posting</p>	11/4/15

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



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

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F 223	<p>Continued From page 1 Findings include:</p> <p>1. Review of resident 1's most current 8/16/15 Minimum Data Set (MDS) assessment revealed: *She had scored a fifteen on her Brief Interview for Mental Status (BIMS) (testing for mental function) evaluation indicating she was alert and able to answer questions. *Her ADL assessment indicated she needed extensive weight bearing support assistance with one staff member.</p> <p>Interview on 10/21/15 at 5:15 a.m. with certified nursing assistant (CNA) B and licensed practical nurse (LPN) C revealed resident 1 required staff assistance of one with ADLs.</p> <p>The above MDS indicated she had: *Been at risk for developing a pressure ulcer. *Not been on a toileting program. *Not been on a repositioning (turning and changing position) program. *Not been on a nutrition or hydration (fluid replacement) intervention program.</p> <p>Review of her 8/16/15 Braden (assessment for risk of skin breakdown) Score assessment revealed a score of eighteen indicating she had been at risk for a pressure ulcer.</p> <p>Review of the 10/11/15 at 2:22 p.m. nurses notes revealed: *"Skin abrasion (scraping off of skin) noted per staff to inner buttock d/t [due to] excoriation (wearing off the skin)/incontinence (unable to control bladder)." *"Resident states 'no one will believe me' when she says that the sores always happen d/t the pull ups (disposable briefs) she wears, that she is</p>	F 223	<p>is updated and accurate at the start of each shift.</p> <p>2. All Residents are at risk.</p> <p>3. The Administrator, Director of Nursing (DON) and governing board will review, revise and create as necessary the policies and procedures about abuse and neglect no later than November 14, 2015 and will include:</p> <ul style="list-style-type: none"> <li>- Identifying a social services designee</li> <li>- Define what abuse, neglect, or any misappropriation of resident property</li> <li>- Review hiring practices – employee background, work review, and response to resident report/grievance about individual staff, including the mandatory reporting role</li> <li>- Review and response to resident reports of potential abuse and neglect</li> <li>- Appropriate investigation and reporting of resident concerns, complaints, or questionable injury.</li> <li>- Review findings of this deficiency</li> </ul> <p>All staff will be educated no later than November 14 on the above. Those not in attendance will be educated prior to their next shift worked.</p> <p>4. The Administrator meet with resident council and advise council of the facility policy on reporting abuse and neglect and the facility grievance process. The Administrator or designee will interview 8 residents a week for 4 weeks to ensure they are not experiencing any abuse or</p>	

*Handwritten:* Audits will be completed by the DON or designee for 2 months and reported to QAPI. LA/SPDO#EL

*Handwritten:* Audits will be completed by administrator for 2 months. Audits will be reported to QAPI. LA/SPDO#EL

*Handwritten:* To include the above cited residents. LA/SPDO#EL

*Handwritten:* Audits will be completed by the administrator with each hire for the next two months. Audits will be reported to QAPI. LA/SPDO#EL

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F 223	Continued From page 2 allergic to them."  Surveyor 32573 Review of the 10/11/15 at 2:26 p.m. nurses notes revealed: *"Irritated abrasion to left upper buttock (bottom) ... nurse further observed and area is what appears to be an old skin abrasion that has healed and the outer layer of skin peeled off." *"After discussing the 'pull ups' it was discovered that yes resident has been wearing the inserts not the pullups to prevent this 'nylon allergy' that resident has." *"Resident emotional this afternoon, crying at times when nurse talking to her regarding staff issues."  Surveyor 32572 Review of the provider's 10/21/15 following reports revealed: *The Moisture Associated Skin Damage (MASD) report indicated she had skin impairment caused by moisture. *The Urinary Continence report indicated she had been frequently (seven or more episodes in seven days) incontinent. *The Urinary Tract Infections (UTI) from April through October 2015 report indicated she had been on antibiotic therapy for a UTI. -Review of the medical record revealed she had been treated for UTI in June and July 2015.  Surveyor: 32573 Interview and observation on 10/19/15 at 7:45 p.m. with resident 1 and the local ombudsman revealed the resident stated: *CNA A was "ornery." *When she had told staff about her incontinent brief allergies and the sores she obtained from	F 223	neglect. Audit will be discussed by the Administrator in monthly Quality Assurance Process Improvement (QAPI) for review and recommendations of continuation/discontinuation of audit and any further action required.  5. November 14, 2015	11-14-15

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F 223	<p>Continued From page 3</p> <p>them she was told "It was her imagination." *She had been left wet. *Night staff did not want to get her up and take her to the bathroom during the night. *She had been instructed by the night CNAs to "Pull her pad [incontinent brief] out of the way and urinate in the bed, because it is easier" to change the pad instead of bring her to the bathroom. *Staff did not always wear their name tags. *A nurse had said "Don't ring your bell again, it won't be answered." *Night staff had jerked on the shoulder she had surgery on (right arm). *That concern had been reported, and that was why there was a sign above her bed. -Observation at that time revealed a sign posted at the head of her bed instructing staff not to pull on her right arm.</p> <p>Surveyor 32572 Surveyor 32573 2. Review of resident 2's most current 8/10/15 MDS assessment revealed: *She had scored a fourteen on her BIMS evaluation indicating she was alert and able to answer questions. *Her ADL assessment scores indicated she needed extensive assistance of one to two staff members. *She had limitations in movement in both of her legs. *She had been at risk for developing a pressure ulcer. *She had not been on a toileting and repositioning program. *She had not been on a nutrition or hydration intervention program.</p> <p>Review of her 10/15/15 Braden score revealed a</p>	F 223		

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F 223	<p>Continued From page 4</p> <p>score of seventeen indicating she was at risk for pressure ulcers.</p> <p>Review of the provider's 10/21/15 following reports revealed:</p> <ul style="list-style-type: none"> <li>*The Urinary Continence report indicated she had been frequently incontinent.</li> <li>*She had not been included on the provider's MASD list.</li> <li>*The UTI from April through October 2015 report revealed she had been on antibiotic therapy for a UTI.</li> <li>-Review of her medical record revealed she had been treated for a UTI on 9/22/15.</li> </ul> <p>Interview on 10/20/15 at 9:00 a.m. with resident 2 revealed:</p> <ul style="list-style-type: none"> <li>*CNA A had a "violent temper."</li> <li>-She had "cursed" at her and "raised her voice at her."</li> <li>-She had also refused to assist her and walked out of the resident's room.</li> <li>*LPN C had a "mouth on her."</li> <li>-"She can put you through the grinder."</li> <li>-"She has walked out" on her when she had asked for care.</li> </ul> <p>3. Review of resident 3's most current 7/27/15 MDS assessment revealed:</p> <ul style="list-style-type: none"> <li>*He had scored a fifteen on his BIMS evaluation indicating he was alert and able to answer questions.</li> <li>*His ADLs indicated he needed limited to extensive (some weight bearing to full weight bearing) assistance of one staff member.</li> <li>*He had limitations in movement to one of his legs.</li> <li>*He had been at risk for developing a pressure ulcer.</li> </ul>	F 223		

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F 223	<p>Continued From page 5</p> <p>*He had not been on a toileting and repositioning program.</p> <p>*He had not been on a nutrition or hydration intervention program.</p> <p>Review of his 7/27/15 Braden score revealed a score of seventeen indicating he was at risk for pressure ulcers.</p> <p>Review of the provider's 10/21/15 following reports revealed:</p> <p>*The Urinary Continence report indicated he had been frequently incontinent.</p> <p>*The Bowel Continence report indicated he had been occasionally incontinent.</p> <p>*He had not been included on the provider's MASD list.</p> <p>*The Pressure Sores list revealed he had a "facility acquired [developed while in the facility]" pressure ulcer.</p> <p>Review of resident 3's 9/1/15 physician's orders revealed "a rash on both upper legs/buttocks from incontinence." The physician had ordered a medication for that rash.</p> <p>Review of the provider's skin assessment book revealed resident 3 had:</p> <p>*On 3/13/15: A pinpoint open area on his scrotum from "moisture and friction." -That area was now healed.</p> <p>*On 8/6/15: A rash on the inner back of both legs. -The right leg rash measured "10 centimeters [cm; unit of measurement 2.5 cm equals 1 inch] X [by] 11 cm with no drainage." -The left leg rash measured "15 cm X 12 cm with no drainage." -The left leg rash had been healed on 9/29/15.</p>	F 223			

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F 223	<p>Continued From page 6</p> <p>Interview on 10/20/15 at 8:50 a.m. with resident 3 revealed the night CNAs:</p> <ul style="list-style-type: none"> <li>*"Leave me on the toilet so now I don't use it anymore."</li> <li>*They had "walked out on him" when he had asked for assistance.</li> <li>*They had raised their voices at him.</li> <li>*He had "hollered at them to come back, but they don't come back."</li> <li>*He stated he had been unable to control his bladder.</li> <li>*He said sometimes they changed his incontinent product, and sometimes they did not.</li> <li>*He has had "sores on his bottom from being left sitting on the stool and being wet."</li> <li>*He had reported his concerns to the charge nurses.</li> </ul> <p>4. Review of resident 5's most current 7/6/15 MDS assessment revealed:</p> <ul style="list-style-type: none"> <li>*She had scored a thirteen on her BIMS evaluation indicating she was alert and able to answer questions.</li> <li>*Her ADLs assessment indicated she needed extensive to total assistance (full weight bearing, staff to complete all of the task) of two staff members.</li> <li>*She had limitations in movement to both of her arms and legs.</li> <li>*She had been at risk for developing a pressure ulcer.</li> <li>*She had not been on a toileting program and repositioning program.</li> <li>*She had not been on a nutrition or hydration intervention program.</li> </ul> <p>Review of her 7/6/15 Braden score revealed it was seventeen indicating she was at risk for pressure ulcers.</p>	F 223		

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F 223	<p>Continued From page 7</p> <p>Interview on 10/20/15 at 9:50 a.m. with resident 5 revealed the following regarding the night CNAs: *One night (she was unable to determine the exact date), two of the night CNAs got mad at her roommate, and they swore at her roommate. Her roommate was unable to make her wants and needs known. *CNA A acted as if she "can't stand me." *The night CNAs acted as if they "just need the money." *She asked to go to the bathroom at 4:10 p.m. on one day (she could not remember the exact day). CNA A had told her there were "only two of us on, you will have to wait." She was finally able to go to the bathroom at "9:00 p.m. after they had put all the other residents to bed." *Some days CNA A was "sweet and some days she is very mouthy." *The resident was able to verbalize she had told the interim administrator (now the director of nursing) and the social services designee (who no longer was employed at the facility) of the above abuse.</p> <p>5. Review of resident 7's most current 9/20/15 MDS assessment revealed: *He had scored a fifteen on his BIMS evaluation indicating he was alert and able to answer questions. *His ADL assessment indicated he needed limited to extensive assistance of one staff member. *He had limitations in movement to one of his legs. *He had been at risk for developing a pressure ulcer. *He had not been on a toileting program and repositioning program. *He had not been on a nutrition or hydration</p>	F 223		

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F 223	<p>Continued From page 8 intervention program.</p> <p>Review of his 9/23/15 Braden score revealed it had been fifteen indicating he was at risk for developing pressure ulcers.</p> <p>Review of the provider's 10/21/15 following reports revealed: *The Urinary Continence report indicated she had been occasionally incontinent. *The MASD report indicated he had skin impairment caused by moisture.</p> <p>Interview on 10/20/15 at 9:25 a.m. with resident 7 revealed the CNAs were: *"Rough" in using the gait belt." He had pain in his left upper rib area because of that gait belt use. *He was "afraid to push his button [call light]." *The CNAs "don't give me time when getting me up, they hurry me." *There was a CNA on "the night before last [10/18/15]" when asked to empty his urinal (container for men to urinate into) stated to him "Where do you want me to put it, on you?" *"Some of the CNAs "grabbed and threw me on the bed. They grab my hands to drag me out of bed. They also grab my leg to pull me in and out of the bed." *He had a CNA "swat" at him. He stated it was "Very frightening." During that interview he stated the following regarding the nurses: *One of the nurse said to him "Why are you shaking, I'm the good nurse?" *One of the nurses told him she was "Afraid to work with the night CNAs." *He had reported the rough behavior to the charge nurses.</p>	F 223			

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F 223	<p>Continued From page 9</p> <p>6. Review of CNA A and B's employee files revealed:</p> <p>*CNA A had signed the Reporting and Investigating of Resident Abuse, Mistreatment, Neglect, and Misappropriation of Personal Property policy on 1/10/15.</p> <p>*CNA B had signed the Reporting and Investigating of Resident Abuse, Mistreatment, Neglect, and Misappropriation of Personal Property policy on 8/6/13.</p> <p>Review of the provider's June 2005 Reporting and Investigating of Resident Abuse, Mistreatment, Neglect, and Misappropriation of Personal Property policy revealed:</p> <p>*The Policy statement:</p> <p>- "It is the policy of [facility name] to provide an environment free from abuse, mistreatment, neglect, and misappropriation of personal property.</p> <p>- If a violation occurs or is suspected, it is the policy of the facility to investigate the alleged violation and take the appropriate action according to the results."</p> <p>*The General statement:</p> <p>- "The resident has a right to be free from verbal, sexual, physical, and mental abuse, corporal [physical] punishment, involuntary seclusion, or misappropriation of property or funds."</p> <p>- "The facility staff is to be aware of the definitions of abuse as defined by the Federal Government and the State of South Dakota, Department of Health, Office of Health Care Facilities Licensure and Certification."</p> <p>- "All staff is to be aware of this policy and procedure and their legal responsibility for following the guidelines."</p> <p>- "Residents must not be subjected to abuse by anyone, including but not limited to: facility staff,</p>	F 223			

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F 223	<p>Continued From page 10</p> <p>other residents, consultants, or volunteers, staff of other agencies serving the individual, family members, legal guardians, friends, or other individuals."</p> <p>-"[facility name] ensures that incidents of possible abuse and neglect are investigated promptly with reports sent to proper regulatory agencies within the state and federal guidelines."</p> <p>Review of the provider's January 2007 Procedure for Incident Reports revealed attached to it was a form titled Nursing Facility Incident Reporting Flowsheet from the South Dakota Department of Health, Office of Licensure and Certification that was not the current form the facilities was to have been using, and the following link to the website (<a href="http://doh.sd.gov/documents/Providers/Licensure/Reporting_Instructions.pdf">http://doh.sd.gov/documents/Providers/Licensure/Reporting_Instructions.pdf</a>) for reference to the reporting flow diagram was provided to the interim administrator on 10/21/15.</p> <p>Review of the provider's 1/1/09 Resident Rights policy revealed: *"Employees shall treat all residents with kindness, respect, and dignity." *Orientation and in-service training programs are conducted to assist our employees in understanding our residents' rights." **"Inquiries concerning residents' rights should be referred to the social services director."</p> <p>Review of the provider's undated Resident Rights form provided to all residents upon admission revealed: "As a resident, you have the right to: -Be treated with respect and dignity. -Be free from physical/mental abuse. -Trained staff. -Voice grievances.</p>	F 223			

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F 223	<p>Continued From page 11</p> <p>-Be informed of your rights."</p> <p>Review of the provider's last formal abuse group education revealed: *It was provided on 12/23/14. *CNA A had attended. *CNA B had not attended.</p> <p>7. Review of the provider's 10/10/15 through 10/25/15 staffing schedule revealed: *CNA A had worked: -10/10 and 10/11 the evening and night shift (2:00 p.m. until 6:30 am). -10/12 from 8:00 p.m. through 6:00 a.m. -10/15 from 8:00 p.m. through 6:00 a.m. -10/17 and 10/18 2:00 p.m. through 6:00 a.m. -10/19 from 6:00 p.m. through 6:00 a.m. *CNA B had worked: -10/11, 10/12, 10/14, 10/19, and 10/20 from 10:00 p.m. through 6:30 a.m. -She had been designated as the CNA to assist the residents in the special care unit (SCU). *LPN C had worked: -10/14, 10/16, 10/17, and 10/20 from 6:45 p.m. through 7:00 a.m.</p> <p>Review of the provider's CNA staff schedule for the dates of the survey (10/19/15 through 10/21/15) revealed the following positions needed to have been filled when the schedule had been posted: *10/19/15: Three evening and two night positions. *10/20/15: One evening from 6:00 p.m. through 10:00 p.m. along with one day and one night position. *Posting a schedule with open positions notified staff of the needs of the facility for potential overtime hours.</p>	F 223			

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F 223	<p>Continued From page 12</p> <p>Review on 10/19/15 at 7:30 p.m. of the provider's 10/19/15 daily staffing sheet revealed: *10/19/15 had not been updated to indicate the registered nurse (RN) had called in ill and had been replaced by LPN C.</p> <p>Interview at that time with LPN C revealed she was going to be working 6:45 p.m. until 11:00 p.m. The director of nursing would be working 11:00 p.m. until 4:00 a.m. The administrator (an RN) would be working from 4:00 a.m. until 5:00 a.m. until the next nurse arrived early.</p> <p>Review on 10/20/15 at 4:45 a.m. of the provider's 10/20/15 daily staffing sheet revealed: *The posting for 10/20/15 had not been updated to indicate the RN had called in ill and had not been replaced. *The posting did not reflect the shorter shifts worked by CNAs on the evening shift.</p> <p>Review of the provider's 2015 Turnover report listed the following number of employees had been terminated or quit: *January: One. *February: Two. *March: Three. *April: Five. *May: Four. *June: Three. *July: Two. *August: None. *September: Three. *October 1 through 20: Four.</p> <p>Review of the provider's job descriptions revealed: *CNA summary: "Performs the functions of a nursing assistant in carrying out all assignments</p>	F 223			

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F 223	<p>Continued From page 13</p> <p>given by the RN or LPN in charge of the facility. Is accountable for all residents' care he/she is assigned during a shift. He/she is responsible for promoting teamwork among co-workers and personal self-development. Maintain confidentiality of information regarding residents, families, health care personnel and [facility name]."</p> <p>"Consequences of Action: Failure to comply with department and or [facility name] policies will result in disciplinary action as outlined in our employee handbook."</p> <p>*Charge Nurse RN/LPN: "The primary responsibility of this position is to take responsibility for supervision and providing quality care to our residents in a friendly home-like atmosphere, while allowing them to make choices. This is done in accordance with our policies, procedures, and the state and federal guidelines and your scope of practice."</p> <p>*The last page of the job description number 31 stated "Report any resident abuse IMMEDIATELY [that was bolded and capitalized]."</p> <p>Interview on 10/21/15 at 7:20 a.m. with the staff development coordinator revealed: *The instructional manual used to train staff was "How to Be a Nursing Assistant" by the American Health Care Association. -Abuse prevention had been included in this manual. *Direct care giver staff had sixteen hours of classroom education before going to the floor and within those sixteen hours abuse and neglect was covered along with the facility's policy.</p> <p>Review of the staff education revealed the last time abuse training was provided to all staff members had been December 2014. That</p>	F 223			

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Continued From page 14  
educational session had been provided by the social service designee (she was no longer employed at the facility).

8. Interview on 10/21/15 at 10:00 a.m. with the interim administrator confirmed the following:  
\*The social services position had been unfilled since June 2015.  
\*The resident abuse policy was to have been followed by all staff members.  
\*CNAs were supervised by the licensed staff members.  
-Licensed staff should have been aware of resident concerns.  
\*She was not aware of the new flow diagram from the South Dakota Department of Health, Office of Licensure and Certification for reporting abuse.  
\*She was not aware of the above residents' concerns.

F 224  
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483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:  
Surveyor: 32573

Surveyor: 32572  
Based on interview, job description review, and policy review, the provider failed to implement

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\*Audits will be completed by the DON or designee for 2 months and reported to QAPI. LA/SDDO/H/EL

\*Audits will be completed on resident grievances by the administrator for 2 months. Audits will be reported to QAPI. LA/SDDO/H/EL

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F224

- No immediate correction action could be taken for the alleged abuse and neglect that occurred in the past for Residents 1, 2, 3 and 5.
- All residents are at risk.
- The Administrator, Director of Nursing (DON) and governing board will review, revise and create as necessary the policies and procedures about abuse and neglect no later than November 14, 2015 and will include:
  - Identifying a social services designee
  - Define what abuse, neglect, or any misappropriation of resident property
  - Review hiring practices – employee background, work review, and response to



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F 224	<p>Continued From page 16</p> <p>shift and found at least eight residents' beds that had not been changed and were soaked with urine.</p> <p>-Beds had been double-padded (with a second soaker pad to soak up urine) instead of being changed.</p> <p>*They had brought resident complaints to the director of nursing (DON) and administrator and nothing was done.</p> <p>*If they complained about the night shift they were asked "well do you just want to work that shift."</p> <p>**"No one they report to will do anything."</p> <p>*One anonymous staff person had been threatened by night staff to physically harm her, because she had brought up complaints to the DON and administrator.</p> <p>*One anonymous staff person had been text messaged threatening statements to her personal cell phone, because they found out she had reported complaints.</p> <p>Interview with an staff who wish to remain confidential revealed:</p> <p>*That staff felt they had to "get out of here."</p> <p>*Residents were being "neglected, because they (staff) can't keep up."</p> <p>*She could not sleep at night, because she was worried about if residents were getting taken care of.</p> <p>*Residents were not getting toileted, because were are so short handed.</p> <p>-Residents that were usually "pretty continent" were having multiple pairs of pants show up daily in laundry, because they were not getting toileted.</p> <p>*One resident's bed had been left without a pad, and she had been laying in "puddles of urine."</p> <p>*That staff person had tried talking to the administrator, and nothing had been done.</p>	F 224			

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F 224	<p>Continued From page 17</p> <p>Review of the provider's job descriptions revealed:</p> <p>*CNA summary-"Performs the functions of a nursing assistant in carrying out all assignments given by the registered nurse (RN) or licensed practical nurse (LPN) in charge of the facility. Is accountable for all residents' care he/she is assigned during a shift. He/she is responsible for promoting teamwork among co-workers and personal self-development. Maintain confidentiality of information regarding residents, families, health care personnel and [facility name]."</p> <p>"Consequences of Action: Failure to comply with department and or [facility name] policies will result in disciplinary action as outlined in our employee handbook."</p> <p>*Charge Nurse RN/LPN-"The primary responsibility of this position is to take responsibility for supervision and providing quality care to our residents in a friendly home-like atmosphere, while allowing them to make choices. This is done in accordance with our policies, procedures, and the state and federal guidelines and your scope of practice."</p> <p>*The last page of the job description number 31 stated "Report any resident abuse IMMEDIATELY [that was bolded and capitalized]."</p> <p>6. Review of the provider's June 2005 Reporting and Investigating of Resident Abuse, Mistreatment, Neglect, and Misappropriation of Personal Property policy revealed:</p> <p>*Policy statement:</p> <p>- "It is the policy of [facility name] to provide an environment free from abuse, mistreatment, neglect, and misappropriation of personal property.</p> <p>- If a violation occurs or is suspected, it is the</p>	F 224			

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F 224	<p>Continued From page 18</p> <p>policy of the facility to investigate the alleged violation and take the appropriate action according to the results."</p> <p>*General statement:</p> <p>-"The resident has a right to be free from verbal, sexual, physical, and mental abuse, corporal [physical] punishment, involuntary seclusion, or misappropriation of property or funds."</p> <p>-"The facility staff is to be aware of the definitions of abuse as defined by the Federal Government and the State of South Dakota, Department of Health, Office of Health Care Facilities Licensure and Certification."</p> <p>-"All staff is to be aware of this policy and procedure and their legal responsibility for following the guidelines."</p> <p>-"Residents must not be subjected to abuse by anyone, including but not limited to: facility staff, other residents, consultants, or volunteers, staff of other agencies serving the individual, family members, legal guardians, friends, or other individuals."</p> <p>-"[facility name] ensures that incidents of possible abuse and neglect are investigated promptly with reports sent to proper regulatory agencies within the state and federal guidelines."</p> <p>Surveyor: 32572</p> <p>7. Review of the gray folder at the nurses station titled Grievance forms and policy revealed in the folder were forms to file a grievance. However there was no policy in the folder for staff to refer to.</p> <p>Review of the provider's 1/1/09 Grievance Procedure revealed:</p> <p>*There were specific time frames the grievance form needed to follow.</p> <p>**"An employee must follow, in order, each step of</p>	F 224		

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F 224	<p>Continued From page 19</p> <p>this grievance procedure until the grievance is resolved. And employee is not allowed to skip any step of this procedure."</p> <p>***Despite any implementation of this policy, the facility reserves the right to administer disciplinary action against any employee for any reason so long as such disciplinary action is not in retaliation [in response to] for employee's use of the grievance procedure."</p> <p>8. Review of the provider's 1/1/09 Workplace Violence policy revealed: ***It is the policy of this facility that all employees, residents, family members, visitors, contractors, vendors, etc., enjoy a positive, respectful productive, and safe environment while on our premises." ***1. Our worksite environment shall remain free of behavior, actions, or language causing or contributing to workplace harassment or bullying." ***2. Violence, the treat of violence, or harassment or bullying by or against an employee will not be condoned." ***8. Employees who, in good faith, report what they believe to be workplace violence or who cooperate in any investigation will not be subject to retaliation."</p> <p>9. Interview on 10/21/15 at 10:00 a.m. with the interim administrator confirmed the following: *The social services position had been unfilled since June 2015. The administrator, the director of nursing, and the Minimum Data Set (MDS) nurse had split the responsibilities of that position. *Resident abuse and dignity policies were to have been followed by all staff members. *CNAs were supervised by the licensed staff members. *She was not aware of the residents' concerns.</p>	F 224			

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F 224	Continued From page 20 *She was not aware of staff-to-staff retaliation that had been occurring. *She was not aware of the new flow diagram from the South Dakota Department of Health, Office of Licensure and Certification for reporting of abuse and/or neglect.	F 224		
F 226 SS=H	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on record review, interview, and policy review, the provider failed to thoroughly investigate 11 of 15 sampled residents' (1, 2, 3, 5, 7, 9, 10, 11, 12, 14, and 15) reports to determine no abuse or neglect had occurred. Findings include:  1. Review of resident 1's medical record and interview with resident on 10/19/15 at 7:45 p.m. revealed concerns of abuse and neglect. Refer to F223, finding 1.  2. Review of resident 2's medical record and interview with resident on 10/20/15 at 9:00 a.m. revealed concerns of abuse and neglect. Refer to F223, finding 2.  3. Review of resident 3's medical record and interview with resident on 10/20/15 at 8:50 a.m.	F 226	<p>*Audits will be completed on resident grievances by the administrator for 2 months. Audits will be reported to QAPI. LA/SDDOH/EL</p> <p>F226</p> <ol style="list-style-type: none"> <li>No immediate correction could be taken for lack of investigation on alleged abuse or neglect for residents 1, 2, 3, 5, 7, 9, 10, 11, 12, 14 and 15.</li> <li>All residents are at risk</li> <li>The Administrator, Director of Nursing (DON) and governing board will review, revise and create as necessary the policies and procedures about abuse and neglect no later than November 14, 2015 and will include: <ul style="list-style-type: none"> <li>- Identifying a social services designed</li> <li>- Define what abuse, neglect, or any misappropriation of resident property</li> <li>- Review hiring practices – employee background, work review, and response to resident report/grievance about individual staff, including the mandatory reporting role</li> <li>- Review and response to resident reports of potential abuse and neglect</li> <li>- Appropriate investigation and reporting of resident concerns, complaints, or questionable injury.</li> <li>- Review findings of this deficiency</li> </ul> </li> </ol> <p>All staff will be educated no later than November 14 on the above, including the no retaliation policy. Those not in</p>	

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NAME OF PROVIDER OR SUPPLIER  <b>PRAIRIE VIEW CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>401 SOUTH FIRST AVENUE POST OFFICE BOX 68 WOONSOCKET, SD 57385</b>		
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F 226	Continued From page 21 revealed concerns of abuse and neglect. Refer to F223, finding 3.  4. Review of resident 5's medical record and interview with resident on 10/20/15 at 9:50 a.m. revealed concerns of abuse and neglect. Refer to F223, finding 4.  5. Review of resident 7's medical record and interview with resident on 10/20/15 at 9:25 a.m. revealed concerns of abuse and neglect. Refer to F223, finding 5.  6. Review of resident 9's medical record revealed concerns of neglect relating to pressure ulcers (injury to skin usually from pressure and frequently over a bony area). Refer to F314, finding 4.  7. Review of resident 10's medical record revealed concerns of neglect relating to pressure ulcers. Refer to F314, finding 5.  8. Review of resident 11's medical record revealed concerns of neglect relating to pressure ulcers. Refer to F314, finding 6.  9. Review of resident 12's medical record revealed concerns of neglect relating to pressure ulcers. Refer to F314, finding 7.  10. Review of resident 14's medical record revealed concerns of neglect relating to pressure ulcers. Refer to F314, finding 8.  11. Review of resident 15's medical record revealed concerns of neglect relating to pressure ulcers. Refer to F314, finding 9.	F 226	attendance will be educated prior to their next shift worked.  4. The Administrator meet with resident council and advise council of the facility policy on reporting abuse and neglect and the facility grievance process. The Administrator or designee will interview 8 residents a week for 4 weeks to ensure they are not experiencing any abuse or neglect. If reports are received, Administrator will ensure there is a corresponding investigation and Department of Health Report filed. Audits will be discussed by the Administrator in monthly Quality Assurance Process Improvement (QAPI) for review and recommendations of continuation or discontinuation of audit and any further action required.  5. November 14, 2015  →*to include the above cited residents. LA/sddot/H/L	11-14-15	

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F 226	<p>Continued From page 22</p> <p>12. Interview with multiple staff who wish to remain confidential revealed they had concerns about neglect. They did not feel concerns had been resolved after reporting. Refer to F224, findings 8 and 9.</p> <p>13. Review of the provider's June 2005 Reporting and Investigating of Resident Abuse, Mistreatment, Neglect, and Misappropriation of Personal Property policy revealed: *Policy statement: -"It is the policy of [facility name] to provide an environment free from abuse, mistreatment, neglect, and misappropriation of personal property. - If a violation occurs or is suspected, it is the policy of the facility to investigate the alleged violation and take the appropriate action according to the results." *General statement: -"The resident has a right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, or misappropriation of property or funds." -"The facility staff is to be aware of the definitions of abuse as defined by the Federal Government and the State of South Dakota, Department of Health, Office of Health Care Facilities Licensure and Certification." -"All staff is to be aware of this policy and procedure and their legal responsibility for following the guidelines." -"Residents must not be subjected to abuse by anyone, including but not limited to: facility staff, other residents, consultants, or volunteers, staff of other agencies serving the individual, family members, legal guardians, friends, or other individuals." -"[facility name] ensures that incidents of possible</p>	F 226			

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F 226	Continued From page 23 abuse and neglect are investigated promptly with reports sent to proper regulatory agencies within the state and federal guidelines." Surveyor: 32573 14. Interview on 10/21/15 at 10:00 a.m. with the interim administrator revealed: *She was unaware of the above residents' concerns. *She was unaware the staffs' concerns.	F 226			
F 241 SS=H	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Surveyor: 32573  Surveyor: 32572 Based on record review, interview, and policy review, the provider failed to ensure dignity had been maintained for four of eight sampled residents (1, 3, 5, and 7). Findings include:  Surveyor 32573 1. Review of resident 1's medical record and interview on 10/19/15 at 7:45 p.m. with the resident revealed dignity had not been maintained in regards to toileting. Refer to F223, finding 1.  2. Review of resident 3's medical record and interview on 10/20/15 at 8:50 a.m. with the resident revealed dignity had not been maintained in regards to toileting. Refer to F223, finding 3.	F 241	F241  1. No immediate correction action could be taken for failure to ensure Residents 1, 3, 5 and 7 are treated with dignity and respect. Residents are toileting per their plan of correction and treated with dignity and respect.  3. No later than November 14, 2015, the Administrator, DON, and governing board will review, revise and create as necessary the policies and procedures on ensuring a culture of providing resident care with dignity and respect of the individual, including the definition of dignity and respect. Findings of the cited deficiency will be reviewed.  All staff will be educated no later than November 14 on the above. Those not in attendance will be educated prior to their next shift worked,  4. The Administrator meet with resident council and advise council of the facility policy on dignity and respect. The Administrator or designee will interview 8 residents a week for 4 weeks to ensure		

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F 241	Continued From page 24  3. Review of resident 5's medical record and interview on 10/20/15 at 9:50 a.m. with the resident revealed verbal respect and dignity had not been maintained. Refer to F223, finding 4.  4. Review of resident 7's medical record and interview on 10/20/15 at 9:25 a.m. with the resident revealed verbal respect and dignity had not been maintained. Refer to F223, finding 5.  5. Review of the provider's revised 4/2/12 Dignity policy revealed: *"Each resident shall receive care in a manner and in an environment that maintains or enhances dignity and respect in full recognition of his or her individuality." *"Interaction between facility staff and residents will demonstrate that each resident's self-worth is maintained or enhanced, as by the following: -"7. Residents will be addressed by name of each resident's choice. Staff will speak with courtesy, listen with care, and treat residents with respect."  Interview on 10/21/15 at 10:00 a.m. with the interim administrator revealed: *Residents 1, 2, 5, and 7 were alert. *She agree those examples provided by the residents were examples of breeches of dignity. *She had not been aware of those residents' concerns.	F 241	residents are treated with dignity and respect. Audits will be discussed by the Administrator in monthly Quality Assurance Process Improvement (QAPI) for review and recommendations of continuation or discontinuation of audit and any further action required.  5. November 14, 2015  *and any concerns will be implemented to the care plan. LA/SDDO#EL	11-14-15
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate	F 278	*Observation audits will be completed by the DON or designee for 2 months. Audit findings will be reported to QAPI. LA/SDDO#EL  1. Residents 1, 2, 3, 5, 7, 8, 9, 10, 14, and 15 assessments and care plans are up to date and reflective of the care they are receiving.*1	

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F 278	<p>Continued From page 25</p> <p>each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on manual review, interview, and record review, the provider failed to ensure residents' assessments, documentation, and care plans coordinated care for 10 of 15 sampled residents (1, 2, 3, 5, 7, 8, 9, 10, 14, and 15). Findings include:</p> <p>1. Review of residents 1, 2, 3, 5, 7, 8, 9, 10, 14, and 15's medical records revealed they were: *At risk for developing a pressure ulcer (injury to skin usually from pressure over bony areas).</p>	F 278	<p>2. All residents are at risk.</p> <p>3. The Administrator, DON and interdisciplinary team will review, revise and create as necessary the policies and procedures on the care planning process and appropriate follow through for pressure ulcer care. Findings cited in this deficiency were reviewed, as well as, ensuring:</p> <ul style="list-style-type: none"> <li>- Accurate and comprehensive assessment – using the MDS and all tools to gather information</li> <li>- Appropriate screening for pressure ulcer risk</li> <li>- Appropriate assessment of existing pressure ulcers</li> <li>-Identifying problems and concerns – work with CAAs, look at resident strengths as well as family dynamics, staff resources, and weaknesses</li> <li>- Prepare goals and plan for outcomes – being realistic, individual resident need and specific and measurable</li> <li>- Resident/family and staff to agree on direction and staffing is adequate</li> <li>- Staff aware of practice standards and regulations, resident safety and basic human needs.</li> <li>- Nurses demonstrate appropriate practices and direct care staff understand the importance of their role</li> <li>- All available items in place (mattresses, chair cushions, etc.) and ensure items are identified as needed</li> <li>- Determine the approaches necessary to meet the goal and positive outcome</li> </ul>		

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F 278	Continued From page 26 *Not on a toileting program and repositioning program. *Not on a nutrition/hydration(fluids) program except for residents 12 and 14.  2. Review of the residents' individualized care plans revealed the Minimum Data Set (MDS) assessments and documentation records did not reflect the care that was being given.  4. Refer to F223, findings 2, 3, 4, 5, and 6; and F314, findings 2, 3, 4, 5, 7, 8, and 9.  Review of the Version 1.13, October 2015, Resident Assessment Instrument (RAI) manual, page 1 through 5, revealed: *"The purpose of this manual is to offer clear guidance about how to use the Resident Assessment Instrument (RAI) correctly and effectively to help provide appropriate care." *"The RAI helps nursing home staff look at residents holistically-as individuals for whom quality of life and quality of care are mutually significant and necessary."	F 278	All staff will be educated no later than November 14 on the above. Those not in attendance will be educated prior to their next shift worked,  4. The DON or designee will audit 8 care plans and assessments per week to ensure they are up to date and reflect the status and care needs of the resident. Audits will continue for 3 months. Audits will be discussed by the DON in monthly Quality Assurance Process Improvement (QAPI) for review and recommendations of continuation or discontinuation of audit and any further action required.  5. November 14, 2015	11-14-15
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280	F280 All residents including Resident 1's care plan has been updated. <i>LA/SDDO/H/EL</i> An observation audits will be completed by the DON or Designee for 2 months. <i>LA/SDDO/H/EL</i> Audit findings will be reported to QAPI. 2. All residents are at risk. 3. The Administrator, DON and interdisciplinary team will review, revise and create as necessary the policies and procedures on the care planning process and appropriate follow through for pressure ulcer care. Findings cited in this	

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F 280	<p>Continued From page 27</p> <p>for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32572</p> <p>Surveyor: 32573 Based on record review and interview, the provider failed to ensure careplans had been updated to reflect the current needs for one of eight sampled residents (1). Findings include:</p> <p>1. Interview on 10/19/15 at 7:45 p.m. with resident 1 revealed: *She was allergic to the materials in regular incontinent briefs (disposable brief). *She had been made to wear regular incontinent briefs. *Those gave her rashes and sores in the past. *Staff had told her, her allergy was "just her imagination."</p> <p>Review of resident 1's complete medical record revealed: *She had scored a fifteen on her Brief Interview for Mental Status (BIMS) (testing for mental function) evaluation indicating she was alert and able to answer questions. *Nylon and polyester allergies had been noted on her admission on 5/9/15.</p>	F 280	<p>deficiency were reviewed, as well as, ensuring:</p> <ul style="list-style-type: none"> <li>- Accurate and comprehensive assessment – using the MDS and all tools to gather information</li> <li>- Appropriate screening for pressure ulcer risk</li> <li>- Appropriate assessment of existing pressure ulcers</li> <li>-Identifying problems and concerns – work with CAAs, look at resident strengths as well as family dynamics, staff resources, and weaknesses</li> <li>- Prepare goals and plan for outcomes – being realistic, individual resident need and specific and measurable             <ul style="list-style-type: none"> <li>- Resident/family and staff to agree on direction and staffing is adequate</li> <li>- Staff aware of practice standards and regulations, resident safety and basic human needs.</li> </ul> </li> <li>- Nurses demonstrate appropriate practices and direct care staff understand the importance of their role             <ul style="list-style-type: none"> <li>- All available items in place (mattresses, chair cushions, etc) and ensure items are identified as needed</li> <li>- Determine the approaches necessary to meet the goal and positive outcome</li> </ul> </li> </ul> <p>All staff will be educated no later than November 14 on the above. Those not in attendance will be educated prior to their next shift worked.</p> <p>4. The DON or designee will audit 8 care plans per week to ensure they are up to date and reflect the status and care needs</p>		

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F 280	Continued From page 28 *Her nursing progress notes had polyester and nylon listed as allergies. *The current care plan had not included any interventions that nylon and polyester incontinence products should not be used. *The current care plan had not included which incontinence products should have been used.	F 280	of the resident. Audits will continue for 3 months. Audits will be discussed by the DON in monthly Quality Assurance Process Improvement (QAPI) for review and recommendations of continuation or discontinuation of audit and any further action required.	11-14-15	
F 314 SS=H	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  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.  This REQUIREMENT is not met as evidenced by: Surveyor: 32573  Surveyor: 32572 Based on observation, interview, record review, job description review, and policy review, the provider failed to ensure skin integrity (normal condition) was maintained for 8 of 15 sampled residents (3, 8, 9, 10, 11, 12, 14, and 15) who had skin breakdown after moving into the facility. Findings include:  1. Review of the provider's 10/20/15 Pressure Sores list revealed nine out of forty-two residents currently residing in the facility were listed as having facility acquired (caused after admission	F 314	5. November 14, 2015  F314 * -> All residents including Resident 3, 8, 9, 11, 12, and 14 are receiving proper care and prevention interventions for pressure ulcers. Resident 10 and 15's pressure ulcers have resolved.  2. All residents are at risk.  3. The Administrator, DON and interdisciplinary team will review, revise and create as necessary the policies and procedures on the care planning process and appropriate follow through for pressure ulcer care. Findings cited in this deficiency were reviewed, as well as, ensuring: - Accurate and comprehensive assessment – using the MDS and all tools to gather information - Appropriate screening for pressure ulcer risk - Appropriate assessment of existing pressure ulcers - Identifying problems and concerns – work with CAAs, look at resident	LA/SD/DK/EL -> have been assessed and LA/SD/DK/EL	

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F 314	<p>Continued From page 29</p> <p>to the facility) pressure ulcers (injury to skin from pressure and frequently over a bony area). That was a 21.43 percent (%) rate. About one in four residents had obtained a pressure ulcer while living in the facility.</p> <p>2. Review of resident 3's medical record revealed the most current Minimum Data Set (MDS) assessment had been completed on 7/27/15 and revealed:</p> <p>*He scored a fifteen on his Brief Interview for Mental Status (BIMS) evaluation (interview to determine ability to reason) indicating he was alert and able to answer questions.</p> <p>*His Activities of Daily Living (ADL)(daily tasks including dressing, grooming, getting in and out of bed, bathing, eating) evaluation indicated he needed limited to extensive assistance of one staff member.</p> <p>*He had limitations with one of his legs.</p> <p>*He had been at risk for developing a pressure ulcer.</p> <p>*He had not been on a toileting and repositioning program.</p> <p>*He had not been on a nutrition or hydration (fluid)intervention program.</p> <p>*His 7/27/15 Braden score (assessment for predicting pressure ulcer development) had been seventeen indicating he was at risk for developing pressure ulcers.</p> <p>Review of the provider's following reports revealed:</p> <p>*The 10/21/15 Urinary Continence one indicated he had been frequently incontinent (loss of control).</p> <p>*The 10/21/15 Bowel Continence one indicated he had been occasionally incontinent.</p> <p>*He had not been included on the provider's</p>	F 314	<p>strengths as well as family dynamics, staff resources, and weaknesses</p> <ul style="list-style-type: none"> <li>- Prepare goals and plan for outcomes – being realistic, individual resident need and specific and measurable             <ul style="list-style-type: none"> <li>- Resident/family and staff to agree on direction and staffing is adequate</li> <li>- Staff aware of practice standards and regulations, resident safety and basic human needs.</li> </ul> </li> <li>- Nurses demonstrate appropriate practices and direct care staff understand the importance of their role             <ul style="list-style-type: none"> <li>- All available items in place (mattresses, chair cushions, etc.) and ensure items are identified as needed</li> </ul> </li> <li>- Determine the approaches necessary to meet the goal and positive outcome</li> </ul> <p>All staff will be educated no later than November 14 on the above. Those not in attendance will be educated prior to their next shift worked.</p> <p>4. The DON or designee will audit all residents with pressure ulcers each week to ensure resident is receiving proper care and treatment of pressure ulcers and care plan is updated to include current interventions for preventions. Additionally, the DON will audit 4 random residents each week to ensure any risk for skin breakdown is identified and interventions are implemented and care planned. Audits will continue for 3 months. Audits will be discussed by the DON in monthly Quality Assurance Process Improvement (QAPI) for review</p>		

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F 314	Continued From page 30 10/21/15 moisture associated skin damage (MASD) list.  Review of the physician's orders revealed on 9/1/15 "a rash on both upper legs/buttocks (bottom) from incontinence." The physician had ordered a medication for that rash.  Review of the revised 5/20/15 care plan revealed: *Focus area: "The resident has an ADL [activities of daily living, dressing, toileting, personal hygiene, and bathing] self-care performance deficit r/t [related to] stroke, dementia (unable to think well enough to do normal activities; forgetful)." *Goal had been: "The resident will maintain current level of function through the review date." *Interventions were: -"I require extensive assistance of 1 for dressing, toileting, personal hygiene, bed mobility, transfers, and bathing." -Hand written and dated "5/20/15 I prefer to change clothes Q [every] 3 days and resist changing when clothes are soiled." *Focus area: "The resident has potential for impairment to skin integrity r/t urinary incontinence and diabetes [lack of blood sugar control]." *Goal had been "The resident will maintain or develop clean and intact skin by the review date." *Interventions were: -"Report skin changes to charge nurse." -"Assist resident to reposition Q 2 hours." -"9/4/15 Nystatin (prescription) cream to MASD as ordered" -"9/21/15 Tegaderm [specific type of dressing] to P.U. [pressure ulcer] change Q 3 days and PRN."  Review of the provider's skin assessment book	F 314	and recommendations of continuation or discontinuation of audit and any further action required.  5. November 14, 2015	11-14-15	

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F 314	<p>Continued From page 31 revealed resident 3 had:</p> <p>*On 3/13/15 a pinpoint open area on his scrotum (posterior[back]) from "moisture and friction." That area had healed on 4/2/15.</p> <p>*On 8/6/15 a rash on inner back of both legs. The right leg rash measured "10 centimeters [cm; unit of measurement, and 2.5 cm equals one inch] X [by]11 cm with no drainage." The left leg rash measured "15 cm X 12 cm with no drainage." -According to the documentation that rash took one and one-half months to heal.</p> <p>Interview on 10/20/15 at 8:50 a.m. with resident 3 revealed the night CNAs (certified nursing assistant):</p> <p>*"Leave you on the toilet so now I don't use it anymore."</p> <p>*He stated he was unable to control his bladder.</p> <p>*Sometimes they changed his incontinent product (disposable brief) and sometimes they did not.</p> <p>*He had "sores on his bottom from being left sitting on the stool and being wet" in the past.</p> <p>3. Review of resident 8's medical record revealed the most current MDS assessment completed on 9/16/15 revealed:</p> <p>*A Braden score of sixteen indicating she was at risk for a pressure ulcer.</p> <p>*No toileting or repositioning program.</p> <p>*No nutrition intervention program.</p> <p>Review of the provider's skin assessment book revealed resident 8 had:</p> <p>*A pressure ulcer on her left buttock noted on 8/19/15.</p> <p>-It had been a stage two (partial loss of skin causing a shallow open ulcer) when found.</p> <p>-Measured 1.4 cm X 0.7 cm X 0.1 cm.</p> <p>-Nutritional/hydration status for "food intake had</p>	F 314		

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F 314	<p>Continued From page 32 been below 50% [percent]." -Preventative measures were: -"Turned q [every]1-2 hours." -"Duoderm [specialized dressing] to the area." -"Lay down in bed on right side in am and pm." *On 8/25/15 that ulcer: -Continued to be a stage two. -Measured 1.1 cm X 1.4 cm X 0.1 cm. -Nutritional/hydration status for "food intake had been below 50%." -Preventative measures: --"Turned q 1-2 hours." --"Lay on side while in bed between meals et [and] noc [night] as allows/cooperates." *On 9/10/15 the ulcer: -Continued to be a stage two. -Measured "0.9 cm X 0.6 cm X 0.1 cm." -Nutritional/hydration status for "food intake had been below 50%." -Preventative measures: --"Repositioning side to side in bed." --"Laying down between meals when resident allows." *On 9/17/15 the ulcer: -Continued to be a stage two. -Measured 1.1 cm X 0.8 cm X 0.1 cm. -The nutrition/hydration status had not been evaluated. -Preventative measures remained the same as above. -Response to treatment stated "Area cleansed polymem [specialized dressing] applied." *On 9/24/15 the ulcer: -Continued to be a stage two. -Measured 0.6 cm X 0.7 cm X [symbol meaning less than] 0.1 cm. -The nutritional/hydration status revealed resident "losing weight and food intake below 50%." -Preventative measures remained the same.</p>	F 314		

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F 314	<p>Continued From page 33</p> <p>*On 10/1/15 the ulcer: -Continued to be a stage two. -Measured 0.5 cm X 0.5 cm X [symbol for less than] 0.1 cm. -Response to treatment: "Area decreasing in size. Resident lays down in bed between meals on right side." -The nutritional/hydration status revealed "food intake below 50%." -Preventative measures: --"Lays in bed on right side between meals et [and] at noc [night]." --"Repo [reposition] Q 1-2 hrs [hours]." *On 10/8/15 the ulcer: -Continued to be a stage two. -Measured 0.8 cm X 0.5 cm X 0.1 cm. -Response to treatment: "Area larger since last week. Duoderm replaced - Rolls off moist skin easily." -Preventative measures: --"Turned q 1-2 hours." --"Enc [encouraged] to lay on side after meals." -The nutritional/hydration status stated "Food intake had been 50-75% and below 50%." *On 10/15/15 the ulcer: -Continued to be a stage two. -Measured 0.5 cm X 0.5 cm X [symbol for less than] 0.1 cm. -The nutritional/hydration status: --"Actual weight-losing." --"Food intake-50-75% and below 50%." -Preventative measures: --"Turned q 1-2 hrs. Repos [repositions] self at times." --"Rest after ea [each] meal on side."</p> <p>On 10/1/15 an open area on coccyx (end of the spine; tail bone) crease had been identified. -It was a stage two when found.</p>	F 314		
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F 314	<p>Continued From page 34</p> <p>-It measured 0.5 cm X 0.4 cm X (symbol for less than) 0.1 cm.</p> <p>-"Duoderm [specific dressing] applied."</p> <p>-Nutritional/hydration status: food intake below 50%.</p> <p>-Preventative measures:</p> <p>--"Turned q 1-2 hrs."</p> <p>--"Resident to lay down on side while in bed. Between meals et noc."</p> <p>--"Repo Q 1-2 hrs."</p> <p>*On 10/8/15 the ulcer:</p> <p>-Continued to be a stage two.</p> <p>-It measured 0.7 cm X 0.3 cm X [symbol for less than] 0.1 cm.</p> <p>-Nutritional/hydration status not addressed on that evaluation.</p> <p>-Preventative measures:</p> <p>--"Turn q 1-2 hrs as allows [hand written]."</p> <p>--"Encouraged to lay down after both am et noon meals."</p> <p>*On 10/15/15 the sheet had been completed and then a diagonal line had been drawn through it and stated "omit." As in the information place on 10/15/15 was incorrect.</p> <p>Review of the following 10/21/15 provider's reports revealed:</p> <p>*The MASD indicated she had skin impairment caused by moisture.</p> <p>*The Urinary Continence one indicated she had been frequently incontinent.</p> <p>*The Pressure Sores one indicated she had a facility acquired pressure sore.</p> <p>4. Review of resident 9's medical record revealed: the most current MDS assessment had been completed on 8/27/15 revealed.</p> <p>*The ADLs indicated she needed extensive assistance of two staff members.</p>	F 314			

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F 314	<p>Continued From page 35</p> <p>*She had limitations with one of her legs.</p> <p>*She had been at risk for developing a pressure ulcer.</p> <p>*She had not been on a toileting and repositioning program.</p> <p>*She had not been on a nutrition or hydration intervention program.</p> <p>Resident 9's 8/27/15 Braden score had been seventeen indicating she was at risk for pressure ulcers.</p> <p>Review of the following 10/21/15 provider's reports revealed:</p> <p>*The Urinary Continence one indicated she had been occasionally incontinent.</p> <p>*She had not been included on the provider's 10/21/15 MASD list.</p> <p>*The Pressure Sores indicated she had a facility acquired pressure sore.</p> <p>Review of the provider's skin assessment book revealed resident 9 had a pressure ulcer on her right outer ankle:</p> <p>*Onset 9/24/15.</p> <p>-The size was 0.6 cm X 0.8 cm.</p> <p>-Unstageable (unable to determine depth) due to "dark purple and black in color."</p> <p>-Interventions:</p> <p>--"Reposition every one to two hours."</p> <p>--"Float [keeping the pressure off] heels."</p> <p>--"No shoe to be worn."</p> <p>*On 10/1/15 the ulcer:</p> <p>-Was 0.5 cm X 0.7 cm in size.</p> <p>-Continued to be unstageable.</p> <p>-Treatment of corn pad [donut like dressing] had been initiated.</p> <p>*On 10/8/15 the ulcer:</p> <p>-Was 0.5 cm in diameter.</p>	F 314		

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F 314	<p>Continued From page 36</p> <p>-Continued to be unstageable. -No change in the treatment. *On 10/15/15 the ulcer: -Was 0.5 cm X 0.7 cm in size. -Continued to be unstageable. -No change in the treatment.</p> <p>Resident 9's care plan had been requested on 10/21/15 at 7:30 a.m. from the director of nursing . It had not been received prior to exit of the survey on 10/21/15 at 12:00 noon.</p> <p>5. Review of resident 10's medical record revealed the most current MDS assessment had been completed on 7/6/15. *The ADLs indicated he needed supervision. *He had not been at risk for developing a pressure ulcer. *He had not been on a toileting or repositioning program. *He had not been on a nutrition or hydration intervention program.</p> <p>Resident 10's 7/6/15 Braden score had been twenty indicating he was not at risk for developing pressure ulcers.</p> <p>Review of the 10/21/15 provider's following reports revealed: *The Urinary Continence one indicated he had been continent. *The MASD report indicated he did not have skin impairment caused by moisture. *The Pressure Sores one indicated he had a facility acquired pressure sore.</p> <p>Review of the provider's skin assessment book revealed a pressure ulcer on the top of resident 10's his left foot.</p>	F 314			

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F 314	<p>Continued From page 37</p> <p>*Onset 9/7/15.</p> <p>-It had been a stage two (partial loss of skin causing a shallow open ulcer).</p> <p>-It measured 0.5 cm X 0.4 cm. with depth zero with a line through it.</p> <p>-Interventions were "switch shoes and use grippy socks."</p> <p>*On 9/14/15 the ulcer:</p> <p>-Continued to be a stage two.</p> <p>-Measured 0.4 cm in diameter and a zero with a line through it for depth.</p> <p>-Interventions: "awaiting new shoes."</p> <p>*On 9/21/15 the ulcer:</p> <p>-Continued to be a stage two.</p> <p>-Measured 0.3 cm with a dash (-) in the depth measurement column.</p> <p>-No change in the interventions.</p> <p>*On 9/28/15 the ulcer:</p> <p>-Continued to be a stage two.</p> <p>-Measured 0.3 cm with a dash in the depth measurement column.</p> <p>-No change in the interventions.</p> <p>*On 10/5/15 the ulcer:</p> <p>-Continued to be a stage two.</p> <p>-Measured 0.3 cm X 0.3 cm with a dash in the depth measurement column.</p> <p>-No change in the interventions.</p> <p>*On 10/12/15 the ulcer:</p> <p>-Continued to be a stage two.</p> <p>-Measured 0.3 cm X 0.3 cm with a dash in the depth measurement column.</p> <p>-No change in the interventions.</p> <p>Review of resident 10's care plan revealed:</p> <p>*A revision on 10/1/15 for a "Stage II [2] P.U. [pressure ulcer] L [left] foot near great toe - new shoes-observe for friction."</p> <p>*A revised 5/5/15 focus area of "The resident is occasional incontinence r/t Dementia. I will</p>	F 314			

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F 314	<p>Continued From page 38</p> <p>occasionally urinate in inappropriate places." -Goal had been: "The resident will be continent during waking hours through the review date of 7/6/15. -Interventions were: --"Incontinent: Check resident and assist him to the bathroom every 2-3 hours while awake and as required for incontinence. Assist with peri-care [cleaning of bottom] 2 x daily and as needed. Change clothing PRN [as needed] after incontinence episodes." --"W/P [whirlpool] bath weekly, report changes in skin to the charge nurse."</p> <p>6. Review of resident 11's medical record revealed: the most current MDS assessment had been completed on 8/10/15 and revealed: *The ADLs indicated he had been independent except for bathing. *He needed limited assistance of one staff member for bathing. *He had not been at risk for developing a pressure ulcer. *He had not been on a toileting or repositioning program. *He had not been on a nutrition or hydration intervention program.</p> <p>The 8/10/15 Braden score had been twenty-two indicating he had not been at risk for a developing pressure ulcer.</p> <p>Review of the 10/21/15 provider's following reports revealed: *The Urinary Continence one indicated he had been continent. *The Bowel Continence one indicated he had been continent. *The MASD one indicated he did not have skin</p>	F 314			

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F 314	<p>Continued From page 39 impairment caused by moisture. *The Pressure Sore one indicated he had a facility acquired pressure ulcer.</p> <p>Review of the provider's skin assessment book regarding resident 11 revealed: *Pressure ulcer onset 9/15/15 on his right ankle at a stage two. -The ulcer measured 0.4 cm X 0.6 cm with no depth documented. -Duoderm had been applied. -Intervention had been "Turned q 1-2 hrs." *On 9/25/15 the ulcer: -Continued to be a stage two. -Measured 0.4 cm X 0.6 cm with unknown as depth. -Response to treatment: --"Has scabbed area." --"Dark purple/red area dry." --"Duoderm in place." -Preventive measures: --"Turned q 1-2 hrs." --"Encouraged to reposition self to keep pressure off area." --"Float heels/ankles in bed." *On 10/8/15 the ulcer: -Continued to be a stage two. -Response to treatment: --"Patient reports [symbol to indicate increase] pain with this area." --"Fax sent requesting scheduled pain relief." -Preventive measures: --"Turned q 1-2 hrs." --"Float heels/ankles." --"Repos self at times." *On 10/15/15 the ulcer: -Continued to be a stage two. -Measured 0.8 cm X 0.8 cm X 0.1 cm. -Response to treatment: "Removed Duoderm"</p>	F 314		
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NAME OF PROVIDER OR SUPPLIER  <b>PRAIRIE VIEW CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>401 SOUTH FIRST AVENUE POST OFFICE BOX 68 WOONSOCKET, SD 57385</b>		
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F 314	<p>Continued From page 40 wash area et placed new Duoderm." -Preventive measures were "Turned q 2 hrs."</p> <p>*The skin assessment pressure book revealed a pressure ulcer on 9/18/15 on his left ankle at a stage two. -It measured 0.5 cm X 0.5 cm X [symbol indicating less than] 0.1 cm. -Response to treatment: --"Circular area difficult to visualize sl [slight] posterior of left ankle bony prominence, cream/white/sl yellow wound bed." --"Denies pain." --"Edges sl macerated [soft] post bath." --"Likely from laying on left side to relieve pressure on right ankle area." -Preventive measures were "Turned q 2 hrs." *On 9/25/15 the ulcer: -Continued to be a stage two. -Measured 0.5 cm X 0.5 cm X [symbol indicating less than] 0.1 cm. -Response to treatment: --"Area unchanged." --"Yellow/cream colored wound bed." --"Duoderm on place." -Preventive measures: --"Turned q 1-2 hrs." --"Encourage resident to keep pressure off area." --"Floating ankles/heels." *On 10/9/15 the ulcer: -Continued to be a stage two. -Measured 0.5 cm X 0.4 cm X [symbol indicating less than] 0.1 cm. -Response to treatment: "Little change." -Preventive measures: --"Turned q 1-2 hrs." --"Repos self at times." --"Float heels/ankles." *On 10/15/15 the ulcer:</p>	F 314		

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F 314	<p>Continued From page 41</p> <p>-Continued to be a stage two. -Measured 0.5 cm X 0.5 cm X 0.1 cm. -Response to treatment: "Removed old Duoderm washed et dried area then place new Duoderm." -Preventive measures: "Turned q 2 hrs."</p> <p>Review of the 8/12/15 care plan revealed: *Focus area: "The resident has potential impairment to skin integrity." Hand written below that was "9/18/15 Pressure sores to left and right ankle." *Goal: "The resident will maintain or develop clean and intact skin by the review date." *Interventions: -"Report changes in skin to charge nurse." -"Assist me with peri care 2 x daily as I allow." -"Duoderm [symbol for change] q with a line over it [every] 3 days &amp; [and] PRN."</p> <p>7. Review of resident 12's medical record revealed the most current MDS assessment had been completed on 9/24/15. The ADLs indicated she needed extensive assistance with ADLs *She had been at risk for developing a pressure ulcer. *She had not been on a toileting and repositioning program. *She had been on a nutrition or hydration intervention program.</p> <p>The 10/17/15 Braden score had been fifteen indicating she had been at risk for developing a pressure ulcer.</p> <p>Review of the 10/21/15 following reports revealed: *The Urinary Continence one indicated she had been frequently incontinent.</p>	F 314		

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F 314	<p>Continued From page 42</p> <p>*The Bowel Continence one indicated she had been frequently incontinent.</p> <p>*The MASD one indicated she had skin impairment caused by moisture.</p> <p>*The Pressure Sore one indicated she had a facility acquired pressure ulcer.</p> <p>Review of the provider's skin assessment book revealed:</p> <p>*A pressure ulcer on 6/27/15 on her coccyx. -It was a stage "three to four (full thickness tissue loss with possible exposed bone, tendon, or muscle)."</p> <p>-It measured 7 cm X 5 cm X 2.5 cm with "serous scant exudate" (small amount of thin watery drainage)."</p> <p>-"No odor."</p> <p>-The wound bed was "pink, moist."</p> <p>-Response to treatment: --"Wound vacuum [vac; device to drain a wound] to area." --"Noted scant serous drainage prior to applying treatment."</p> <p>-Nutritional status: food intake "50-75%."</p> <p>-Preventive measures: --"Turned q 1-2 hrs." --Pressure relieving interventions mattress. Supplements TID (three times a day)). -High protein supplements had been checked. *On 7/31/15 the ulcer: -Was a stage three to four. -Measured 7 cm X 5 cm X 2.0 cm with "serous small exudate." -Had "no odor." -The wound bed was "pink, moist." -Response to treatment: --"Wet to dry dressing to area." --"Changed after bath." --"Nutritional supplements TID."</p>	F 314			

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F 314	Continued From page 43 -Preventive measures: --"Turned q 1-2 hrs." --Pressure relieving interventions mattress." -High protein supplements had been checked. *On 7/10/15 the ulcer: -Was a stage three to four. -Measured 6 cm X 4.5 cm X 2 cm. -It had "small serous" exudate an had "no odor." -The wound bed was "pink et moist." -Response to treatment: --"Wet-to-dry dressing changed BID [twice a day]." --"Area (down arrow) (decrease) in size." --"Wound pink et moist with small area that has tan drainage." --"No odor." --"Does have reddened surrounding area d/t moisture from wet-to-dry." --"Cream applied." -Nutritional status: food intake had been "50-75%." -Preventive measures: --"Turned every 1-2 hours as allows." --"Pressure relieving interventions mattress." --"High protein supplements." *On 7/20/15 the ulcer: -Was a stage three to four measuring 6 cm X 5 cm X 2 cm. -It had "small purulent" [containing pus] exudate. with "no odor." -The wound bed was "pink/white moist." -The response to treatment: --"Wet to dry dressing changed BID." --"Area moist." --"Patient tolerated ok." -Nutritional status: food intake had been "50-75%." -Preventive measures: --"Turned every 1-2 hours as allows."	F 314			

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F 314	<p>Continued From page 44</p> <p>*On 7/29/15 the ulcer: -Was a stage four measuring 5 cm X 3.5 cm X 3.5 cm. -There was "yellow, sm [small] amt" [amount] exudate with "no odor." -The wound bed was "pink, white, scant yellow plaques [build up]." -Response to treatment: --"Wet to dry dressing cont. [continued] BID." --"Interior of wound moist." --"No heat, swelling or odor." --"Area reduced in size." --"TAC [special prescription cream] to areas of buttocks surrounding wound." --"Area improving." -Nutritional status had not been addressed. -Preventive measures: --"Turned every 1-2 hours as allows." --"Pressure relieving interventions, mattress." *On 8/4/15 the ulcer: -Was a stage four measuring 4 cm X 3.5 cm X 3 cm (standing) and 4.5 cm X 4 cm X 2 cm (laying on R [right] side. -There was "no odor." -The wound bed was "pink moist, some slough [dead tissue separating from living tissue] to (L) [left] inner side." -Response to treatment: --"Wet to dry dressing being changed BID." -Preventive measures: --"Turned every 1-2 hours." --"Pressure relieving interventions mattress, W/C [wheelchair] cushion (pressure redistributing)" --"High protein supplements." --"Multivitamins *On 8/10/15 the ulcer: -Was a stage four. -It measured standing 4.2 cm X 4 cm X 3.7 cm at deepest area of tunneling (creating a channel).</p>	F 314		

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F 314	<p>Continued From page 45</p> <ul style="list-style-type: none"> <li>-There was "mod [moderate] yellow slough" with "no odor."</li> <li>-The wound bed was "red, pink, yellow slough in places."</li> <li>-Response to treatment: <ul style="list-style-type: none"> <li>--"Note wet to dry dressing (zero with a line through it) [none] remove dry (capitalized) remains wet (c with a line over it) [with] slough present also."</li> <li>-- "Patient [resident] only partially coop [cooperative] during measurements."</li> <li>--"[Zero with line through it, no] C/O [complaints of] pain regarding area."</li> <li>--"At times uncoop [uncooperative] with repo [reposition] et cares."</li> </ul> </li> <li>-Nutritional status: food intake "50-75% checked and below 50% with 'at times' hand written below circled."</li> <li>-Preventive measures: <ul style="list-style-type: none"> <li>--"Turned every 1-2 hours as allows."</li> <li>--"Pressure relieving interventions mattress, W/C cushion."</li> <li>--"High protein supplements and multivitamins."</li> </ul> </li> <li>*On 8/18/15 the ulcer: <ul style="list-style-type: none"> <li>-Was a stage four measuring 3.8 cm X 4.0 cm X 3.6 cm.</li> <li>-There was " yellow dng [drainage] small amt" exudate.</li> <li>-There was "1.8 cm" tunneling</li> <li>-The box titled odor had a diagonal line drawn through it.</li> <li>-The wound bed was "red (c with a line over it) [with] scant yellow slough."</li> </ul> </li> <li>-Response to treatment: <ul style="list-style-type: none"> <li>--"Area reducing in size slightly."</li> <li>--"(Zero with a line through it) [No] C/O pain."</li> <li>--"Packing to area falls out easily."</li> <li>--"Tegaderm placed over 2nd [second] packing place this date."</li> </ul> </li> </ul>	F 314		

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F 314	Continued From page 46 -- "Notably fewer areas of yellow slough noted to wound bed." -Nutritional status had not been addressed. -Preventive measures: --"Turned every 1-2 hours as allows." --"Pressure relieving interventions air mattress, WC [wheelchair] cushion." --"High protein supplements" hand written above it was "frequent refusals." --"Multivitamins" hand written beside it was "DC'd [discontinued] 8/18/15." *On 8/24/15 the ulcer: -Was a stage four measuring 3.8 cm X 4.0 cm X 2.8 cm. -It had "brownish mild to mod [moderate]" exudate. -There had been "1.2 cm" tunneling. --"(Zero with a line through it) C/O pain." -The wound bed was "red (c with a line over it) scant yellow slough." -Response to treatment: --"Depth reducing requiring less packing." --"(Zero with a line through it) C/O pain during packing (triangle with an 's) [changes]." --"Difficulty keeping packing in place with Tegaderm due to moisture in crease area." -Nutritional status had not been addressed. -Preventive measures: --"Turned every 1-2 hours as allows." --"Pressure relieving interventions air mattress, WC cushion." --"High protein supplements" hand written above it was "frequent refusals." --"Multivitamins" hand written beside it was "DC'd [discontinued] 8/18/15." *On 8/31/15 the ulcer: -Was a stage four measuring 2.5 cm X 3.0 cm X 2.4 cm. -It had "yellow/small" exudate with "faint foul"	F 314		

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F 314	<p>Continued From page 47</p> <p>odor.</p> <ul style="list-style-type: none"> <li>-The tunneling had not been addressed.</li> <li>-The wound bed had been "red (c with line over it) with areas of white/yellow slough."</li> <li>-Response to treatment: <ul style="list-style-type: none"> <li>--"Area decreasing in size."</li> <li>--"Dressing packing changed after bath."</li> <li>--"No C/O pain (c with line over it) with dressing change."</li> </ul> </li> <li>-Nutritional status: food intake stated "50-75%."</li> <li>-Preventive measures: <ul style="list-style-type: none"> <li>--"Turned every 1-2 hours."</li> <li>--"Pressure relieving interventions mattress, WC cushion."</li> <li>--"High protein supplements."</li> </ul> </li> </ul> <p>*On 9/10/15 the ulcer:</p> <ul style="list-style-type: none"> <li>-Was a stage four measuring 2.5 cm X 3.0 cm X 2.4 cm.</li> <li>-It had "yellow/small" exudate with "foul" odor.</li> <li>-The tunneling had not been addressed.</li> <li>-The wound bed had been "red (c with line over it) with yellow edges."</li> <li>-Response to treatment: <ul style="list-style-type: none"> <li>--"Area decreasing in size."</li> <li>--"Packed with Aquacel [specialized dressing] after bath (c with line over it) with dressing applied."</li> <li>--"No pain (c with line over it) with dressing placement."</li> </ul> </li> <li>-Nutritional status, Food intake stated "50-75%."</li> <li>-Preventive measures: <ul style="list-style-type: none"> <li>--"Turned every 1-2 hours."</li> <li>--"Pressure relieving interventions mattress, WC cushion."</li> <li>--"High protein supplements."</li> </ul> </li> </ul> <p>*On 9/17/15 the ulcer:</p> <ul style="list-style-type: none"> <li>-Was a stage four measuring 2.5 cm X 3.0 cm X 2.4 cm.</li> <li>-It had "yellow/small" exudate.</li> </ul>	F 314		

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F 314	<p>Continued From page 48</p> <ul style="list-style-type: none"> <li>-The tunneling had not been addressed.</li> <li>-The odor box had a zero with a line through it [no].</li> <li>-The wound bed had been "red/yellow plaques."</li> <li>-Response to treatment: <ul style="list-style-type: none"> <li>--"Area decreasing in-depth et overall dimensions."</li> <li>--"Repacked with Aquacel AG (p with line over it) [after] bath it clear dressing applied over."</li> <li>--"Zero with line over it [no] pain with dressing change."</li> </ul> </li> <li>-Nutritional status: food intake stated "50-75%."</li> <li>-Preventive measures: <ul style="list-style-type: none"> <li>--"Turned every 1-2 hours."</li> <li>--"Pressure relieving interventions "air mattress."</li> <li>--"High protein supplements" hand written above it was "occ [occasional] refuses."</li> </ul> </li> <li>*On 9/24/15 the ulcer: <ul style="list-style-type: none"> <li>-Was a stage four measuring 2.0 cm X 2.5 cm X 2.2 cm.</li> <li>-It had "yellow/small" exudate with "faint" odor.</li> <li>-The tunneling had not been addressed.</li> <li>-The wound bed stated "pink with tan patches."</li> <li>-Response to treatment: <ul style="list-style-type: none"> <li>--"Area decreasing in size."</li> <li>--"Dressing changed as ordered."</li> </ul> </li> <li>-Nutritional status: food intake stated "50-75%."</li> <li>-Preventive measures: <ul style="list-style-type: none"> <li>--"Turned every 1-2 hours."</li> <li>--"Pressure relieving interventions were "repo onto side when in bed."</li> <li>--"High protein supplements."</li> </ul> </li> </ul> </li> <li>*On 10/1/15 the ulcer: <ul style="list-style-type: none"> <li>Was a stage four measuring 2.0 cm X 2.5 cm X 2.2 cm.</li> <li>-It had "yellow/small" exudate.</li> <li>-The tunneling had not been addressed.</li> <li>-The odor box stated "none."</li> <li>-The wound bed stated "pink/moist with white/tan"</li> </ul> </li> </ul>	F 314			

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F 314	Continued From page 49 patches." -Response to treatment, "Area unchanged from last measurement." -Nutritional status: food intake stated "50-75%." -Preventive measures: --"Turned every 1-2 hours." --Pressure relieving interventions were: --"Mattress." --Reposition onto right side while on bed." --"Lay down between meals." *On 10/8/15 the ulcer: -Was a stage four measuring 2.0 cm X 2.5 cm X 2.3 cm. -It had "small amt brownish" exudate. -The tunneling had not been addressed. -The odor box stated "mild." -The wound bed stated "pink/light brown." -Response to treatment: --"Little change." --"Replaced gauze dressing." -Nutritional status: food intake stated "50-75%." -Preventive measures: --"Turned every 1-2 hours." --Pressure relieving interventions were: --"Mattress." --Repo to sides in bed." --"Laying down between meals." *On 10/11/15 the ulcer: -Was a stage four measuring 3.0 cm X 4.0 cm X 3.0 cm. -It had "green purulent" exudate with "foul" odor. -The tunneling had not been addressed. -The wound bed stated "pink and brown-tan areas X 3." -Response to treatment: --"Assessment done wide open while resident standing with easy stand [mechanical lift]." --"Necrotic [dead] brown area inside right wound edge 1.4 cm X 0.5 cm with occ [occasional] drip	F 314			

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F 314	<p>Continued From page 50 of bl.ing [bleeding] noted from site." --"Left inside of wound edge 0.7 cm X 0.5 brown eschar" --"Inside to back of wound tan eschar area 1.2 cm in diameter." --"Rest of inside wound pink in color." --"Repacked with gauze." --"No pain expressed." -Nutritional status: --Food intake: "50-75%." --Hand written in by actual weight was "loss the past week." -Preventive measures: --"Turned every 2 hours." --Pressure relieving interventions were: --"Air mattress on bed." --Repo in bed and lay down after meals or in recliner to her side." --"High protein supplements.</p> <p>Review of the 4/29/15 care plan revealed: * Focus: "I am on a regular diet and once weighted close to 300 lbs [pounds]." -Goal: "I will maintain my weight between 150-155 # [pound] this quarter." -Interventions: --On "6/26/15 NIP (nutrition intervention program) d/t weight loss." --"Offer me substitutes if I am not eating." --"I like to look out window at meals." --"Weigh weekly, monitor for edema." *Focus: "I have an ADL [activities of daily living, dressing, toileting, walking, locomotion [moving], and personal hygiene] self-care performance deficit r/t dementia." -Goal: "The resident will maintain current level of function in adls through the review date." -Interventions: "Extensive assist of 2 for bed mobility, transfer, walk in room/corridor, loc</p>	F 314		

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F 314	<p>Continued From page 51</p> <p>[locomotion] on/off unit, dressing, toilet and personal hygiene." *Focus: Skin and hand written on "6/26/15 Stage III-IV [three to four] pressure ulcer to sacrum." -Goal: "I will maintain clean and intact skin by the review date." -Interventions: --On "7/21/15 Redistributing pressure cushion/mattress." --"7/21/15 Supplements TID [three times a day] between meals." --"Remind me of the importance of repositioning Q [every] 2 hours. I am able to make major/frequent changes in position independently." --"Whirlpool bath weekly." --"Skin changes to be reported to charge nurse." *Focus: "Bowel/Bladder: I am incontinent of bowel and bladder. I have constipation." -Goal: "The resident will have no skin breakdown r/t incontinence." -Interventions: --"I wear incontinent products." --On "7/3/15 Pericare 2 X daily and PRN."</p> <p>Review of the provider's nursing notes revealed she had recently been hospitalized for "debridement [surgical cleaning] of coccyx wound." Those notes revealed: *10/17/15 "admitting diagnoses of "Infected decubitus ulcer and osteomyelitis [bone infection]." -"Resident has catheter [tube in bladder to drain urine] and is incontinent of bowel." -"Changes to wound treatment, now hydrogen peroxide diluted with saline." -"Returned with PICC [intravenous catheter for antibiotic therapy] line to right arm with IV [intravenous] antibiotics BID."</p>	F 314		

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F 314	<p>Continued From page 52</p> <p>*10/19/15 nurses note stated: -"Resident is post hospitalization for debridement of coccyx wound that was showing signs of necrosis."</p> <p>Random observations from 10/19/15 at 7:30 p.m. through 9:30 p.m. revealed resident 12 sat in her wheelchair and had not been repositioned in over two hours. Interview at that time with CNA B and LPN C revealed: *She was one of the last residents to go to bed because she was loud at times when in bed. *She sat at the nurses station from after supper to bedtime to watch the happenings while other residents were put to bed. She sat from 5:30 p.m. until 9:30 p.m. before she had been repositioned.</p> <p>Review of the dining times revealed supper had been served at 5:30 p.m.</p> <p>8. Review of resident 14 medical record revealed: *The most current MDS assessment had been completed on 7/6/15. *ADLs indicated he had needed extensive assistance of two staff members for ADLs such as mobility and transferring. *He needed total staff assistance of two staff members for toileting. *He had been at risk for developing a pressure ulcer. *He had an unhealed pressure ulcer. *He had not been on a toileting and repositioning program. *He had been on a nutrition or hydration intervention program. *He had a urinary tract infection within the last thirty days.</p> <p>The 7/6/15 Braden score had been twelve</p>	F 314		

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F 314	<p>Continued From page 53 indicating he had been at risk for developing a pressure ulcer.</p> <p>Review of the 10/21/15 provider's following reports revealed: *The Urinary Continence one indicated he had been always incontinent. *The Bowel Continence one indicated he had been always incontinent. *The MASD one indicated he did have skin impairment caused by moisture. *The Pressure Sore one indicated he had a facility acquired pressure ulcer.</p> <p>Review of the provider's skin assessment book revealed resident 14 had: *A pressure ulcer on 4/1/15 on the left outer foot bony prominence. -On 7/6/15 it had been staged as "II [two]." -In the measurement column it stated "see below." -There was a zero with a line through it (none) in the exudate column. -The tunneling had not been addressed. -The odor column stated "none." -The wound bed was "moist." -Response to treatment stated: --"Entire area measures 1.4 cm X 1.1 cm." with the depth had not addressed. --"Center area measures 0.4 cm X 0.4 cm." with the depth had not addressed. --"Edges pink et raised." --"Cleaned et applied polymem dressing." Nutritional status had not been addressed. Preventive measures had not been addressed. *On 7/14/15 the ulcer: -Was staged a two. -In the measurements column it stated "see below."</p>	F 314		

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F 314	<p>Continued From page 54</p> <ul style="list-style-type: none"> <li>-It had "scant" exudate.</li> <li>-The tunneling column had not been addressed.</li> <li>-It had "none" odor.</li> <li>-The wound bed was "tan moist."</li> <li>-Response to treatment stated:</li> <li>--"Entire area measures 1.4 cm X 1 cm" with the depth not been addressed.</li> <li>--"Center measures 0.4 cm X 0.4 cm with scant drainage noted" with the depth had not been addressed.</li> <li>--"Edges pink et raised."</li> <li>--"Area cleaned et Polymem dressing applied."</li> <li>-Nutritional status stated, food intake at "50-75%."</li> <li>-Preventive measures were:</li> <li>-"Turned q 1-2 hours."</li> <li>-Pressure relieving interventions "mattress, protective boots."</li> <li>-"High protein supplements."</li> <li>*On 7/23/15 the ulcer:</li> <li>-Was a stage two measuring 0.8 cm X 0.8 cm X 0.1 cm.</li> <li>-It had "scant serous" exudate.</li> <li>-The tunneling column had not been addressed.</li> <li>-The odor column stated "none."</li> <li>-Response to treatment stated:</li> <li>--"Scant amount of serous drainage noted."</li> <li>--"Cleaned et applied new Polymem dressing."</li> <li>-Nutritional status: food intake at "50-75%."</li> <li>-Preventive measures:</li> <li>-"Turned q 1-2 hours."</li> <li>-Pressure relieving interventions:</li> <li>--"Protective foam around area, heel protectors/protective boots."</li> <li>--"Noted to change position per self."</li> <li>*On 7/27/15 the ulcer:</li> <li>-Was a stage two measuring 0.5 cm X 0.5 cm X 0.1 cm.</li> <li>-The exudate column had a line drawn through it.</li> <li>-The tunneling column had not been addressed.</li> </ul>	F 314		

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F 314	Continued From page 55 -The odor column stated had a line drawn through it." -Response to treatment stated "New polymem dsg [dressing] after bath." -Nutritional status: food intake at "50-75%." -Preventive measures: --"Turned q 1-2 hours." --Pressure relieving interventions were "Heel protector boots on." *On 8/4/15 the ulcer: -Was a stage three measuring 1.0 cm X 1.0 cm X 0.1 cm. -It had "scant purulent" exudate. -The tunneling column had not been addressed. -The odor column stated "none." -Response to treatment stated: --"Scant amount of purulent drainage." --"Area increase in size." --"Applied polymem." --"Rolled 4 X 4 dressings and applied to surrounding area, leaving (raised) around sore." [Creating a donut dressing.] --"No pressure to area with rolled 4 X 4s in place." -Nutritional status: food intake at "50-75%." -Preventive measures: --"Turned q 1-2 hours." --"High protein supplements." * On 8/10/15 the ulcer: -Was a stage three measuring "1.2 cm X 0.9 cm [with no depth measured], overall 1.7 cm X 1.7 cm X 0.2 cm." -It had "serous" exudate. -The tunneling column had a diagonal line drawn through it. -The odor column had a zero with a line drawn through it. -Response to treatment: --"Surrounding edges whitened with maceration	F 314			

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F 314	Continued From page 56 [moisture] after bath." --"Area sensitive." --"Polymem applied with rolled gauze edge/frame around area." --"Shakes head no when asked about pain." --"Polymem dressing placed." --"0.5 cm X 0.6 cm purple bruise noted near open area." -Nutritional status: food intake at "50-75%." -Preventive measures: --"Turned q 1-2 hours." --Pressure relieving interventions "mattress, wc [wheelchair]." --"Does turn self back onto back, side." *On 8/10/15 resident 14's left lateral foot/ankle ulcer had become "unstageable." -The ulcer measured "1.5 cm X 1.2 cm, with an unk [unknown] depth." -In the exudate column there was a line drawn through the box. -In the tunneling column "unk" was hand written in. -The wound bed was "purplish red [zero with a line drawn through it] open." -Response to treatment revealed: --"Assessed by [physician name]." --"Caused by rolled 4 X 4's ordered previously as frame around polymembraned sore on bony prominence." --"[physician name] instructs to stop framing." --"Monitor." --"Keep pressure off if able." -Nutritional status had not been addressed. -Preventive measures: --"Turned q 1-2 hours." Hand written in was "Repos self." --Pressure relieving interventions "mattress." --"High protein supplements" had been checked. --"Multivitamins/Zinc" had been checked.	F 314			

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F 314	Continued From page 57 *On 8/17/15 the ulcer: -The column labeled stage had been left blank. -It measured "2 cm X 2.1 cm X 0.3 cm." -It had "yellow" exudate. -The tunneling column had been left blank. -The odor column had a zero with a line through it. -The wound bed column had been left blank. -Response to treatment stated "Area is larger with dark yellow black center area with new area starting above." -Nutritional status had not been addressed. -Preventive measures were: --"Turned q 1-2 hours." --Pressure relieving interventions "mattress-booties." --"High protein supplements" had been checked. --"Multivitamins/Zinc" had been checked. *On 8/20/15 the ulcer: -The column labeled stage had been left blank. -It measured "2.5 cm X 2.2 cm X 2 mm [millimeters]." -It had "yellow/green/brown copious [large amount]" exudate. -The tunneling column had "unk" written in. -The odor column had a "foul necrotic" written in. -The wound bed column had "black/brownish/yellow slough." -Response to treatment: --"Changed since updated Dr. [doctor] on 17 th." --Pt [patient] Duoderm sloughed off." --"Area cleansed." --"Duoderm replaced." --Pt repos self back onto this area frequently." --Updated clinic with change." -Nutritional status had not been addressed. -Preventive measures: --"Turned q 1-2 hours." --Pressure relieving interventions "mattress, heel	F 314			

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F 314	Continued From page 58 protectors, repo off area. Tylenol TID [three times a day] on schedule." --"High protein supplements" had been checked. --"Multivitamins/Zinc" had been checked. --Pain "no verbalize pain, flinches with care of wound." *On 8/24/15 the ulcer: -Was "unstageable." -The size was "2.2 cm X 2.9 cm X unk 1-2 mm." -It had "yellow/green/brown sm amount" exudate. -The tunneling column had "unk" written in. -The wound bed was "black and yellow and eschar." -Response to treatment: --"Wet to dry dressing used." --"Post bath are has very faint odor." --"Pt continues to repo self back on this area." --"Plan to have [name of physician] assess today for possible change in treatment." -Nutritional status had not been addressed. -Preventive measures: --"Turned q 1-2 hours." --Pressure relieving interventions "mattress, heel protectors, attempting to repo off area. Tramadol [stronger pain medication] TID now ordered." --"High protein supplements" had been checked. --"Multivitamins/Zinc" had been checked. --Pain had been checked as "yes." *On 8/31/15 the ulcer: -Was staged as three measuring 2.5 cm X 2.2 cm X 0.3 cm. -It had "small purulent drng [drainage]." -The tunneling column "unknown" was written in. -The odor column stated "faint." -The wound bed was "white/yellow slough." -Response to treatment: --"Area assessed after bath." --"Center is yellow/white et moist with "slight foul odor."	F 314			

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F 314	<p>Continued From page 59</p> <ul style="list-style-type: none"> <li>--"Wet to dry dressing changed after bath."</li> <li>-Nutritional status had not been addressed.</li> <li>-Preventive measures:</li> <li>--"Turned q 1-2 hours."</li> <li>--Pressure relieving interventions "mattress, heel protectors."</li> <li>--"High protein supplements" had been checked.</li> <li>--"Multivitamins/Zinc" had been checked.</li> <li>--Pain had not been addressed."</li> <li>*On 9/7/15 the ulcer:</li> <li>-Was staged as three measuring 3.0 cm X 2.0 cm X 0.3 cm.</li> <li>-It had "yellow/green drainage with "foul" odor.</li> <li>-The tunneling column had been left blank.</li> <li>-The wound bed was "gray/white."</li> <li>-Response to treatment:</li> <li>--"Area assessed after bath."</li> <li>--"Center is yellow with gray around moist foul smell."</li> <li>--"Wet to dry dressing changed."</li> <li>-Nutritional status had not been addressed.</li> <li>-Preventive measures had not been addressed.</li> <li>*On 9/14/15 the ulcer:</li> <li>-Was staged as three measured 2.0 cm in diameter X 0.2 cm deep.</li> <li>-It had "tan exudate on the inner edges with "foul" odor.</li> <li>-The tunneling column had been left blank.</li> <li>-The wound bed was "tan/pink."</li> <li>-Response to treatment:</li> <li>--"Wound moist - pink - dark pink in middle."</li> <li>--"Tan exudate to edges."</li> <li>--"Wet to dry dressings."</li> <li>-Nutritional status:</li> <li>--Food intake "50-75 %.</li> <li>--Skin turgor "Fair."</li> <li>-Preventive measures:</li> <li>--"Turned q 2 hours."</li> <li>--Pressure relieving interventions "repo, Broda</li> </ul>	F 314		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435118</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/21/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRAIRIE VIEW CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>401 SOUTH FIRST AVENUE POST OFFICE BOX 68 WOONSOCKET, SD 57385</b>		
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F 314	<p>Continued From page 60</p> <p>chair [specialized wheelchair], heel protectors." --"High protein supplements." --Pain "yes when touched." *On 9/21/15 the ulcer: -Was staged as three measuring 2.2 cm X 2.4 cm X 0.4 cm. -It had "small" exudate. -The tunneling column had been left blank. -The odor column had a zero with a line through it. -The wound bed was "yellow/gray slough." -Response to treatment: --"Does C/O [complain of] pain, swearing when dressing placed." --"Difficulty positioning off area." --"Fentanyl [strong pain medication] patch." --"Denies pain at all other times." -Nutritional status had not been addressed. -Preventive measures: --"Turned q 1-2 hours." --Pressure relieving interventions "repo, Broda chair, soft boots." --"High protein supplements." --Pain "yes." *On 9/28/15 the ulcer: -Was staged as three measuring 2.2 cm X 2.4 cm X 0.4 cm. -It had "small yellow/brown" exudate. -The tunneling column had written in "unk" [unknown]. -The odor column was "very sl" [slight]. -The wound bed was "yellow/red/pink." -Response to treatment was "Unchanged in size and depth." -Nutritional status had not been addressed. -Preventive measures: --"Turned q 1-2 hours as allows." --Pressure relieving interventions "repo, Broda chair, soft boots."</p>	F 314			

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F 314	<p>Continued From page 61</p> <p>--"High protein supplements."</p> <p>*On 10/5/15 the ulcer:</p> <p>-Was staged as three measuring 2.2 cm X 2.1 cm X 0.4 cm.</p> <p>-It had "small amt. tan/yellow" exudate with "scant" odor.</p> <p>-The tunneling column had written in "unk."</p> <p>-The wound bed was "pink/moist."</p> <p>-Response to treatment:</p> <p>--"Area slightly decreased in size."</p> <p>--"Wound bed is pink et moist."</p> <p>--"Dressing changed after bath"</p> <p>--" Resident noted to self reposition onto side of sore while in chair."</p> <p>--"Turns feet et rubs."</p> <p>-Nutritional status:</p> <p>--Ideal body weight "below" had been checked.</p> <p>--Actual weight had "losing" checked.</p> <p>--Food intake had "50-75 %" checked.</p> <p>-Preventive measures:</p> <p>--"Turned q 1-2 hours as allows."</p> <p>--Pressure relieving interventions "reposition protective boots."</p> <p>--"High protein supplements."</p> <p>*On 10/15/15 the ulcer:</p> <p>-Was staged as four measuring 2.0 cm X 2.3 cm X 0.3 cm.</p> <p>-It had "frank small amt."</p> <p>-The tunneling column had been left blank.</p> <p>-The odor column had a zero with a line drawn through it.</p> <p>-The wound bed was "red, small area yellow slough top left corner."</p> <p>-Response to treatment:</p> <p>--"Area free from most slough et entire bed of wound now visible."</p> <p>--"White silver bone now apparent to 600 [six o'clock] position of wound very near edge."</p> <p>--"Rest of wound bed red with small corner of</p>	F 314			

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F 314	<p>Continued From page 62 yellow slough at 1100 [eleven o'clock] position." --"Call out to clinic to update." -Nutritional status: --Ideal body weight "below" had been checked. --Actual weight had "losing" checked. --Food intake had "50-75 %" checked and "below 50% 'at times'" was written in. -Preventive measures: --"Turned q 1-2 hours. Repos self back onto area." --Pressure relieving interventions "protective soft boots. Unna [specialized treatment] boot to left lower leg." --"High protein supplements."</p> <p>Review of the 8/12/15 care plan revealed: *Focus area: "Nutrition: I am on a regular diet with pureed textures and nectar thick liquids." -Goal: "I will allow staff to asst. [assist] me with meals. Weight at symbol for greater than 185# [pounds]." -Interventions: --"I will be on the NIP [nutrition intervention] program." --"I will receive supplements 3 X daily between meals. Magic cups will be my supplement." --"I will set at a asst. table so they can help me eat." --"Wake me up if I should fall asleep at table." *Focus area: "Skin: The resident is at risk for skin breakdown r/t [related to] decreased mobility, contractures, and incontinence. The resident has a pressure sore to outer aspect of left foot et MASD [moisture associated skin damage] to buttocks/gluteal fold. 8/10/15 Unstageable pressure ulcer to left lateral foot/ankle." -Goal: "The resident will maintain or develop clean and intact skin by the review date of 7/14/15."</p>	F 314		

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F 314	<p>Continued From page 63</p> <p>-Interventions: --"Encourage good nutrition and hydration in order to promote healthier skin." --"Heel protectors when in bed/chair." --"Identify/document potential causative factors and eliminate/resolet where possible." --"Unna boot change weekly 10/7/15." --"Keep skin clean and dry." * Focus area: "Bowel/Bladder: The resident is always incontinent of bowel and bladder r/t physical limitations and dementia." -Goal: "The resident will remain free from skin breakdown due to incontinence and brief use through the review date of 7/14/15." -Interventions: --"Clean peri-area with each incontinence episode." --"Incontinent products worn." --"Assure resident is clean and free from odor." --"Report changes in my skin related to incontinence to my charge nurse." --"W/P [whirlpool] bath weekly."</p> <p>9. Review of resident 15's medical record revealed: the most current MDS assessment had been completed on 8/25/15. *ADLs indicated she needed set-up assistance of one staff member for toileting. *She needed extensive assistance of one staff member for dressing. *She had not been at risk for developing a pressure ulcer. *She had not been on a toileting or repositioning program. *She had not been on a nutrition or hydration intervention program.</p> <p>*The 8/25/15 Braden score had been twenty-two indicating she had not been at risk for developing</p>	F 314			

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F 314	<p>Continued From page 64 a pressure ulcer.</p> <p>Review of the 10/21/15 provider's following reports revealed: *The Urinary Continence one indicated she had been occasionally incontinent. *The Bowel Continence one indicated she had been continent. *The MASD one indicated she did not have skin impairment caused by moisture. *The Pressure Sore one indicated she had a facility acquired pressure ulcer.</p> <p>Review of the provider's skin assessment book revealed resident 15 had: *A pressure ulcer on her right buttock on 10/9/15. -It was staged at two measuring 0.5 cm X 0.9 cm X [symbol that indicated less than] 0.1 cm. -In the column for exudate it had a zero with a line through it. -The tunneling column had a diagonal line drawn through it. -The odor column had a zero with a line drawn through it. -The wound bed was "pink." -Response to treatment: --"S.O. [standing order from the physician] Duoderm placed." --Zero with line through it "C/O pain." --"Education provided regarding need to not sit on area all the time and to use bed to lie down on sides." -Nutritional status: Ideal body weight "above." -Preventive measures pressure relieving interventions "Lay on side in bed." -Pain "No."</p> <p>Resident 15's care plan had been requested on 10/21/15 at 7:30 a.m. from the director of nursing</p>	F 314			

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F 314	<p>Continued From page 65 but had not been received prior to survey exit on 10/21/15 at 12:00 noon.</p> <p>10. All of the pressure ulcer forms (except for residents 12 and 13) did not have an indication if the residents had been receiving protein supplements or a multivitamin with zinc. That area was to have been evaluated and documented on the provider's Weekly Pressure Ulcer Record by the nurse completing the form.</p> <p>Surveyor:32573 Review of the provider's undated charge nurse job description revealed nurse responsibilities included: *Assessing residents as necessary and making nursing judgements based on those assessments. *Monitoring resident care "(dress, personal hygiene, turning, food intake, bowel and bladder program). *Observing and reporting any change in residents condition, alertness, or resident's complaints. *Assisting residents with transfers or changing positions. *Assisting in training and education of other staff.</p> <p>Review of the provider's undated nurse aide/orderly job description revealed aides responsibilities included: *Assisting residents in and out of bed. *Assisting residents in bathing and dressing. *Assisting residents in the bathroom and with peri-care. *Assisting with routine care and treatments. *Report any change in the resident's status to a nurse with important information.</p> <p>Review of the provider's undated bath aide job</p>	F 314			

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F 314	<p>Continued From page 66</p> <p>description revealed bath aides responsibilities included:</p> <ul style="list-style-type: none"> <li>*Reporting "anything unusual such as (the following had been in bold font): weakness, pallor [pale color], sores, lumps, etc."</li> <li>*Paying "special attention to coccyx and genitalia [female and male body area] (wipe gently but thoroughly)."</li> <li>*Making sure "the resident is well dried (especially under breast, folds, creases and between toes)."</li> <li>*Giving a written report of all bathed residents to a charge nurse at the end of shift.</li> </ul> <p>Surveyor: 32572</p> <p>Review of the provider's policies revealed:</p> <ul style="list-style-type: none"> <li>*They did not have a toileting program policy.</li> <li>*They did not have a policy on Braden assessments.</li> </ul> <p>The 12/12/11 reviewed Pressure Ulcer Prevention policy stated:</p> <ul style="list-style-type: none"> <li>- "Purpose: To promote healthy intact skin, and prevent breakdown."</li> <li>- "Policy: Resident's that are identified as 'at risk' will have interventions initiated to reduce the risk of skin breakdown."</li> <li>- "Procedure: Bath aid will keep a daily log of all skin concerns and present them to the charge nurse at the end of the shift. Charge nurse is responsible to follow up on any and all concerns."</li> <li>- "Interventions: <ul style="list-style-type: none"> <li>--Implement a turning schedule, changing position at least every two hours. Position changes can be made in chairs and with toileting."</li> <li>---"Limit sitting time to no longer than two hours at a time. Encourage or shift residents' weight at least hourly when up in any type of chair."</li> </ul> </li> </ul>	F 314		

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F 314	Continued From page 67 --"DO NOT use a donut type device." --"Inspect area at least once a day." --"Manage urinary and/or fecal incontinence." --"Review all related information and documents to look for evidence of identified causes for the condition or problem."  Interview on 10/21/15 at 10:00 a.m. with the interim administrator confirmed: *Wounds had been found at stage II or greater, never at stage I. She was unsure if the CNA staff knew about stage I pressure ulcers. *All forms were to be completed fully and accurately. *Documentation needed to reflect what was done; if not charted it was not done. -Repositioning had been on the care plans for some of the residents, but no documentation of the repositioning was found.	F 314			
F 353 SS=H	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS  The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.  The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:  Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.	F 353	F353  1. The facility will maintain adequate staffing to provide nursing and related services to attain or maintain the highest practical physical, mental, and psychosocial well-being of each resident.*1  2. All residents are at risk.  3. The Administrator will in-service all staff on staffing levels and expectations no later than November 14, 2015. Those not in attendance will be educated prior to their first shift worked.  4. The DON or designee will review daily staffing and adjust assignments as		

\*Audits will be completed by the DON or designee for 2 months to ensure staffing measures were implemented with staff changes. Audits will be reported to QAPI. LA/SPD004/EL

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F 353	<p>Continued From page 68</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: Surveyor: 32572</p> <p>Surveyor: 32573 Based on observation, record review, interview, and policy review the provider failed to maintain adequate staff to prevent resident care issues related to abuse, neglect, and dignity, and meet basic care needs to ensure the well-being of all residents in the facility. Findings include:</p> <ol style="list-style-type: none"> <li>1. Interview with staff who wish to remain confidential during the survey revealed they did not believe there was enough staffing to properly care for residents. Refer to F224, findings 8 and 9.</li> <li>2. Residents had not been free of abuse and neglect. Refer to F223, all findings.</li> <li>3. Residents' dignity had not been maintained. Refer to F241, all findings.</li> </ol> <p>Surveyor: 32572</p> <ol style="list-style-type: none"> <li>4. Review of the provider's 2015 Turnover report listed the following number of employees had been terminated or quit: *January: One. *February: Two. *March: Three. *April: Five.</li> </ol>	F 353	<p>necessary based on resident care needs. Daily review will continue for 1 month and will be discussed by the DON in monthly Quality Assurance Process Improvement (QAPI) for review and recommendations of continuation or discontinuation of audit and any further action required.</p> <p>5. November 14, 2015</p>	11-14-15	

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F 353	<p>Continued From page 69</p> <p>*May: Four. *June: Three. *July: Two. *August: None. *September: Three. *October 1 through 20: Four. January through October 20, 2015, twenty seen employees had either been terminated or quit.</p> <p>Surveyor 32573 5. Interview on 10/21/15 at 10:00 a.m. with the administrator revealed: *Staffing was hard to find in rural areas. *Current staff had stepped up to fill in the gaps. *She had implemented a program to cross train staff into multiple departments. *Licensed nursing staff were responsible for monitoring aides and reporting any issues back to management. *Licensed nursing staff were expected to take any issues with staff to that person right away. *When looking at hiring someone, administration looked at the board of nursing website and did a background check to make sure they qualified. *She tried to place staff into groups where they worked with residents they got along best with. -That was to help with staff burnout. -Residents could form closer relationships with staff in many departments. *Staff had preceptors they could talk to if they became frustrated about work. *Staff were monitored every two months for how much overtime they worked to watch for burnout. *She did not feel there were not enough staff to take care of all the residents' needs.</p> <p>Review of the provider's undated Resident Rights policy given to all residents on admission revealed residents had the right to:</p>	F 353			

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F 353	Continued From page 70 *Be treated with respect and dignity. *Be free from physical/mental abuse. *Have reasonable accommodation made. *Trained staff. *Voice grievances."	F 353			
F 490 SS=H	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Surveyor: 32572  Surveyor: 32573 Based on interviews, observations, record reviews, and policy reviews throughout the course of the survey from 10/19/15 through 10/21/15 revealed the administration had not ensured all residents attained and/or maintained their highest practicable physical, mental, and psychosocial well-being. Findings include:  1. Refer to F223, F224, F226, F278, F280, F314, and F353.  2. Review of the provider's job descriptions revealed: *CNA summary-"Performs the functions of a nursing assistant in carrying out all assignments given by the RN or LPN in charge of the facility. Is accountable for all residents' care he/she is assigned during a shift. He/she is responsible for	F 490	F490  1. The Director of Operations has reviewed the job description with the Administrator.  2. All residents are at risk.  3. The Director of Operations will conduct bi-monthly phone conferences or visits to the facility to monitor progress <i>Audits findings will be discussed with the director of operations. LA/SPD/H/EL</i> 4. Identified problems will be brought to monthly QAPI and discussed with the Director of Operations for further recommendations or actions  5. November 14, 2015	11-14-15	

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435118</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/21/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRAIRIE VIEW CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>401 SOUTH FIRST AVENUE POST OFFICE BOX 68 WOONSOCKET, SD 57385</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 490	Continued From page 71 promoting teamwork among co-workers and personal self-development. Maintain confidentiality of information regarding residents, families, health care personnel and [facility name]." "Consequences of Action: Failure to comply with department and or [facility name] policies will result in disciplinary action as outlined in our employee handbook." *Charge Nurse registered nurse (RN)/ licensed practical nurse (LPN)-"The primary responsibility of this position is to take responsibility for supervision and providing quality care to our residents in a friendly home-like atmosphere, while allowing them to make choices. This is done in accordance with our policies, procedures, and the state and federal guidelines and your scope of practice." *The last page of the job description number 31 stated "Report any resident abuse IMMEDIATELY [That was bolded and capitalized]." *An administrator job description had been requested but was not provided by the time of the survey exit at 12:00 noon on 10/21/15.  Surveyor: 32572 Review of the provider's 1/1/09 Hiring policy revealed: **The following criteria will be considered in determining whether an applicant is qualified for a particular job position: -Ability to perform the essential functions of the job (with or without reasonable accommodations); -Skill, knowledge, training, efficiency, ets.; and -Certifications and licenses." "The administrator will determine how to seek applicants from outside the facility."	F 490		
F 520	483.75(o)(1) QAA	F 520		

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F 520 SS=H	<p>Continued From page 72 <b>COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</b></p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on record review, interview, and policy review, the provider failed to ensure an effective quality assurance (QA) program had been maintained to identify concerns within the facility and to develop and implement corrective action for issues involving pressure ulcers (injury to the skin usually from pressure and over bony area), abuse, neglect, dignity, and staffing concerns.</p>	F 520	<p>F520</p> <ol style="list-style-type: none"> <li>All deficiencies will be discussed in monthly QAPI. Weekly audits will be reviewed and further recommendations or actions discussed and implemented.</li> <li>All residents at risk.</li> <li>The Administrator, DON and interdisciplinary team will review the QAPI guidelines no later than November 14, 2015.</li> <li>The Director of Clinical Services will review monthly QAPI meeting minutes and attend a QAPI meeting at least quarterly.</li> <li>November 14, 2015.</li> </ol> <p>completed by the administrator or designee and LA/SPD00H/EL</p>	11-14-15
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NAME OF PROVIDER OR SUPPLIER  <b>PRAIRIE VIEW CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>401 SOUTH FIRST AVENUE POST OFFICE BOX 68</b> <b>WOONSOCKET, SD 57385</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 520	<p>Continued From page 73</p> <p>Findings include: Surveyor: 32573</p> <p>1. Interview on 10/21/15 at 10:00 a.m. with the administrator revealed:</p> <ul style="list-style-type: none"> <li>*The facility was transitioning from their traditional QA plan to a different Quality Assurance and Performance Improvement (QAPI) program.</li> <li>*They would keep their current QA plan in place until QAPI was fully implemented.</li> <li>*They had started QAPI activities such as using performance improvement projects (PIP) to address quality issues.</li> <li>*They had done falls and were currently working on a pressure ulcer PIP.</li> </ul> <p>Review of the provider's 1/15/13 Quality Assessment and Assurance Committee policy revealed:</p> <ul style="list-style-type: none"> <li>*The purpose of the QA committee was to "ensure the facility maintains a high level of quality care of its residents."</li> <li>*The committee was responsible for identifying issues and concerns related to quality deficiencies and develop plans to improve them.</li> </ul> <p>Refer to all findings in F223, F224, F226, F241, F278, F314, F353, and F490.</p> <p>Surveyor: 32572 An Attempt was made to reach the medical director for a phone interview on 10/21/15 however he was not in the office.</p>	F 520			