

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

**ORIGINAL**

PRINTED: 06/09/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435032</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/01/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>CUSTER REGIONAL SENIOR CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1065 MONTGOMERY ST CUSTER, SD 57730</b>	
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F 000	INITIAL COMMENTS  Surveyor: 29162 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/31/16 through 6/1/16. Areas surveyed included quality of care and safety. Custer Regional Senior Care was found not in compliance with the following requirements: F155, F279, F281, F323, F490, F514, and F520.	F 000	*Addendums noted with in asterisk per 6/3/16 per facility administrator and DON. JD/SPD/HJEL	
F 155 SS-K	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES  The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.  The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.  This REQUIREMENT is not met as evidenced by: Surveyor: 29162	F 155		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

*Veronica Stewart* administrator 6/15/16

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.

JUN 20 2016

SD DOH L&C

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F 155	<p>Continued From page 1</p> <p>Based on record review, policy review, and interview, the provider failed to ensure CPR would be initiated in the event of a cardiac arrest for ten of ten sampled residents (5, 6, 7, 8, 9, 10, 11, 12, 13, and 14) who were a full code status per resident choice.</p> <p><b>NOTICE:</b> On 6/1/16 at 11:07 a.m. notice of immediate jeopardy was given verbally to the administrator and director of nurses (DON). They were asked for an immediate plan of correction (POC) to ensure all residents who chose CPR in the event of cardiac arrest had their choice carried out.</p> <p><b>PLAN:</b> An immediate plan of correction (POC) for correct CPR initiation for residents electing the same was accepted on 6/1/16 at 2:40 p.m. That plan follows:</p> <ol style="list-style-type: none"> <li>1. "Advanced Directive Policy reviewed and revised by DON, Administrator and Social Service Coordinator to include the following statement: Prior to arrival of emergency medical services (EMS), CRSC will provide basic life support, including the initiation of CPR, to a resident who experiences cardiac arrest (cessation of respirations and/or pulse) in accordance with that resident's advanced directives or in the absence of advance directives or a Do Not Resuscitate (DNR) order. CPR-Certified staff must be available at all time."</li> <li>2. "The CRSC Resuscitation Policy/Statement form revised by DON, Administrator and Social Service Coordinator deleting the statement: In the event of a non-witnessed cardiopulmonary arrest, no heroic measures will be taken regardless of the code status."</li> <li>3. "All staff on shift on this date will be educated</li> </ol>	F 155	<p>Short term action plan for immediate jeopardy:</p> <p>All current and future residents are potentially affected by deficiency regarding the right to refuse treatment and formulating an advanced directive.</p> <ol style="list-style-type: none"> <li>1) The Advanced Directive policy was reviewed and revised by DON, Administrator, and Social Service (SS) Coordinator on 6/1/16 to include the following statement: Prior to arrival of emergency medical services (EMS), Custer Regional Senior Care (CRSC) will provide basic life support, including initiation of CPR, to a resident who experiences cardiac arrest (cessation of respirations and/or pulse) in accordance with that resident's advanced directives or in the absence of advanced directives or a Do Not Resuscitate (DNR) order. CPR (Cardio-pulmonary resuscitation)-Certified staff must be available at all times.</li> <li>2) The CRSC Resuscitation Policy/Statement form was reviewed by DON (Director of Nursing), Administrator and SS Coordinator deleting the</li> </ol>	

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F 155	<p>Continued From page 2</p> <p>on the updated policy and procedure regarding Advanced Directives immediately. Staff not on shift will be educated by their supervisor upon reporting for their next shift."</p> <p>4. "The Administrator will update medical staff of the revisions to the policy immediately."</p> <p>5. "Residents with current full code status will have their resuscitation form reviewed and updated with them by end of 6/1/16 by Social Service Coordinator and designated staff to assist."</p> <p>6. "The remainder of the residents that have DNR status will have their resuscitation form sent to them to reviewed and signed by 7/1/16."</p> <p>7. "All new staff will be educated by their supervisor upon hire regarding the revised policy and procedures of Advanced Directives."</p> <p>8. "All new resident/family will be educated by Social Service Coordinator upon admission of revised policy and procedures of Advanced Directive."</p> <p>9. "Code status change forms will be audited by Social Service Coordinator through the Care Conference Log utilized for MDS data input beginning immediately and reported to QAPI who will determine future audit schedule."</p> <p>10. "All staff will be able to identify full code status either by heart on the resident's chart, C.N.A. report sheet or the form designated for other staff review."</p> <p>During the survey on 6/1/16 at 2:40 p.m. the surveyors confirmed removal of the immediate jeopardy situation. Findings include:</p> <p>Surveyor 32333</p> <p>1. Review of resident 5's medical record revealed: *A Resuscitation Policy/Statement.</p>	F 155	<p>statement: In the event of a non-witnessed cardiopulmonary arrest, no heroic measures will be taken regardless of the code status.</p> <p>3) All staff on shift on this date (6/1/16) on the updated policy and procedure regarding Advanced Directives immediately. Staff not on shift will be educated by their supervisor upon reporting for their next shift.</p> <p>4) The Administrator will update medical staff of revisions to the policy immediately.</p> <p>5) Residents 5,6,7,8,9,10, 11,12,13,14 with current full code status will have their resuscitation form reviewed and updated with them by the end of 6/1/16 by SS Coordinator and designated staff to assist.</p> <p>6) The remainder of the residents that have DNR status will have their resuscitation form sent to them to be reviewed and signed by 7/1/16. (Certified letters sent to all families/Power of Attorneys week of 6/6/16 through 6/10/16).</p> <p>7) All new staff will be educated by their supervisor upon hire regarding the revised policies and procedures regarding Advanced Directives- ongoing</p>	

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F 155	<p>Continued From page 3</p> <p>*That statement had been signed by the resident's power of attorney on 4/15/16, the physician on 5/3/16, the administrator on 4/26/16, and the director of nursing (DON) on 4/18/16.</p> <p>*The type of resuscitation the resident had selected stated, "Use CPR and transfer to the hospital with the expectation that mechanical and medical intervention will be utilized including intubation and ventilation. Also known as a FULL CODE."</p> <p>*Number 5 on the same form stated, "In the event of a NON-WITNESSED cardiopulmonary arrest, no heroic measures will be taken REGARDLESS of the code status."</p> <p>Interview on 6/1/16 at 11:30 a.m. with resident 5 confirmed his choice to have CPR in the event of cardiac arrest.</p> <p>Interview on 6/1/16 at 3:05 p.m. with resident 5 and his daughter revealed: *She had signed the form. *Her father had some difficulty with writing. *They had not been informed of statement number 5 on the form. *She had not read the fine print.</p> <p>Surveyor 29162 2. Review of resident 6's medical record revealed: *A Resuscitation Policy/Statement. *That statement had been signed by the resident's power of attorney on 3/2/15, the physician's signature had not been dated, the administrator on 3/3/15, and DON on 3/4/15. *The type of resuscitation the resident had selected stated, "Use CPR and transfer to the hospital with the expectation that mechanical and medical intervention will be utilized including</p>	F 155	<p>8) All new resident/family will be educated by SS Coordinator or designee upon admission of revised policy and procedures for Advanced Directives- ongoing</p> <p>9) Code status Change forms will be audited by Social Service Coordinator through the Care conference Log utilized for MDS data input beginning immediately and continued ongoing. These findings will be reported to QAPI (Quality Assurance Performance Improvement) team who will determine future auditing schedule.</p> <p>10) All staff will be able to identify residents with full code status either by heart on the resident's chart, C.N.A report sheet or the form designated for other staff to review.</p> <p>11) Education will be provided to all staff at meetings to include the new policy review, resident's right to refuse treatment and formulate an advanced directive as well as identification of a resident with full code status no later than 6/24/16.</p> <p>12) Staff who are unable to attend d/t leave of absence, vacation or other excused absence will receive the</p>	<p>*X6 months *X6 months *then months</p> <p>JD/SB/DCH/EL</p>

*\*Weekly for any resident are for an MDS assessment.*

*\*X6 months*

*\*X6 months*

*\*then months*

*JD/SB/DCH/EL*

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F 155	<p>Continued From page 4 intubation and ventilation. Also known as a FULL CODE." *Number 5 on the same form stated, "In the event of a NON-WITNESSED cardiopulmonary arrest, no heroic measures will be taken REGARDLESS of the code status."</p> <p>Interview on 6/1/16 at 11:30 a.m. with resident 6 confirmed her choice to have CPR in the event of cardiac arrest. She stated, "Yes, I want CPR started and so do my kids."</p> <p>3. Review of resident 7's medical record revealed: *A Resuscitation Policy/Statement. *That statement had been signed by the resident's power of attorney on 6/25/15, physician on 7/28/15, administrator on 7/20/15, and DON on 7/15/15. *The type of resuscitation the resident had selected stated, "Use CPR and transfer to the hospital with the expectation that mechanical and medical intervention will be utilized including intubation and ventilation. Also known as a FULL CODE." *Number 5 on the same form stated, " In the event of a NON-WITNESSED cardiopulmonary arrest, no heroic measures will be taken REGARDLESS of the code status."</p> <p>Interview on 6/1/16 at 11:40 a.m. with resident 7 confirmed her choice to have CPR in the event of cardiac arrest. She stated, "Yes, if I have any chance at all do CPR."</p> <p>4. Review of resident 8's medical record revealed: *A Resuscitation Policy/Statement. *That statement had been signed by the</p>	F 155	<p>education upon their next shift worked by their supervisors.</p> <p>***Quality Assurance Performance Improvement purpose is to establish data-driven, facility-wide processes that improve the quality of care, quality of life and clinical outcomes of our residents. ***</p>	6/24/16

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F 155	<p>Continued From page 5</p> <p>resident's power of attorney on 4/9/14, physician on 4/10/14, administrator on 4/9/14, and DON on 4/9/14.</p> <p>*The type of resuscitation the resident had selected stated, "Use CPR and transfer to the hospital with the expectation that mechanical and medical intervention will be utilized including intubation and ventilation. Also known as a FULL CODE."</p> <p>*Number 5 on the same form stated, "In the event of a NON-WITNESSED cardiopulmonary arrest, no heroic measures will be taken REGARDLESS of the code status."</p> <p>Interview on 6/1/16 at 11:35 a.m. with resident 8 confirmed her choice to have CPR in the event of cardiac arrest. She stated, "Yes, I want CPR. Please talk to my kids too."</p> <p>5. Review of resident 9's medical record revealed: *A Resuscitation Policy/Statement. *That statement had been signed by the resident on 4/16/16, physician on 4/20/16, administrator on 4/26/16, and DON on 4/20/16. *The type of resuscitation the resident had selected stated, "Use CPR and transfer to the hospital with the expectation that mechanical and medical intervention will be utilized including intubation and ventilation. Also known as a FULL CODE." *Number 5 on the same form stated, " In the event of a NON-WITNESSED cardiopulmonary arrest, no heroic measures will be taken REGARDLESS of the code status."</p> <p>6. Review of resident 10's medical record revealed: *A Resuscitation Policy/Statement.</p>	F 155		

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F 155	<p>Continued From page 6</p> <p>*That statement had been signed by the resident's power of attorney on 12/19/15, physician on 12/15/15, administrator on 12/14/15, and DON on 12/9/15.</p> <p>*The type of resuscitation the resident had selected stated, "Use CPR and transfer to the hospital with the expectation that mechanical and medical intervention will be utilized including intubation and ventilation. Also known as a FULL CODE."</p> <p>*Number 5 on the same form stated, " In the event of a NON-WITNESSED cardiopulmonary arrest, no heroic measures will be taken REGARDLESS of the code status."</p> <p>7. Review of resident 11's medical record revealed: *A Resuscitation Policy/Statement. *That statement had been signed by the resident on 1/15/15, the physician on 2/4/15, the administrator on 2/9/15, and DON on 2/4/15. *The type of resuscitation the resident had selected stated, "Use CPR and transfer to the hospital with the expectation that mechanical and medical intervention will be utilized including intubation and ventilation. Also known as a FULL CODE." *Number 5 on the same form stated, " In the event of a NON-WITNESSED cardiopulmonary arrest, no heroic measures will be taken REGARDLESS of the code status."</p> <p>8. Review of resident 12's medical record revealed: *A Resuscitation Policy/Statement. *That statement had been signed by the resident's power of attorney on 3/8/16, the physician on 3/9/16, the administrator on 3/14/16, and DON on 3/8/16.</p>	F 155		

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F 155	<p>Continued From page 7</p> <p>*The type of resuscitation the resident had selected stated, "Use CPR and transfer to the hospital with the expectation that mechanical and medical intervention will be utilized including intubation and ventilation. Also known as a FULL CODE."</p> <p>*Number 5 on the same form stated, " In the event of a NON-WITNESSED cardiopulmonary arrest, no heroic measures will be taken REGARDLESS of the code status."</p> <p>9. Review of resident 13's medical record revealed: *A Resuscitation Policy/Statement. *That statement had been signed by the resident's power of attorney on 9/6/14, the physician's signature had not been dated, the administrator on 9/8/14, and DON on 9/8/14. *The type of resuscitation the resident had selected stated, "Use CPR and transfer to the hospital with the expectation that mechanical and medical intervention will be utilized including intubation and ventilation. Also known as a FULL CODE." *Number 5 on the same form stated, " In the event of a NON-WITNESSED cardiopulmonary arrest, no heroic measures will be taken REGARDLESS of the code status."</p> <p>10. Review of resident 14's medical record revealed: *A Resuscitation Policy/Statement. *That statement had been signed by the resident's power of attorney on 8/22/14, the physician on 10/2/14, the administrator on 9/30/14, and DON on 9/25/14. *The type of resuscitation the resident had selected stated, "Use CPR and transfer to the hospital with the expectation that mechanical and</p>	F 155		

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F 155	<p>Continued From page 8</p> <p>medical intervention will be utilized including intubation and ventilation. Also known as a FULL CODE."</p> <p>*Number 5 on the same form stated, " In the event of a NON-WITNESSED cardiopulmonary arrest, no heroic measures will be taken REGARDLESS of the code status."</p> <p>11. Interview on 5/31/16 with licensed practical nurse (LPN) B revealed in the event of a resident cardiac arrest she would: *Refer to her assignment sheet that told her if the resident should have CPR. *If the resident had no pulse or respirations she would not start CPR. *Probably do CPR if the resident had wanted CPR. *She might not do CPR if the resident appeared to have "been gone awhile." *Stated, "I guess I would start CPR though if that is what they wanted."</p> <p>Interview on 5/31/16 at 4:15 p.m. with LPN C revealed she would not start CPR for any resident in the event of an unwitnessed cardiac event. That would have included residents who had chose to have CPR.</p> <p>Surveyor 32333 Interview on 5/31/16 at 4:10 p.m. with LPN D revealed she would start CPR on a resident with a full code status in the event of an unwitnessed cardiac event.</p> <p>Interview on 5/31/16 at 4:15 p.m. and at 4:20 p.m. with unlicensed assistive personnel (UAP) E revealed: *In the event of of an unwitnessed cardiac event on a resident with a full code status she would</p>	F 155			

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F 155	<p>Continued From page 9</p> <p>page a nurse and wait for that nurse to come and tell her what to do. *At 4:20 p.m. UAP changed her answer and said she would page a nurse and then start CPR.</p> <p>Interview on 6/1/16 at 9:10 a.m. with the director of nursing revealed: *She would start CPR on on a resident with a full code status in the event of an unwitnessed cardiac event dependant on certain parameters. *She was not sure what those parameters would be. *The policy says we are to start CPR. *She was not aware of the Advance Directive policy.</p> <p>Interview on 6/1/16 at 1:25 p.m. with the social services coordinator revealed: *She had not been informing residents of the statement in the Advance Directive policy that CPR would not be initiated in an unwitnessed cardiac event. *She did not even realize that statement was on the form. *She did not understand the referenced statement, its like saying the residents choice does not matter.</p> <p>Surveyor 29162 AHA guidelines for CPR provide the standard for the American Red Cross, state EMS, agencies, healthcare providers, and the general public. The American Heart Association (AHA) urges all potential rescuers to initiate CPR unless: *A valid no CPR order was in place. *There were obvious signs of death such as: -Rigor Mortis, the stiffening of the joints after death. -Lividity, an unnatural color of the skin.</p>	F 155			

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F 155	Continued From page 10 -Decapitation. -Transection, cut in half. -Decomposition. *Initiating CPR would harm the rescuer.  Review of the provider's Advance Directives policy effective 5/31/15 revealed: **"A resident's choice about advance directives will be respected." **"In the event of a NON-WITNESSED cardiopulmonary arrest NO heroic measures will be taken, REGARDLESS of the advance directives code status." **"The care plan team will review the advance directives at least annually with the resident and/or representative to ensure the directives on file are still the wishes of the resident/representative." Surveyor: 32333	F 155			
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise	F 279			

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F 279	<p>Continued From page 11</p> <p>be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on record review, interview, and policy review the provider failed to update and revise care plans for: *One of one sampled resident (2) that died after a fall. *One of four sampled residents (3) with falls. Findings include:</p> <p>1. Review of resident 2's complete medical record revealed: *He was admitted on 2/20/16. *He had six falls since his admission. *His last fall was on 5/17/16. *He died on 5/22/16.</p> <p>Review of resident 2's 3/16/16 care plan revealed: *A focus area related to falls. *A goal with a target date of 3/14/16 stated "I will have no serious injury should I fall through the next review date." *The care plan had not been updated or revised with the resident's six falls.</p> <p>2. Review of resident 3's complete medical record revealed: *She was admitted on 2/2/16. *She had twenty-four falls since admission during the following months: -February, she had four falls.</p>	F 279	<p>All current and future residents are potentially affected by deficiency regarding comprehensive care plan development.</p> <ol style="list-style-type: none"> <li>1) No immediate action taken for resident #2 as he is no longer residing in the facility.</li> <li>2) Resident #3 care plan reviewed and revised to reflect resident's current status by 6/13/16.</li> <li>3) Future residents care plans will be updated with current data in accordance with the care planning policy-upon immediate intervention with event or within 7 days of notification of concern.</li> <li>4) Comprehensive care plan policy reviewed and revised by MDS Coordinator and DON to include updating the care plan by nursing staff immediately for events and interventions. 6/13/16</li> <li>5) Fall Prevention policy and a fall protocol was reviewed and revised by Quality Specialist and DON to include longer documentation requirements 72 hours vs 24 hours for follow up on falls as well as changes in the names of policies referenced per current facility policies and how to link notes to care plans. 6/13/16</li> <li>6) Nursing staff education regarding</li> </ol>	
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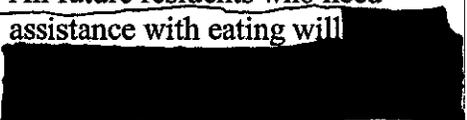
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F 279	<p>Continued From page 12</p> <p>-March, she had eight falls. -April, she had four falls. -May, she had eight falls.</p> <p>Review of resident 3's 2/25/16 care plan revealed: *She had a focus area of potential for falls. *There were multiple fall interventions in place. *Her care plan had not been updated with her falls. *Her care plan had not been updated or revised until 5/24/16. *A focus area of frequent falls was initiated on 5/20/16. -A goal to have no hip injuries due to falls. -An intervention for hipsters to be worn at all times.</p> <p>Interview on 6/1/16 at 5:25 p.m. with the director of nursing revealed the care plans should have been updated and revised with residents' falls.</p> <p>Review of the provider's revised 9/17/15 Care-plans Comprehensive policy revealed: *"Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require careful data gathering, proper sequence of events and complex clinical decision making. No single discipline can manage the task in isolation. The resident's physician (or primary healthcare provider) is integral to this process, based on his/her assessment results." *Assessment of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. The nurses who provide direct care are responsible for keeping care plans current."</p>	F 279	<p>"how to" care plan, document, and implement actions after each fall. Nursing staff reminded of the step by step guides for care planning and fall protocol that placed in the "facility protocol book" at the nurse' station previously- 6/14/16</p> <p>7) MDS Coordinator or designee will audit care plans of all residents events weekly x4 weeks then 15% of residents monthly x12 months to ensure care plan is updated timely and for accuracy of resident status. MDS Coordinator or designee will bring all findings to QAPI every [REDACTED]</p> <p><i>KMATH</i> <i>SD/SDD/H/EL</i></p>	6/24/16	

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F 279	Continued From page 13 Refer F323, finding 1.	F 279		
F 281 SS=E	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on record review, interview, and policy review, the provider failed to ensure complete, accurate, and professional documentation had been recorded for two of two sampled residents (1 and 4) who had choked. Findings include: 1. Review of resident 1's medical record revealed: *She was admitted on 12/23/10. *The Resuscitation Policy/Statement signed on 9/9/14 by her power of attorney chose no CPR in the event of a witnessed cardiac arrest (no pulse or respiration). *A physician's order for no CPR (life saving measures). *The 4/25/16 quarterly Minimum Data Set assessment stated she was supervised with set-up assistance from staff for meals and eating. *A monthly nursing assessment dated 5/2/16 stated she fed herself in the dining room or her room. *Interventions on her last revised 5/12/16 care plan for: -Regular diet -No CPR per physician's 8/26/13 order. *A physician's order for "regular diet with regular texture and consistency per resident</p>	F 281	<p>All current and future residents are potentially affected by the deficiency regarding services provided meet the professional standards.</p> <p>1) No immediate action is taken for resident #1 as she no longer a resident in the facility.</p> <p>2) </p> <p>3) All future residents who need assistance with eating will </p> <p>A policy called Emergency Care for Choking Victim (Conscious or Unconscious) was created by DON, MDS Coordinator and Quality Specialist to help staff identify choking signs, steps in</p>	

*\*resident #1 will be evaluated for his current risk for choking. Immediate steps have been taken to decrease risk of choking which include all small items are no longer available for assisted tables.*

*These risks and interventions are documented in the resident's medical record.*

*JD/SDDOT/EL*

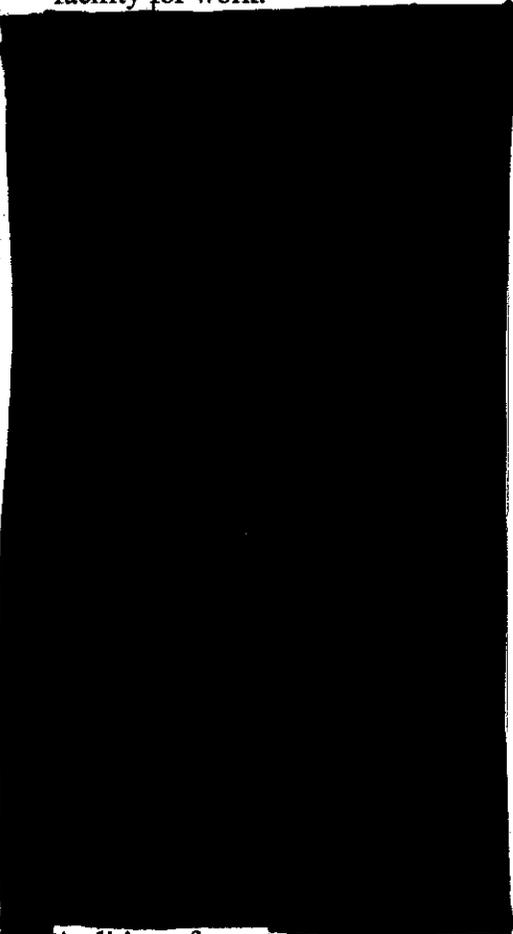
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F 281	<p>Continued From page 14 tolerance/comfort cares."</p> <p>Review of the progress note signed and dated 5/22/16 at 12:50 p.m. by RN A revealed, "[resident name] started choking after eating in the cafeteria myself and an aide did the heimlick and unable to remove what she was choking on. Pt passed about 1250 today."</p> <p>Review of the progress note "Incorrect Documentation" progress note that had been signed and dated on 5/22/16 at 13:00 (1:00 p.m.) by RN A revealed, "Note Text: At about 12:30 today [resident name] was in cafeteria having lunch. I was at nurses station charting and doing charge duties when an aide came out and said need a nurse quick. So I ran to the cafeteria, had 2 individuals stand her up and I did 3 thrusts of heimlick, then [CNA] did 3 thrusts and then I said quick lets get her to O2 and suction we took her in the wheel chair to a room that the crash cart was in but it wasn't there and so we started to wheel her to her room and she fell out of the wheel chair she was mottled I heard no air exchange we picked her up took her to her room and I will asking [CNA] to get me some suctioning and O2, but the crash cart was not in full operation. During this time in her Room [CNA name], CNA had her in the floor doing abdominal thrusts. We confirmed in her chart she was no cpr and no life saving measures. I asked [CNA] to stop. She had no apical pulse, no air exchange. I asked them to get her in the bed and get her cleaned up I am calling the daughter and [physician]. I called resident name] daughter daughter's name] and explained to her what had happened that she should come over to see her mom. [daughters name] said this is what mom has been wanting for a long time. I left messages</p>	F 281	<p>administering abdominal thrusts then moving to CPR if indicated and then documenting and monitoring residents after the event to include initiation of downgraded diet and speech therapy as well as some ways to prevent choking hazards.</p> <p>5) Standards of nursing care policy, resident evaluation and re-evaluation, nursing assistant documentation policy reviewed and revised to include changes related to this deficiency.</p> <p>6) All available staff will be educated by 6/24/16 regarding new policies and procedures related to choking. Staff who is unavailable because of leave or other excused absence will be educated upon next shift worked. All new staff will be educated by their supervisor upon hire/orientation to the facility.</p> <p>7) Certified nursing assistants will be educated regarding documentation standards to include legal guidelines for recording to include: guidelines- charting only for yourself, rationale- you are accountable for information you enter into the residents' charts, correct action- never chart for someone else by 6/24/16.</p>	

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F 281	<p>Continued From page 15</p> <p>with [name] our DON, I lefted messages on [physician name] and [physician name] cell phones, I called and spoke to [name] at Nurses's station in the hospital to let [physicna name] know [resient name] had passed. I also sent written communication over to fax to [physician name] office. [daughter's name] and her husband came, she asked me to call funeral home and I did and McColley's Funeral Home came and got her. Daughter and son in law cleaned up [resident's name] room, our Infection Control Full Time Nurse came in. Strike Out Date: 5/23/16 10:21 Author: [RN A]-Registered Nurse [e-Signed]."</p> <p>Interview on 6/1/16 at 5:00 p.m. with the DON regarding resident 1 revealed: *She stated, "I do not believe the documentation accurately described the situation/incident objectively." *She agreed the progress note completed by RN A had not been written professionally. *The suction machine had been in use in another room. *The crash cart was available on the opposite hallway and had a breathing bag and CPR face masks in it. *She thought RN A had struck out the note of 5/22/16 at 1:00 p.m., because it referred to staff names. She was not entirely sure of that. *Had not seen the shorter progress note RN A wrote before she left the facility. *RN A no longer was employed at the facility.</p> <p>Interview on 6/1/16 at 11:29 a.m. with the certified dietary manager revealed: *Resident 1 ate independently in the dining room. *She had no other choking spells he had been aware of. *All dietary staff had been trained in CPR and</p>	F 281	<p>Staff unavailable for the education provided to the aides by 6/24/16 will be educated upon return to facility for work.</p>  <p>Auditing of event documentation by nursing staff to be done on *8) 100% event x4 weeks the 15% of events/ month by DON or X12 months Designee to ensure care plans and SDDDH/JP</p>

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F 281	<p>Continued From page 16</p> <p>abdominal thrusts. *They did not begin serving the residents until a nursing staff member was in the dining room.</p> <p>2. Review of resident 4's medical record revealed he had a choking incident on 5/17/16. The progress note stated: *Oxygen saturation level dropped to 78 percent. *"Skin was pallor pale." *He had "Labored breathing." *His "Lung sounds had fine crackles with slight rhonchi to the upper lobes noted." *Oxygen was started at 2 liters. *Oxygen saturation went up to 90 percent. *He had no temperature. *"MD notified." *Power of attorney notified. *"Will monitor and assess." *There had been no further monitoring or assessing of the incident recorded in the resident's progress notes.</p> <p>Interview on 6/1/16 at 5:00 p.m. with the DON revealed she expected three days of documentation by the nurses on an event like resident 4 had experienced.</p> <p>3. Review of the provider's undated Nursing Process and Documentation policy revealed: *An RN or LPN completes ongoing assessment as needed. *The ongoing assessment or re-evaluation could be in response to a change in condition. *Documentation was the responsibility of the nurse assigned to the patient each shift.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., Elsevier, St. Louis, Mo., 2013, pages 350 and 351, revealed:</p>	F 281	<p>documentation is complete and accurate related to events. All findings of audits will be reported by DON or Designee to QAPI meeting [redacted] x12 months. *9) JD/SDDOHEC *MONTHLY JD/SDDOHEC</p>	6/24/16	

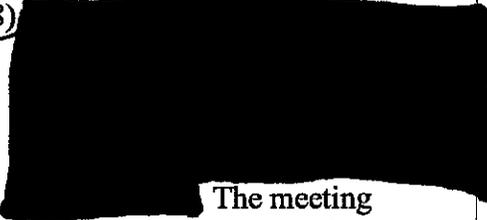
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F 281	Continued From page 17 **The record is the most current and accurate continuous source of information about a patient's [resident] health care status (350)." **The record must describe exactly what happened to a patient and follow agency standards (350)." **Legal guidelines for recording: -Guidelines - Chart only for yourself. -Rationale - You are accountable for information you enter into the patient's chart. -Correct Action - Never chart for someone else."	F 281			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on interview, record review, and policy review, the provider failed to ensure fall interventions had been evaluated, monitored, and revised for: *One of one sampled resident (2) that had died after a fall. *One of four sampled residents (3) with falls. Findings include:  1. Review of resident 2's complete medical record revealed: *He was admitted on 2/20/16.	F 323	All current and future residents are potentially affected by the deficiency regarding free from accident/hazards supervision/devices. See Plan of Correction for F329 and F520 also. 1) No immediate action to be taken on resident #2 as he is no longer residing at facility. 2) Resident #3 care plan was reviewed and revised for current status and interventions in place for frequent falls. 6/13/16 3) A protocol for falls has been initiated by quality specialist and DON to ensure that nurses are reviewing and revising care plans after each fall/event. Education to nursing staff provided on 6/14/16. Nursing staff that are unavailable will be educated upon return to work. 4) Quality Specialist initiated a flow sheet for monitoring falls for		

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F 323	<p>Continued From page 18</p> <p>*He had six falls since his admission. *His last fall was on 5/17/16. *He died on 5/22/16.</p> <p>Review of resident 2's nursing progress notes revealed: 5/17/16, "Resident found on floor with back to wall next to bathroom in his bedroom." 5/18/16, "He was taken to ER [emergency room] per MD [medical doctor] order for evaluation after fall with back of head injury using the ambulance service as he was not responding to stimuli." 5/18/16, The resident returned to the facility on comfort cares. 5/22/16, The resident died.</p> <p>Review of resident 2's 5/18/16 emergency department note revealed "The patient's CT scan showed a large intracranial hemorrhage..."</p> <p>Review of resident 2's 3/16/16 care plan revealed: *A focus area related to falls. *A goal with a target date of 3/14/16 that stated "I will have no serious injury should I fall through the next review date." *The care plan had not been updated or revised with the resident's six falls.</p> <p>2. Review of resident 3's complete medical record revealed: *She was admitted on 2/2/16. *She had twenty-four falls since admission during the following months: -February, she had four falls. -March, she had eight falls. -April, she had four falls. -May, she had eight falls.</p>	F 323	<p>trending purposes. This flow sheet will be reviewed during fall committee weekly and as needed.</p> <p>5) The Quality Specialist implemented a process of keeping minutes of Fall team meetings and reporting to QAPI quarterly. Fall prevention, resident incident and variance report, and safety and supervision of resident's policies were reviewed and revised to address the concerns from this deficiency.</p> <p>7) Education provided to nurses on 6/14/16 to include review of policies and procedures on documentation, care planning, standards of care, fall prevention, incident and variance report, resident evaluation and re-evaluation, follow up monitoring for events.</p> <p>8)  The meeting minutes will be sent to the Leadership team weekly to review. (Leadership team consists of Activity Director, SS Coordinator, DON, C.N.A supervisor or Resident Care</p>	

*\*all findings JD/SDD/HJL*

*\*The fall team (quality specialist, activity director, CNA supervisor, DON, and physician rounding nurse) will continue to meet weekly to review all falls with documentation of new interventions. JD/SDD/HJL*

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F 323	<p>Continued From page 19</p> <p>Review of resident 3's 2/25/16 care plan revealed:</p> <ul style="list-style-type: none"> <li>*She had a focus area of potential for falls.</li> <li>*There were multiple fall interventions in place.</li> <li>*Her care plan had not been updated with her falls.</li> <li>*Her care plan had not been updated or revised until 5/24/16.</li> <li>*A focus area of frequent falls was initiated on 5/20/16.</li> <li>-A goal to have no hip injuries due to falls.</li> <li>-An intervention for hipsters to be worn at all times.</li> </ul> <p>3. Interview on 6/1/16 at 4:35 p.m. with the Minimum Data Set (MDS) assessment coordinator revealed:</p> <ul style="list-style-type: none"> <li>*The care plans should have been updated after falls, but that did not always happen.</li> <li>*There was a fall committee.</li> <li>*The fall committee consisted of the clinical quality specialist and the therapy department manager.</li> <li>*The fall committee met weekly.</li> <li>*She would review fall committee notes to update the care plans.</li> <li>*Falls were not discussed in the quarterly quality assurance meetings.</li> <li>*The process to update the care plans was a work in progress.</li> </ul> <p>Interview on 6/1/16 at 11:04 a.m. with the clinical quality specialist revealed:</p> <ul style="list-style-type: none"> <li>*They had implemented a fall committee in February 2016.</li> <li>*The fall committee was herself and the therapy department manager.</li> <li>*They met weekly to discuss fall interventions.</li> <li>*They had not been documenting those meetings.</li> <li>*They had not been tracking and trending falls</li> </ul>	F 323	<p>Supervisors, Quality Specialist, EVS supervisor, Plant Operations Supervisor, Administrator, Therapy supervisor, MDS Coordinator, and Dietary director or designee.</p> <p>9) The Quality Specialist or designee will report findings to QAPI  <span style="background-color: black; color: black;">[REDACTED]</span> ongoing  <i>*monthly</i>  <i>JDP/DOH/EL</i></p>	6/24/16

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F 323	<p>Continued From page 20 since March 2016. *They had not brought any fall information to their quarterly quality assurance meetings.</p> <p>Interview on 6/1/16 at 5:25 with the director of nursing revealed: *The fall committees weekly meetings should have been documented. *The care plans should have been updated with resident falls. *Falls should have been included in the quarterly quality assurance meetings.</p> <p>Review of the provider's revised 3/24/15 Fall Prevention policy revealed "Seeking agreement on an acceptable margin of safety with the resident, family, and staff and formulating interventions to improve that margin of safety is also important."</p> <p>Review of the provider's December 2007 Safety and Supervision of Residents policy revealed **"The QA&amp;A Committee and staff shall monitor interventions to mitigate accident hazards in the facility and modify as necessary. ***Implementing interventions to reduce accident risks and hazards shall include the following: a. communicating specific interventions to all relevant staff; b. assigning responsibility for carrying out interventions; c. providing training, as necessary; d. ensuring that interventions are implemented; and e. documenting interventions." ***Monitoring the effectiveness of interventions shall include the following: a. ensuring that interventions are implemented correctly and consistently;</p>	F 323		

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F 323	Continued From page 21 b. evaluating the effectiveness of interventions; c. modifying or replacing interventions as needed; and d. evaluating the effectiveness of new or revised interventions."	F 323			
F 490 SS=F	<b>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</b>  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: 29162 Based on record review, interview, policy review, and job description review, the provider failed to make sure the facility was operated and administered in a manner that maintained the safety and overall well-being of the residents by ensuring: *Cardiopulmonary resuscitation (CPR) would be initiated in the event of a cardiac arrest for ten of ten sampled residents (5, 6, 7, 8, 9, 10, 11, 12, 13, and 14) who were a full code status per resident choice. *Complete, accurate, and professional documentation had been recorded for two of two sampled residents (1 and 4) with choking events requiring follow-up nursing documentation. *Care plans had been modified and updated for one of one sampled resident (2) that had died after a fall and for one of four sampled residents (3) with falls. *Fall interventions had been evaluated,	F 490	<b>All current or future residents are affected by this deficiency regarding effective administration/ resident well-being.</b> <b>1) See plan of correction items regarding F155</b> <b>2) See plan of correction items regarding F281 and F514</b> <b>3) See plan of correction items regarding F279, F323 and F520</b> <b>4) The administrator will direct and/or oversee the plans of correction for all system changes and QAPI audits related to F155, F279, F281, F323, F490, F514, and F520. Correcting the above listed tags will indicate compliance with this requirement.</b>	<b>6/24/16</b>	

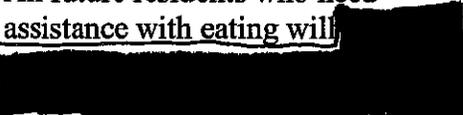
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F 490	<p>Continued From page 22</p> <p>monitored, and revised for one of one sampled resident (2) that had died after a fall and one of four sampled residents (3) with falls. *Quality assurance monitoring of all falls. Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of resident 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14's medical records revealed they had selected to have CPR started in the event of cardiac arrest. Refer to F155.</li> <li>2. Review of resident 1 and 4's medical records revealed incomplete and unprofessional nursing documentation. Refer to F281 and F514.</li> <li>3. Review of resident 2 and 3's medical records revealed incomplete care planning, fall safety evaluations, and quality assurance involvement. Refer to F279, F323, and F520.</li> </ol> <p>Review of the provider's Chief Executive Officer job description revealed: *"The Network Hospital Administrator is assigned full management operational responsibility for the designated facility under Regional health network." *"The Administrator shall have all authority and responsibility necessary to operate the institution and in all of its activities and departments and carry our its objectives in the provision of health care, including the execution of policy. *Standards of Performance included: -Accountability. -Communication. -Professionalism. -Quality and safety. -Respect.</p>	F 490		

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F 490	Continued From page 23 -Service. -Teamwork. -Management Staff. --Effectively manage performance and hold people accountable for results to advance goals of Regional health.	F 490		
F 514 SS=E	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State and progress notes.</p> <p><i>Immediate steps have been taken to decrease risk of choking which include all small items are no longer available for assisted tables. These risks and interventions are documented in the residents' medical records.</i></p> <p>Surveyor: 29162 Based on record review, interview, and policy review, the provider failed to ensure complete, accurate, and professional documentation had been recorded by licensed nurses for two of two of sampled residents (1 and 4) requiring follow-up documentation of choking episodes. Findings include:</p> <p>1. Review of resident 1's medical record revealed she had a choking episode on 5/22/16 that resulted in death.</p>	F 514	<p>All current and future residents are potentially affected by the deficiency regarding resident records- complete/ accurate/ accessible. Please see F281 plan of correction.</p> <p>1) No immediate action to be taken on resident #1 as she no longer resides in the facility.</p> <p>2) </p> <p>3) All future residents who need assistance with eating will </p> <p>4) Policy review and revisions related to this deficiency includes choking policy, nursing evaluation</p>	

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F 514	Continued From page 24 Refer to F 281, finding 1.	F 514	and re-evaluation and nursing documentation policies as well as eating environment.	
F 520 SS=E	2. Review of resident 4's medical record revealed he had experienced a choking episode on 5/17/16. Refer to F 281, finding 2. 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  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.  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.  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.  Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.  This REQUIREMENT is not met as evidenced by: Surveyor: 32333	*JD/SDDO/H/EL	5) All staff will be educated during mandatory all staff meeting on 6/21/16 regarding elimination of choking hazards at tables. 6) Nursing staff will be educated on 6/14/16 regarding documentation, resident evaluation and re-evaluation policies. 7) Staff not available for the meetings will be educated by their supervisors upon return for work status. 8) Audits will be conducted by the dietary manager or designee on available items for tables daily x1 week the 2-3 times/ week x 3 more weeks, then weekly x1 month then monthly for a total of 12 months. 9) Negative findings will be reported by dietary personnel to QAPI [redacted] x4. *monthly JD/SDDO/H/EL	6/24/16

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F 520	<p>Continued From page 25</p> <p>Based on interview, record review, policy review, and job description review, the provider failed to ensure an effective quality assurance program had been developed to include fall prevention. Findings include:</p> <p>1. Review of the provider's quality assurance and performance improvement (QAPI) meetings from 11/25/15 to 5/25/16 revealed falls were not included in those meetings.</p> <p>Interview on 6/1/16 at 11:04 a.m. with the clinical quality specialist revealed: *They had implemented a fall committee in February 2016. *The fall committee was herself and the therapy department manager. *They met weekly to discuss fall interventions. *They had not been documenting those meetings. *They had not been tracking and trending falls since March 2016. *They had not brought any fall information to their quarterly quality assurance meetings.</p> <p>Interview on 6/1/16 at 5:25 p.m. with the director of nursing revealed: *The fall committees weekly meetings should have been documented. *The care plans should have been updated with residents' falls. *Falls should have been included in the quarterly quality assurance meetings.</p> <p>Review of the provider's Clinical Quality Specialist job description revealed "The Quality Specialist will coordinate the multiple facets of the Quality, Infection Control, Wound Care, and Risk Management programs and teams for CRSC [Custer Regional Senior Care] - serving as a</p>	F 520	<p>All current and future residents are potentially affected by the deficiency regarding QAA committee-members/meet <del>plan</del> <i>plan. *monthly</i></p> <p>1) The QAA team mentioned above includes the QAPI team members. This team will consist of the Quality Specialist, DON, Medical Director, Dietary Director, Activities Director, MDS coordinator, Resident Care Supervisor or designee, Social Service Coordinator, Direct care staff as well as EVS and Plant-ops Supervisors.</p> <p>2) The QAPI program will be revised with updated policies and procedures to include fall prevention, fall trending and addressing root cause analysis of recurrent falls as well as the process of identifying risks and intervention effectiveness. This process will be used to develop and implement plans of action to correct identified quality deficiencies. <i>*The Quality Specialist will monitor plans of actions and report findings to</i></p> <p>3) QAPI meeting minutes will be available to all members within 24-48 hours after meeting for review. <i>monthly QAPI meetings monthly. The Quality Specialist will be responsible to ensure fall prevention is covered in the monthly QAPI meetings.</i></p>	<p><i>JD P.../EC</i></p> <p><i>6/24/16</i></p>	

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F 520	Continued From page 26 resource person and to monitor compliance with facility policies and regulatory agencies."  Review of the providers Quality Assurance and Performance Improvement (QAPI) Plan revealed "The primary purpose of the Quality Assurance and Performance Improvement Program is to establish data-driven, facility-wide processes that improve the quality of care, quality of life and clinical outcomes of our residents."  Refer to F323, finding 1.	F 520			