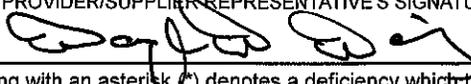
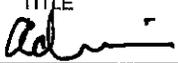


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435051</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - MEADOWBROOK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 ARROWHEAD DR RAPID CITY, SD 57702</b>
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F 000	INITIAL COMMENTS  Surveyor: 32572 An extended complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/16/16 through 8/18/16 and 8/22/16 through 8/24/16. Golden LivingCenter - Meadowbrook was found not in compliance with the following requirements: F166, F223, F225, F226, F241, F248, F280, F281, F311, F312, F314, F323, F325, F328, F353, F441, F490, F493, F501, and F520.	F 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES  A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.  This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on interview, review of resident grievance log, and resident council minutes, and admission packet information review, the provider failed to follow-up with the multiple residents including residents 8, 23, and 24 or family member on grievance concerns. Findings include:  1. Review of the provider's grievance tracking log revealed: *An entry for 7/18/16 "Multiple residents not getting baths/showers." -Resolution was "adjusted bath schedules and bath audits." -Was documented as resolved on 7/22/16.	F 166	F166 – Prompt Efforts to Resolve Grievances  Resident #8 and 23 have discharged from the facility so we are unable to address their bathing concerns.  Resident # 24 has been interviewed and her preferences for bathing reestablished and care planned.  The facility will re-establish bathing preferences for all current residents by September 14, 2016.  All residents residing in the facility have the potential to be affected in a similar manner.	9/14/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE 	(X8) DATE <b>9-8-16</b>
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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.

SEP 12 2016

SD DOH L&C

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F 166	<p>Continued From page 1</p> <p>-Check up on 7/22/16 revealed "Satisfied with resolution? Not really." -Additional follow-up needed? Yes." *On 7/25/16 resident 8 had a grievance of "Not gotten showers per schedule." -Resolved: "Not." -Resolution: "Offered showers several times and he refused." -Follow-up: "With resident." -Check up date, satisfied with resolution, and additional follow-up questions all had a line drawn through the box. *On 7/27/16 resident 23 had a grievance of "No baths per schedule." -Resolution was documented on 8/5/16 as "Bath audits and CNA [certified nursing assistant] coaching." -Follow-up: "Resident discharged before resolution completed." *On 7/27/16 resident 24 had a grievance "No bath since admission." She had been admitted on 7/21/16. -Resolution was documented on 7/27/16. -Check up: 7/29/16. Satisfied with resolution: "Yes." -Follow-up as needed with resident and son."</p> <p>Review of the July and August 2016 resident council meeting minutes revealed no mention of bathing grievances having been discussed.</p> <p>Review of the bath audit revealed only one audit had been completed on 8/1/16, and revealed six out of eight residents had received their baths as scheduled for that day. There had been no other audits completed.</p> <p>Review of the admission packet given to all residents included a pamphlet entitled Long-Term</p>	F 166	<p><b>Resident Bath and Showers – A Designated Team will be established by September 14, 2016 to provide consistent completion of bathing activities for all residents. New admissions will be interviewed for their bathing preferences within 24 hours of their admission to the facility.</b></p> <p><b>The Executive Director, Director of Nursing, and the Interdisciplinary team have reviewed the grievance process.</b></p> <p><b>All Staff members will be re-educated on the grievance process by the Multi-site Director of Clinical Education by the September 14, 2016.</b></p> <p><b>Residents have been re-educated on the grievance process during the Resident Council by the social worker on September 9, 2016.</b></p> <p><b>Executive Director or designee will complete 5 random interviews to include but not limited to resident # 24 weekly X 4 weeks then monthly X2 months to ensure resident's grievances have been resolved.</b></p>		

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F 166	Continued From page 2 Care Facilities Resident's Bill of Rights. The pamphlet revealed: *"You are entitled to quality of life. A facility must provide care and an environment that contributes to your quality of life including: -A safe, clean, comfortable and home-like environment. -Maintenance or enhancement of your ability to preserve individuality, exercise self-determination and control every day physical needs. -Freedom from physical or chemical restraints used for purposes of discipline or convenience. -Freedom from theft of personal property; verbal, sexual, physical or mental abuse; and involuntary seclusion, neglect or exploitation imposed by any one."  Interview on 8/24/16 at 11:30 a.m. with the social service designee (SSD) revealed she would have completed the grievance form. She then reported the grievance to the director of nursing (DON). She confirmed she expected the DON to follow-up with those concerns. An interview with the DON or the emergency permit holder (EPH) was not completed, because they were unavailable during the last days of the survey.	F 166	Executive Director will provide the results of the audits to the monthly QAPI committee for further evaluation and recommendations.		
F 223 SS=J	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION  The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.  The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.	F 223	F223- Free from Abuse/Involuntary Seclusion  Resident #10 has a BIMS score of 4 and exhibits short term memory deficits. He does not verbalize awareness of past verbal and mental abuse nor was there evidence documented of ill effects.	9/14/16	

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F 223	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333</p> <p>Based on interview and policy review, the provider failed to ensure all residents including resident 10 with cognitive impairment were free from verbal and mental abuse by one registered nurse (RN) (E) and one licensed practical nurse (LPN) (F).</p> <p>NOTICE: On 8/17/16 at 3:15 p.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 were free from abuse.</p> <p>PLAN: During the survey on 8/17/16 at 5:22 p.m. the surveyors confirmed removal of the immediate jeopardy situation. The following is the plan for the removal of the immediate jeopardy.</p> <p>**All residents will be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. Residents have the right to exercise his/her rights." **Initial investigation will be completed immediately by the facility. An Executive Director or Consultant from outside the facility will complete the final investigation. Two nurses involved in the allegations of abuse are suspended effective August 17, 2016." **All oncoming staff will be re-educated on the Abuse and Neglect Policy and Procedure and the appropriate steps to prevent the occurrences of abuse, neglect, injuries of unknown origin, and misappropriation of resident property and to ensure that all alleged violations of Federal and</p>	F 223	<p>All residents have the potential to be affected.</p> <p>All residents will be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. Residents have the right to exercise his/her resident rights.</p> <p>RN E was terminated from employment on August 24, 2016 thus re-education on Abuse and Neglect was not provided. A report was filed with the South Dakota Board of Nursing.</p> <p>LPN F was terminated from employment on August 24, 2016 thus re-education on Abuse and Neglect was not provided. A report was filed with the South Dakota Board of Nursing.</p> <p>The Emergency Permit Holder (EPH) was terminated from employment on August 24, 2016 and thus re-education was not provided. A report was filed with the South Dakota Board of Administrators and the South Dakota Social Workers.</p>		

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F 223	Continued From page 4 State law which involve mistreatment, neglect, abuse, injuries of unknown origins, and misappropriation of resident property ("alleged violations"), Mandatory Reporting, and Caring for Residents with Dementia." *"All staff will be re-educated on the Long Term Care Facilities Resident's Bill of Rights provided by the SD Department of Social Services Adult Services and Aging: Ombudsman Program." Leadership: ED, DNS, HRG will receive the education as listed above as well: Elder Justice Acts, Reporting Suspected Crimes Under the Federal Elder Justice Act, and Reporting and Investigations of Alleged Violations of Federal State Laws Involving mistreatment, neglect, abuse, injuries of unknown source, and misappropriation of resident's property." *"All residents have the potential to be affected. The Abuse and Neglect Policy and Procedure will be followed as well as disciplinary actions as warranted." *Staff currently working and oncoming staff will be immediately re-educated on the Abuse and Neglect Policy and Procedure and the appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown origin, and misappropriation of resident property and to ensure that all alleged violations of Federal and State laws which involve mistreatment, neglect, abuse, injuries of unknown origin, and misappropriation of resident property ("alleged violations") and on the Long Term Care Facilities Resident's Bills of Rights provided by the SD Department of Social Services Adult Services and Aging: Ombudsman Program." *ED and/or DNS or designee will complete resident x 5 and staff x 5 interviews weekly x 8 weeks to ensure residents are free from verbal, sexual, physical, and mental abuse, corporal	F 223	The DNS was terminated from employment on August 24, 2016 and thus re-education was not provided. A report was filed with the South Dakota Board of Nursing.  All on-coming staff were re-educated on Abuse and Neglect policy and procedures; appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown origin, and misappropriation of resident property and to ensure that all alleged violations of Federal or State laws which involve the 7 components of the Abuse Prevention.  All staff were re-educated on the Long Term Facilities Resident's Bill of Rights provided by the South Dakota Department of Social Services Adult Services and Aging: Ombudsman Program and on the Abuse and Neglect policy and procedure and the appropriate steps to prevent occurrence of abuse and neglect, injuries of unknown origin and misappropriation of resident property, and to ensure that all alleged violations		

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F 223	Continued From page 5 punishment, and involuntary seclusion and residents feel they have the right to exercise his/her resident rights." Findings include: *"The results of these interviews will be brought to the QAPI committee for further review and recommendations." Findings include:  1. Interview on 8/17/16 at 10:16 a.m. with an anonymous certified nursing assistant (CNA) revealed: *Approximately a couple of weeks ago she had reported resident abuse to the director of nursing (DON). *At approximately 6:00 a.m. regarding that incident revealed the anonymous CNA had observed RN E and LPN F at the end of west hall. *RN E was screaming "hello" over and over again at resident 10. *Resident 10 had a diagnosis of dementia and repeated himself when talking. *RN E was mocking what resident 10 was saying. *LPN F was laughing. *She stated she along with other staff members had reported abuse to the DON and human resources more than once. *The DON and the human resources staff member had laughed at them when they reported abuse. *An anonymous resident had witnessed RN E mocking resident 10. *An anonymous resident had reported the abuse to the DON. *This morning RN E told staff "State is in the building and you all need to be very scared for your jobs."	F 223	are investigated and reported with appropriate actions taken. Education was provided by the Multi-Site Director of Clinical Education and was presented twice on 09/06/2016. All on-coming staff that did not attend the sessions was provided the exact educational materials prior to their next scheduled shift.  The Executive Director or designee will conduct a minimum of 5 resident interviews to include Resident #5, 10 and 12 weekly X 8 weeks; monthly X 2 months and the results of these audits presented to the QAPI committee for further recommendations.		

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F 223	Continued From page 6  Surveyor: 23059 Interview on 8/17/16 at 2:35 p.m. with the DON, emergency permit holder (EPH), and the EPH's preceptor revealed: *They defined physical abuse as an inappropriate "laying-on of hands" to any part of the resident's body. *They defined verbal abuse as yelling, speaking to a resident in a childish manner, belittling, or ridiculing a resident. *They defined emotional abuse as speaking down to a resident. *They would consider an employee hollering down the hall and mocking a resident with dementia as verbal and emotional abuse. *The EPH if made aware of the situation would have immediately removed staff from the situation and started an investigation. The staff person in question would have been placed on suspension pending the results of the investigation. *Their goal was to ensure resident safety. *They confirmed the DON and EPH were aware of the situation where an RN and LPN had mocked and laughed at a resident with dementia. *The EPH and DON confirmed they had been told of the situation by staff and residents. *The DON had been told by the nurses in question they were "just being silly." *They confirmed neither nurse had been removed from the situation or suspended. *They confirmed an investigation had not been started. *They confirmed mocking and laughing at a resident did not create a safe environment for all residents.	F 223			
F 225	483.13(c)(1)(ii)-(iii), (c)(2) - (4)	F 225			

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F 225 SS=J	<p>Continued From page 7 <b>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</b></p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F 225	<p><b>F225 Investigate/Report Allegations/Individuals</b></p> <p><b>Resident #10 has a BIMS score of 4 and exhibits short term memory deficits. He does not exhibit awareness of past verbal and mental abuse. An investigative report was completed and filed with the South Dakota Department of Health at the time of the August 24, 2016 survey.</b></p> <p><b>No investigative report about Resident #14s injury of unknown origin could be completed because of the timeframe involved.</b></p> <p><b>All residents have the potential to be affected.</b></p> <p><b>All residents will be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. Residents have the right to exercise his/her resident rights.</b></p> <p><b>RN E was terminated from employment on August 24, 2016 thus re-education</b></p>	9/14/16	

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F 225	Continued From page 8  This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on record review, interview, and policy review, the provider failed to ensure: *An allegation of abuse for one of one sampled resident 10 with dementia by a registered nurse (RN) (E) and licensed practical nurse (LPN) (F) had been investigated and reported to the South Dakota Department of Health (SD DOH). *An injury of unknown origin for one of one sampled resident (14) who was unable to speak for herself had been documented, investigated, and reported to the SD DOH. Findings include:  1. Review of the providers 11/17/15 Preventing, Investigating, and Reporting Alleged Sexual Assault and Abuse Violation policy revealed: *"It is the responsibility of all employees to immediately report any alleged violation of abuse, neglect injuries of unknown origin, source and misappropriation of resident property." *"It is the policy of this center to take appropriate steps to prevent the occurrence of: -Abuse -Neglect Misappropriation of resident property." *"It is also the policy of this center to take appropriate steps to ensure that all alleged violations of federal and state laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property ("alleged violation") are reporting immediately to the executive director of the center." *"Such violations are also reported to state agencies in accordance with existing state law. The center investigates each such alleged	F 225	on Abuse and Neglect was not provided. A report was filed with the South Dakota Board of Nursing.  LPN F was terminated from employment on August 24, 2016 thus re-education on Abuse and Neglect was not provided. A report was filed with the South Dakota Board of Nursing.  The Emergency Permit Holder (EPH) was terminated from employment on August 24, 2016 and thus re-education was not provided. A report was filed with the South Dakota Board of Administrators and the South Dakota Social Workers.  The DNS was terminated from employment on August 24, 2016 and thus re-education was not provided. A report was filed with the South Dakota Board of Nursing  The Executive Director, Director of Nursing, Interdisciplinary Team, a member of the Governing Board and the Medical Director have reviewed and reinstated the Abuse and Neglect reporting and investigation policies		

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F 225	Continued From page 9 violation thoroughly and reports the result of all investigations to the executive director or his or her designee, as well as to state agencies as required by state and federal law." *" If the suspected perpetrator is an employee or family, friend or visitor the ED [executive director] places the employee on immediate investigatory suspension while completing the investigation. It is explained to the employee that if the investigation results do not require suspension or termination, the employee may be allowed to return to work and any scheduled days missed during the investigation time may be paid. If it is a family member, visitor or friend, they will not be allowed to visit the resident until the investigation is completed. The results of the investigation will determine the future contact with the resident." *"Where the circumstances of the alleged violation warrants, the DNS or designee initiates a physical and mental assessment of the resident and documents the findings. Only factual information is documented, not assumptions. The DNS also notifies the attending physician regarding the alleged violation and findings and documents the contact." *"An employee who suspects an alleged violation immediately notifies the ED, or designee. The ED notifies the appropriate state agency in accordance with state law and the regional vice president." *"The results of all investigations are reported to the ED or designee and the appropriate state agency, as required by state law and the regional vice president." *"The center reports to the state nurse aide registry and licensure authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service." *"The DNS, or designee, initiates a care plan to	F 225	with appropriate corrective actions taken when Abuse or Neglect is verified; Conducting Employee Background Investigation and hiring practices.  All staff was re-educated about their role and responsibilities as mandatory reporters by the Multi-site clinical education director, this was completed by September 6, 2016.  Executive Director or designee will complete 5 random audits weekly X 4 then Monthly X 2 of new employees that have been hired after August 24, 2016 to assure background checks has been completed to ensure all 7 components of the Abuse Prevention Policy have been met.  Executive Director will provide the results of the audits to the QAPI committee for further review and recommendations.  Executive Director or designee will be responsible for conducting an		

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F 225	<p>Continued From page 10</p> <p>reflect the resident's condition and measures to be taken to prevent recurrence, where appropriate."</p> <p>*"Appropriate steps are taken to prevent recurrence of the incident. This may include in-services or other measures as appropriate. The steps taken are documented."</p> <p>*"Documentation in the medical record is made where necessary for continuity of care for the resident."</p> <p>*"Separate incident reports or other written reports, when required by state law, are maintained and produced in accordance with state law."</p> <p>Refer to tag F223, findings 1 and 2.</p> <p>Surveyor: 32355</p> <p>2. Review of resident 14's medical record revealed:</p> <p>*She had been readmitted to the facility on 7/5/16 from an acute care hospital.</p> <p>*Diagnoses included amyotrophic lateral sclerosis (ALS), failure to thrive, dysphagia, reflux disease, pain, history of weight loss, and a history of pneumonia.</p> <p>*She had no muscle control and required assistance from the staff for positioning and transfers.</p> <p>*She had required the use of a transfer aide to get in and out of the bed.</p> <p>*She would have sat in her wheelchair (w/c) once or twice a week per her choice.</p> <p>*On 7/25/16 a skin tear had been identified on her sacral area after she had returned from a trip to the emergency room.</p> <p>*On 8/22/16 another skin tear had been identified below the first skin tear.</p>	F 225	<p>investigation of all allegations or suspicions of Abuse or Neglect as well as documentation and reporting outcomes of such investigations.</p>	

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F 225	<p>Continued From page 11</p> <p>Review of resident 14's nurses' progress notes revealed on:</p> <p>*7/25/16, "Resident back to facility by ambulance via stretcher. Resident has a new skin tear noted in lumbar area. Made MD aware and order received to cleanse with normal saline, apply bacitracin and dressing. Change dressing every 3 days or as needed."</p> <p>*8/22/16 "She has a sore on her sacrum that started out as a skin tear. Just below this at the 5 o'clock area she has a small skin tear is 1.0 cm [centimeter] x 0.3 cm.</p> <p>-No documentation the MD or family had been notified of the new skin tear.</p> <p>Interview on 8/23/16 at 4:05 p.m. with licensed practical nurse D regarding resident 14 revealed:</p> <p>*The resident received the first skin tear when the ambulance crew transferred her from their gurney to her bed.</p> <p>*She had identified the second skin tear yesterday, 8/22/16.</p> <p>*She had not been aware how the second skin tear had occurred.</p> <p>The above progress notes revealed no documentation to support:</p> <p>*An incident report for an injury of unknown origin had been completed on both of the skin tears.</p> <p>*The skin tears had been investigated and reported to the SD DOH to support physical abuse had not occurred.</p> <p>LPN D had not been available for further interview after the continued review of resident 14's progress notes.</p> <p>Interview on 8/24/16 at 10:30 a.m. with the field services clinical director revealed:</p>	F 225		

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F 225	<p>Continued From page 12</p> <p>*She had not been aware resident 14 had acquired two skin tears during her stay in the facility.</p> <p>*She not been able to locate an incident report for injuries of unknown origin for those skin tears.</p> <p>*She would have expected the staff to have:</p> <ul style="list-style-type: none"> <li>-Completed an incident report for an injury of unknown origin on both of the skin tears.</li> <li>-Completed an investigation to support physical abuse had not occurred on the first skin tear that occurred on 7/25/16.</li> <li>-Started an investigation on the second skin tear that had been identified on 8/22/16.</li> </ul> <p>*She confirmed any type of injury of unknown origin should have ben investigated and reported to the SD DOH.</p> <p>Surveyor: 23059</p> <p>4. Interview on 8/17/16 at 8:15 a.m. with two residents who wished to remain confidential revealed:</p> <ul style="list-style-type: none"> <li>*About "two to three weeks ago" they had heard a staff member yelling in the hallway. They stated it was around 6:00 a.m. when the yelling had occurred.</li> <li>*They were aware that staff person yelling was a nurse.</li> <li>*The resident had been repetitively requesting help.</li> <li>*The nurse began mocking the resident by yelling down the hall what the resident had been saying.</li> <li>*Another nurse in the middle of the hallway had been laughing at the nurse's mocking words.</li> <li>*One of the confidential residents yelled out "You need to be quiet. We are trying to sleep."</li> <li>*They were scared by what they had heard.</li> <li>*One confidential resident stated "I am starting to lose my memory. I'm scared that they will treat</li> </ul>	F 225		

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F 225	<p>Continued From page 13 me the same way." *They had reported their concerns to the DON.</p> <p>5. Interview on 8/17/16 at 1:10 p.m. with a CNA who requested to remain confidential revealed: *About two and a half weeks ago she had heard an RN yelling down the hall mocking a resident with dementia who had been requesting assistance. *That had occurred at the time of a shift change and was around 6:00 a.m. *The RN was repeating over and over "Nurse, nurse, help me, help me." After that the nurse started yelling "Hello. Hello." *An LPN who was down the hall was laughing at what the above nurse was doing. *She had reported it to the DON. *She felt nothing had been done to reprimand the nurse. *She stated that same RN had threatened many aides they might be fired. *She also stated that same RN had refused to help residents in need. She had stated that was not her job as she was in management.</p> <p>6. Interview on 8/17/16 at 2:35 p.m. with the DON, emergency permit holder (EPH), and the EPH's preceptor revealed: *They defined physical abuse as an inappropriate "laying-on of hands" to any part of the resident's body. *They defined verbal abuse as yelling, speaking to a resident in a childish manner, belittling, or ridiculing a resident. *They defined emotional abuse as speaking down to a resident. *They would consider an employee hollering down the hall and mocking a resident with dementia as verbal and emotional abuse.</p>	F 225		

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F 225	<p>Continued From page 14</p> <p>*The EPH if made aware of the situation would have immediately removed staff from the situation and started an investigation. The staff person in question would have been placed on suspension pending the results of the investigation.</p> <p>*Their goal was to ensure resident safety.</p> <p>*They confirmed the DON and EPH were aware of the situation where an RN and LPN had mocked and laughed at a resident with dementia.</p> <p>*The EPH and DON confirmed they had been told of the situation by staff and residents.</p> <p>*The DON had been told by the nurses in question they were "just being silly."</p> <p>*They confirmed neither nurse had been removed from the situation or suspended.</p> <p>*They confirmed an investigation had not been started.</p> <p>*They confirmed mocking and laughing at a resident did not create a safe environment for all residents.</p> <p>Review of the provider's 7/12/16 Reporting and Investigation of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source, and Misappropriation of Resident's Property policy revealed:</p> <p>*"It is the policy of the Company to take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown origin and misappropriation of resident property and to ensure that all alleged violations of Federal or State laws which involve mistreatment, neglect, abuse, injuries of unknown origin are reported immediately to the Executive Director [ED] of the center and the Director of Rehabilitation.</p> <p>*Such violations will also be reported to state agencies in accordance with existing state law.</p>	F 225		

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F 225	Continued From page 15 *The ED will direct a thorough investigation of each such alleged violation unless there is a conflict of interest or the Ed is implicated in the alleged violation. *The Ed is responsible to report the results of all investigations to the state agencies as required by state and federal law."	F 225		
F 226 SS=J	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: 32333 Based on interview, and policy review, the provider failed to follow their abuse policies for: *A witnessed event of verbal abuse for one of one sampled resident (10) with dementia by one of one registered nurse (RN) (E) and one of one licensed practical nurse (LPN) (F). *One of one sampled resident (14) who had been unable to speak for herself and had an injury of unknown origin. Findings include:  1. Interview on 8/17/16 at 10:16 a.m. with a certified nursing assistant (CNA) who wished to remain anonymous revealed: *Approximately a couple of weeks ago she had reported resident abuse to the director of nursing (DON). *At approximately 6:00 a.m. regarding that	F 226	F226 – Develop/Implement Abuse/Neglect, ETC Policies  Resident #10 has a BIMS score of 4 and exhibits short term memory deficits. He does not exhibit awareness of past verbal and mental abuse. An investigative report was completed and filed with the South Dakota Department of Health at the time of the August 24, 2016 survey.  No investigative report about Resident #14s injury of unknown origin could be completed because of the timeframe involved.  All residents have the potential to be affected.  All residents will be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary	9/14/16

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F 226	<p>Continued From page 16</p> <p>incident the anonymous CNA had observed RN E and LPN F at the end of the west hall. *RN E was screaming "hello" over and over again at resident 10. *Resident 10 had a diagnosis of dementia and repeated himself. *RN E was mocking what resident 10 was saying. *LPN F was laughing. *The anonymous CNA stated she along with other staff members had reported abuse to the DON and human resources person more than once. *The DON and human resources staff member had laughed at them when they reported abuse. *An anonymous resident had witnessed RN E mocking resident 10 and had reported the abuse to the DON. *An anonymous resident had reported the abuse to the DON. *That morning RN E told staff "State is in the building and you all need to be very scared for your jobs."</p> <p>2. Review of the provider's Protection from Abuse policy revealed "All residents in the LivingCenter will be free from verbal, sexual, physical, or mental abuse, neglect, corporal punishment, and involuntary seclusion, according to the outlined in the LivingCenter abuse prevention plan." Refer to F223 and F225.</p> <p>Surveyor: 32355</p> <p>3. Review of resident 14's medical record revealed: *She had been readmitted on 7/5/16 from an acute care hospital. *Diagnoses were: amyotrophic lateral sclerosis (ALS), failure to thrive, reflux disease, dysphagia,</p>	F 226	<p>seclusion. Residents have the right to exercise his/her resident rights.</p> <p>RN E was terminated from employment on August 24, 2016 thus re-education on Abuse and Neglect was not provided. A report was filed with the South Dakota Board of Nursing.</p> <p>LPN F was terminated from employment on August 24, 2016 thus re-education on Abuse and Neglect was not provided. A report was filed with the South Dakota Board of Nursing.</p> <p>The Emergency Permit Holder (EPH) was terminated from employment on August 24, 2016 and thus re-education was not provided. A report was filed with the South Dakota Board of Administrators and the South Dakota Social Workers.</p> <p>The DNS was terminated from employment on August 24, 2016 and thus re-education was not provided. A report was filed with the South Dakota Board of Nursing.</p>		

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F 226	<p>Continued From page 17</p> <p>pain, history of weight loss, and a history of pneumonia.</p> <p>*On 7/25/16, a skin tear had been identified on her sacral area after she had returned from a trip to the emergency room.</p> <p>*On 8/22/16, another skin tear had been identified below the first skin tear.</p> <p>Review of resident 14's nurses' progress notes revealed:</p> <p>*On 7/25/16, "Resident back to facility by ambulance via stretcher. Resident has a new skin tear noted in lumbar area. Made MD aware and order received to cleanse with normal saline, apply bacitracin and dressing. Change dressing every 3 days or as needed."</p> <p>*On 8/22/16, "She has a sore on her sacrum that started out as a skin tear. Just below this at the 5 o'clock area she has a small skin tear is 1.0 cm [centimeter] x 0.3 cm." There was no documentation the MD or family had been notified of the new skin tear.</p> <p>Interview on 8/23/16 at 4:05 p.m. with licensed practical nurse D revealed:</p> <p>*The resident had received the first skin tear when the ambulance crew transferred her from their gurney to her bed.</p> <p>*She had identified the second skin tear yesterday, 8/22/16.</p> <p>*She had not been aware of how the second skin tear had occurred.</p> <p>The above progress notes revealed no documentation to support:</p> <p>*An incident report for an injury of unknown origin had been completed on both of the skin tears.</p> <p>*The skin tears had been investigated and reported to the SD DOH to support physical</p>	F 226	<p>The Executive Director, Director of Nursing, Interdisciplinary Team, a member of the Governing Board and the Medical Director have reviewed and reinstated the Abuse and Neglect reporting and investigation policies with appropriate corrective actions taken when Abuse or Neglect is verified; Conducting Employee Background Investigation and hiring practices.</p> <p>All staff were re-educated about their role and responsibilities as mandatory reporters by the Multi-Site Clinical Education director on September 6, 2016.</p> <p>Executive Director or designee will complete 5 random audits weekly X 4 then Monthly X 2 of all employees to assure they are aware of their individual role and responsibility in identifying potential Abuse and Neglect events; who they report suspicions to and what the next steps are in the process.</p>		

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F 226	<p>Continued From page 18 abuse had not occurred.</p> <p>Interview on 8/24/16 at 10:30 a.m. with the field services clinical director revealed: *She would have expected the staff to have: -Completed an incident report for an injury of unknown origin on both of the skin tears. -Completed an investigation to support physical abuse had not occurred on the first skin tear that occurred on 7/25/16. -Started an investigation on the second skin tear that had been identified on 8/22/16. *She confirmed any type of injury of unknown origin should have ben investigated and reported to the SD DOH.</p> <p>Review of the provider's 7/12/16 Reporting and Investigation of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source, and Misappropriate of Resident's Property policy revealed: **It is the policy of the Company to take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown origin and misappropriation of resident property and to ensure that all alleged violations of Federal or State laws which involve mistreatment, neglect, abuse, injuries of unknown origin are reported immediately to the Executive Director [ED] of the center and the Director of Rehabilitation. *Such violations will also be reported to state agencies in accordance with existing state law. *The ED will direct a thorough investigation of each such alleged violation unless there is a conflict of interest or the Ed is implicated in the alleged violation. *The Ed is responsible to report the results of all investigations to the state agencies as required</p>	F 226	<p>Executive Director will provide the results of the audits to the QAPI committee for further review and recommendations.</p>		

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F 226	<p>Continued From page 19 by state and federal law."</p> <p>Surveyor: 23059</p> <p>4. Interview on 8/17/16 at 8:15 a.m. with two residents who wished to remain confidential revealed:</p> <ul style="list-style-type: none"> <li>*About "two to three weeks ago" they had heard a staff member yelling in the hallway. They stated it was around 6:00 a.m. when the yelling had occurred.</li> <li>*They were aware that staff person yelling was a nurse.</li> <li>*The resident had been repetitively requesting help.</li> <li>*The nurse began mocking the resident by yelling down the hall what the resident had been saying.</li> <li>*Another nurse in the middle of the hallway had been laughing at the nurse's mocking words.</li> <li>*One of the confidential residents yelled out "You need to be quiet. We are trying to sleep."</li> <li>*They were scared by what they had heard.</li> <li>*One confidential resident stated "I am starting to lose my memory. I'm scared that they will treat me the same way."</li> <li>*They reported their concerns to the DON.</li> </ul> <p>5. Interview on 8/17/16 at 1:10 p.m. with a CNA who requested to remain confidential revealed:</p> <ul style="list-style-type: none"> <li>*About two and a half weeks prior she had heard an RN yelling down the hall mocking a resident with dementia who had been requesting assistance.</li> <li>*That had occurred at the time of a shift change and was around 6:00 a.m.</li> <li>*The RN was repeating over and over "Nurse, nurse, help me, help me." After that the nurse started yelling "Hello. Hello."</li> <li>*An LPN who was down the hall was laughing at what the above nurse was doing.</li> </ul>	F 226		

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F 226	<p>Continued From page 20</p> <ul style="list-style-type: none"> <li>*She reported it to the DON.</li> <li>*She felt nothing had been done to reprimand the nurse.</li> <li>*She stated that same RN had threatened many aides that they may be fired.</li> <li>*She also stated that same RN refused to help residents in need. She had stated that was not her job as she was in management.</li> </ul> <p>6. Interview on 8/17/16 at 2:35 p.m. with the DON, emergency permit holder (EPH), and the EPH's preceptor revealed:</p> <ul style="list-style-type: none"> <li>*They defined physical abuse as a inappropriate "laying-on of hands" to any part of the resident's body.</li> <li>*They defined verbal abuse as yelling, speaking to a resident in a childish manner, belittling, or ridiculing a resident.</li> <li>*They defined emotional abuse as speaking down to a resident.</li> <li>*They would consider an employee hollering down the hall and mocking a resident with dementia as verbal and emotional abuse.</li> <li>*The EPH if made aware of the situation would have immediately removed staff from the situation and started an investigation. The staff person in question would have been placed on suspension pending the results of the investigation.</li> <li>*Their goal was to ensure resident safety.</li> <li>*They confirmed the DON and EPH were aware of the situation where an RN and LPN had mocked and laughed at a resident with dementia.</li> <li>*The EPH and DON confirmed they had been told of the situation by staff and residents.</li> <li>*The DON had been told by the nurses in question they were "just being silly."</li> <li>*They confirmed neither nurse had been removed from the situation or suspended.</li> </ul>	F 226			

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F 226	<p>Continued From page 21</p> <p>*They confirmed an investigation had not been started.</p> <p>*They confirmed their policy and procedures for abuse/neglect of residents had not been followed.</p> <p>-They had not interviewed staff and residents regarding the situation.</p> <p>-They had not reported the abuse to the South Dakota Department of Health nor to the South Dakota Board of Nursing.</p> <p>-They had been told by the CNAs that morning a nurse had told them their "jobs were on the line."</p> <p>-No follow-up or investigation had been started regarding that treatment of staff.</p> <p>Review of the provider's 7/12/16 Reporting and Investigation of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source, and Misappropriate of Resident's Property policy revealed:</p> <p>*"It is the policy of the Company to take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown origin and misappropriation of resident property and to ensure that all alleged violations of Federal or State laws which involve mistreatment, neglect, abuse, injuries of unknown origin are reported immediately to the Executive Director [ED] of the center and the Director of Rehabilitation.</p> <p>*Such violations will also be reported to state agencies in accordance with existing state law.</p> <p>*The ED will direct a thorough investigation of each such alleged violation unless there is a conflict of interest or the Ed is implicated in the alleged violation.</p> <p>*The Ed is responsible to report the results of all investigations to the state agencies as required by state and federal law."</p>	F 226			

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F 241 F 241 SS=E	Continued From page 22 483.15(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: 32333  Surveyor: 32355 Based on observation, record review, interview, pamphlet review, and policy review, the provider failed to ensure dignity was maintained for six of six sampled residents (2, 4, 7, 13, 19, and 20) who were dependent upon the staff to assist them with activities of daily living (ADL). Findings include:  Surveyor: 32333 1. Interview on 8/16/16 at 4:45 p.m. with resident 2 revealed: *Her call light waiting time could be up to an hour. -Usually that happened in the mornings. *She had a wound on her bottom. *Sometimes her bed would be soaked with urine from her catheter leaking. -Staff would tell her they would change her bed when the nurse came in to do her dressing change. -Sometimes staff would change the turning sheet instead of changing all of the bedding. -The last time it had happened was that morning. *Some days she had to lay in bed until 10:30 a.m. -She had asked to get up earlier.	F 241 F 241	F 241 Dignity and Respect of Individuality  Resident #2 - Field Services Clinical Director (FSCD) and staff met with the resident on September 1, 2016 for her scheduled care conference. Mutual agreement was reached with her as to the time of her ordered wound care and out of bed schedule to allow her to eat meals in the Dining Room. These changes were made to her care plan.  Resident # 4, 7, 13, 20 - Urinal and personal care items were rearranged to assure dignity and respect for each of their well-being are maintained.  Resident # 19 - Personal care items were rearranged to assure dignity and respect for her well-being is maintained.  Residents residing in the facility have the potential to be affected in a similar manner.  The Executive Director, Director of Nursing, and the Interdisciplinary Team have reviewed the dignity and respect policy.	9/14/16	

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F 241	<p>Continued From page 23</p> <p>-She would have liked to get up between 8:00 a.m. and 9:00 a.m.</p> <p>-She had been told she could not get up until the nurse had come into do her dressing change.</p> <p>*She was told they were short staffed.</p> <p>*She was supposed to have a bath every Tuesday, Thursday, and Saturday.</p> <p>*It had been well over two weeks since she had a bath.</p> <p>Interview on 8/17/16 at 8:05 a.m. with certified nursing assistant G regarding resident 2 revealed:</p> <p>*The resident would like to get up earlier.</p> <p>*They could not get her up for the day until the nurse changed her dressings.</p> <p>*She had observed a couple of nurses just change the turn sheet when the resident's bedding had been soaked with urine.</p> <p>Interview on 8/17/16 at 10:16 a.m. with a CNA who wished to remain confidential revealed LPN F would not change resident 2's sheets when they were wet.</p> <p>Surveyor: 32355</p> <p>2. Observation and interview on 8/23/16 at 10:22 a.m. with licensed practical nurse (LPN) D regarding resident 2 revealed:</p> <p>*She had gathered supplies and prepared to change a dressing to the resident's buttock.</p> <p>*The resident had refused to have her dressing changed yesterday (8/22/16).</p> <p>*The nurse stated:</p> <p>- "I had been busy with another resident when she wanted the dressing change done."</p> <p>- "When I got done and checked on the resident she refused to let me change it."</p> <p>- "She has a history of doing that. When she</p>	F 241	<p>All Nursing staff was re-educated to provide each resident to direct their personal care as they are able.</p> <p>All Nursing staff will be re-educated about appropriate personal care including bed linens changes, turning and repositioning, dressing changes etc. by the Multi-site Director of Clinical Education by September 14, 2016.</p> <p>Director of Nursing or designee will complete 5 random audits weekly X 4 then Monthly X 2 of all employees to assure they are aware of their individual role and responsibility in identifying potential Abuse and Neglect events; who they report suspicions to and what the next steps are in the process.</p> <p>Director of Nursing will provide the results of the audits to the QAPI committee for further review and recommendations.</p>	

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F 241	<p>Continued From page 24</p> <p>wants her dressing changed, she wants it done now."</p> <p>*The resident had been laying in her bed.</p> <p>*She appeared very thin and weak.</p> <p>*Her bones were easily noticed through her skin.</p> <p>*The staff used a turning/repositioning sheet to assist her with repositioning in the bed.</p> <p>*When she had been turned onto her side her bottom revealed multiple wounds and open areas.</p> <p>*Several of those wounds had not been covered with a protective dressing.</p> <p>-The exposed wounds had been laying directly on the turning/repositioning sheet.</p> <p>*The turning/repositioning sheet had a large wet area with drainage from those wounds.</p> <p>-The drainage had been green and brown in color.</p> <p>*The resident had stated:</p> <p>-"I didn't have my dressing changed yesterday. I waited all day."</p> <p>-"I had told the evening staff to tell the nurse I was ready to have my dressing changed. The nurse never came."</p> <p>-"When I told the night nurse she told me it should have already been done, and she refused to do it."</p> <p>Interview on 8/23/16 at 2:20 p.m. with certified nursing assistant (CNA) A regarding resident 2 revealed:</p> <p>*She would not have:</p> <p>-Repositioned the resident unless she requested to be turned.</p> <p>-Assisted the resident out of her bed until after she had her dressing changed to her bottom.</p> <p>*The resident had preferred to stay in bed until after she had her dressing change completed.</p>	F 241		

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F 241	<p>Continued From page 25</p> <p>3. Random observations on 8/22/16 from 4:10 p.m. through 6:00 p.m. of resident 20's room revealed:</p> <ul style="list-style-type: none"> <li>*He had an end table located by his bed.</li> <li>*On the end table had been: <ul style="list-style-type: none"> <li>-Several opened straws and plastic spoons.</li> <li>-Used combs and hair brushes with hair attached to them.</li> <li>-A pitcher of water.</li> <li>-Two shavers.</li> <li>-Several toothbrushes.</li> </ul> </li> <li>*Sitting next to the above items had been a urinal full of urine.</li> </ul> <p>Interview on 8/22/16 at 4:10 p.m. with resident 20 revealed:</p> <ul style="list-style-type: none"> <li>*He had not been able to empty the urinal on his own and relied upon the staff to empty it.</li> <li>*He had been told "They will empty it sometime today."</li> </ul> <p>4. Random observation on 8/23/16 from 11:30 a.m. through 2:45 p.m. of resident 13's room revealed:</p> <ul style="list-style-type: none"> <li>*His bed and end table had been located by the door.</li> <li>*When the door was opened the end table had been viewable from the hallway.</li> <li>*On top of the end table had been a pitcher filled with water.</li> <li>-The resident drank his water from that pitcher.</li> <li>*Sitting next to the pitcher of water had been a urinal half full of urine.</li> <li>*Several staff members, residents, and visitors had been observed walking by his room.</li> </ul> <p>Interview on 8/23/16 at 2:00 p.m. with resident 13 revealed:</p> <ul style="list-style-type: none"> <li>*He had not been able to empty the urinal on his</li> </ul>	F 241		

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F 241	<p>Continued From page 26</p> <p>own and had relied upon the staff to empty it. *He stated "I told them earlier it needed to be emptied, but no one has done it yet."</p> <p>Surveyor: 32572</p> <p>5. Multiple random observations on 8/23/16 from 8:25 a.m. through 5:30 p.m. revealed residents 4 and 7's urinals were one-third to one-half full hanging on the wastebasket in their rooms. Also during that time, resident 19's catheter bag was exposed to viewing by anyone who walked in the hallway. There were other residents, family, and visitors walking in that hallway during that time. The exposed bag revealed the color and sediment of the urine in that bag.</p> <p>6. Random observations on 8/23/16 from 8:25 a.m. through 5:30 p.m. revealed the resident rooms of cognitively intact residents were picked up, neat, and tidy. Rooms of residents who were not cognitively intact were untidy.</p> <p>Review of a list from the provider revealed fourteen of sixty-five residents had a Brief Interview of Mental Status score indicating severe cognitive impairment.</p> <p>7. Interview on 8/24/16 from 9:07 a.m. until 10:10 a.m. with the field services clinical director confirmed she had expected any time a staff member who had been in a resident's room should have picked up the room, emptied the urinals, and properly placed and covered the catheter bag.</p> <p>Surveyor: 32355 Interview on 8/23/16 at 4:30 p.m. with the field services clinical director revealed:</p>	F 241		

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F 241	<p>Continued From page 27</p> <p>*She would have expected the staff to:</p> <ul style="list-style-type: none"> <li>-Empty the urinals frequently throughout the day or when they had been in the resident's room.</li> <li>-Change the dressing on resident 2's bottom upon her request.</li> <li>-Change resident 2's turning/repositioning sheet when soiled.</li> </ul> <p>Review of the provider's 3/31/16 Dignity policy revealed a policy statement "All residents will be treated in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of her or her individuality." The purpose of that policy was "Treating resident with dignity and respect maintains and enhances each resident's self-worth and improves his or her psychosocial well-being and quality of life."</p> <p>8. Review of the admission packet given to all residents included a pamphlet entitled Long-Term Care Facilities Resident's Bill of Rights. The pamphlet revealed:</p> <p>"You are entitled to quality of life. A facility must provide care and an environment that contributes to your quality of life including:</p> <ul style="list-style-type: none"> <li>-A safe, clean, comfortable and home-like environment.</li> <li>-Maintenance or enhancement of your ability to preserve individuality, exercise self-determination and control every day physical needs.</li> <li>-Freedom from physical or chemical restraints used for purposes of discipline or convenience.</li> <li>-Freedom from theft of personal property; verbal, sexual, physical or mental abuse; and involuntary seclusion, neglect or exploitation imposed by any one." <p>Review of the 8/15/16 staff huddle notes revealed</p> </li></ul>	F 241			

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F 241	Continued From page 28 "Urinals-please empty them every time they have urine in them."  Review of the provider's 11/17/15 Preventing, Investigating, and Reporting Alleged Sexual Assault and Abuse Violation policy revealed: **"It is the policy of this center to take appropriate steps to prevent the occurrence of neglect." *Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness."  Review of the provider's 9/25/14 certified nursing assistant job description revealed: **"Essential Job Duties were: -Maintain resident's rooms in neat, orderly and clutter-free manner. -Support residents' participation in activity program. -Directly respond, within scope, to needs and concerns of resident and family members including call lights. -Ensure residents' comfort while assisting them in achieving their highest practicable level of functioning."	F 241			
F 248 SS=F	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES  The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Surveyor: 32333	F 248	F248 Activities Meet Interests/Needs of Each Resident  Resident 2, 3, 4, 5, 6, 7, 8, 10, 11, 13, 14, 18 - We are unable to recreate documentation for Activities attendance during the months of July and August.	9/14/16	

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F 248	<p>Continued From page 29</p> <p>Surveyor: 32355</p> <p>Surveyor: 32572</p> <p>Based on interview, record review, and policy review, the provider failed to ensure an activities program had been actively in-place for 11 of 21 sampled residents (2, 3, 4, 6, 7, 8, 10, 11, 13, 14, and 18's). Findings include:</p> <p>1. Review of residents 2, 3, 4, 6, 7, 8, 10, 11, 13, 14, and 18's medical records revealed no documentation of activity participation for July and August 2016.</p> <p>Review of the paper records in the activity department revealed minimal activities had been performed for the first seven days of July and nothing for August 1 through 23, 2016.</p> <p>Review of the admission packet given to all residents included a pamphlet entitled Long-Term Care Facilities Resident's Bill of Rights. That pamphlet revealed: **You are entitled to quality of life. A facility must provide care and an environment that contributes to your quality of life including: -A safe, clean, comfortable and home-like environment. -Maintenance or enhancement of your ability to preserve individuality, exercise self-determination and control every day physical needs.</p> <p>Review of the provider's 3/31/16 CMS (Center for Medicare and Medicaid Services) Provision of Activities policy revealed: **In long-term care, an ongoing program of activities refers to the provision of activities in accordance with and based upon an individual</p>	F 248	<p>All residents remain at risk for minimal Activities while residing in the facility.</p> <p>An Activities Calendar was created and published and distributed to resident's September 7, 2016.</p> <p>A temporary assignment was created for a facility staff member to provide a variety of Activities beginning on September 7, 2016. This assignment will remain in place until a permanent Activities staff is hired.</p> <p>Executive Director or designee will conduct 5 random resident interviews including resident #2, 3, 4, 5, 7, 10, 13, 14, 18 weekly X 4, monthly X 2 to ensure the residents are informed of a variety of individual and group activities to attend as well as individualized therapeutic Activities.</p> <p>Executive Director or designee will provide the results of the audits to the QAPI committee for further review and recommendations.</p>	

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F 248	<p>Continued From page 30</p> <p>resident's comprehensive assessment. Residents in nursing homes need to receive care and/or services to maximize their highest practicable quality of life. However, defining 'quality of life' has been difficult, as it is subjective for each person. Thus, it is important for the facility to conduct an individualized assessment of each resident to provide additional opportunities to help enhance a resident's self-esteem and dignity."</p> <p>***Residents want activities that are relevant and valuable to their quality of life and considered a part of their dignity. Activities need to amount to something and be meaningful to the resident's lives. Residents with dementia are happier and less agitated in homes with many planned activities for them."</p> <p>***Residents want a variety of activities, including those that are not childish, required thinking (such as word games), are gender-specific, produce something useful, relate to previous work of residents, allow for socializing with visitors and participating in community events, and are physically active."</p> <p>Surveyor: 23059</p> <p>2. Interview on 8/23/16 at 8:15 a.m. with two residents who requested to remain confidential revealed:</p> <p>*There had been no activities director for at least two months.</p> <p>*There used to be a lot of activities; now they only had bingo, church, Bible study, and occasionally a band would come in to play.</p> <p>*They used to have many more activities.</p> <p>*They missed the activities, because there was not much to do.</p> <p>***"We pretty much just sit in our rooms waiting for meal times."</p>	F 248		

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F 248	Continued From page 31 **I don't think they have any staff person doing activities. There are volunteers that come for bingo, church, and Bible study. If they didn't come in nothing would get done." *They were sure no one-to-one activities had been conducted for residents who spent most of the their time in their rooms.  3. Interview on 8/24/16 from 9:07 a.m. through 10:10 a.m. with the field services clinical director revealed there was no formal activity program. The only activities were church and bingo, and those were provided by volunteers. Those activities were not documented in the resident medical records. The activity director had resigned approximately two months ago.	F 248			
F 280 SS=E	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 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.	F 280	F 280 Right to participate planning Care-Revise CP  Resident # 2 met with the Field Services Clinical Director (FSCD) and an additional staff member on September 1, 2016 for her scheduled care conference. An agreement was negotiated for her ordered wound care and subsequent out of bed schedule to allow her to eat meals in the Dining Room. Care plan was revised on September 1, 2016. Care Plan has continued to be revised through September 7, 2016 per resident wishes.	9/14/16	

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F 280	<p>Continued From page 32</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, interview, record review, and policy review, the provider failed to ensure care plans reflected the current status for 8 of 21 sampled residents (2, 5, 6, 8, 10, 13, 14, and 18). Findings include:</p> <p>1. Review of resident 6's medical record revealed: *She had been admitted on 7/1/16. *Admission was for therapy services after a hip fracture. *Her Brief Interview for Mental Status (BIMS) testing score indicated she had mild cognitive (thought) impairment.</p> <p>Review of resident 6's 7/1/16 care plan revealed: *She had a history of depression and occasional confusion. -The care plan for confusion stated to anticipate her needs, and re-orient to the facility as needed. *She had fallen on 7/1/16, 7/9/16, 7/18/16, and 7/21/16. -Interventions had been put in place after the 7/1/16, 7/18/16, and 7/21/16 falls. -Those included reminding the resident frequently to use her call bell or ask for assistance.</p> <p>Review of the provider's Post Fall Analysis/Plan for resident 6 revealed: *A fall occurred on 7/1/16 at 11:15 p.m. The resident explained "she was trying to get to her bathroom, but someone had moved her room around."</p>	F 280	<p>Resident #5 – Care Plan was revised on August 24, 2016 to reveal the healed pressure ulcer.</p> <p>Resident #6 was discharged. We were unable to revise the care plan.</p> <p>Resident # 8 was discharged from the facility on July 29, 2016. We were unable to revise the care plan.</p> <p>Resident #10 – Care Plan was revised on September 9, 2016 to reflect current fall risk interventions as identified on his Post Fall plan as recommended by the Interdisciplinary team.</p> <p>Resident #13 - Care Plan will be revised on September 9, 2016 to reflect resident's current blood pressure status condition and treatment. His status for assistance out of bed and facility participation has also been updated. His care plan for wound care has been revised to reflect current treatment orders.</p> <p>Resident #14 –Care plan will be updated on September 9, 2016 to reflect current fluid intake, continence</p>	

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F 280	<p>Continued From page 33</p> <p>-She had a "history of falls, an impaired safety awareness/judgement, and a recent changes in environment."</p> <p>-Recommendation/Interventions were "Freq [frequent] reminders to call for assistance or use her call light, freq. rounding."</p> <p>-The report indicated the care plan had been revised.</p> <p>--The frequent rounding had not been added to the care plan.</p> <p>*A fall occurred on 7/9/16 at 7:30 p.m. The resident did not explain what she was doing.</p> <p>-She had an "impaired safety awareness/judgement."</p> <p>-Possible causal/Contributing factors and observations were "garbage can out of resident's reach."</p> <p>-Recommendation/Interventions were "Ensure that items are within resident's reach."</p> <p>-The report indicated the care plan was revised.</p> <p>--Items within reach had not been added to the care plan.</p> <p>*A fall occurred on 7/18/16 at 5:20 a.m. The resident's explanation was "going to the bathroom."</p> <p>-She had "history of falls and impaired safety awareness/judgement."</p> <p>-Recommendation/Interventions were "frequent checks, remind resident to ask for help/use call light, use wheelchair."</p> <p>-The report indicated the care plan was revised.</p> <p>--Frequent checks had not been placed on the care plan.</p> <p>*A fall occurred on 7/21/16 at 3:50 a.m. There was no resident explanation of what had occurred.</p> <p>-She had "history of falls and impaired safety awareness/judgement."</p> <p>-Recommendations/Interventions were</p>	F 280	<p>status, skin issues, meal service, bathing and weight monitoring.</p> <p>Resident #18 – Care Plan will be revised on September 9, 2016 to reflect the current condition and treatment to her pressure area.</p> <p>All residents remain at risk for care plan accuracy. Each Resident chart and care plan will be reviewed by the Interdisciplinary team within 72 hours of admission and within 24 hours of noted changes of condition including adverse events</p> <p>All current residents' care plans will be reviewed by the Interdisciplinary Team (IDT) throughout the next quarter to assure correct interventions are identified and implemented.</p> <p>All admissions after September 1, 2016 will have the Interim Care plans developed following the completion of the Admission evaluations by the IDT. A Comprehensive Care plan will be developed and completed within 7 days of the Comprehensive assessment by</p>		

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F 280	<p>Continued From page 34</p> <p>"Reeducated client on the use of call bell. Resident voiced she understood."</p> <p>*A fall occurred on 7/22/16 at 1:30 p.m. There was no resident explanation of what had occurred.</p> <p>-She had "history of falls and impaired safety awareness/judgement."</p> <p>-There was no possible causal/contributing factors or recommendations/interventions.</p> <p>-The report stated the care plan was not revised.</p> <p>All of the interdisciplinary team (IDT) review and recommendations on the above reports were blank.</p> <p>2. Review of resident 18's medical record revealed:</p> <p>*She had been admitted on 7/15/16.</p> <p>*She was on a "Regular diet, 1/2 sweets and 1500 cc [cubic centimeters] FR [fluid restriction]."</p> <p>Review of the 7/25/16 comprehensive care plan and the following revealed no mention of the fluid restriction:</p> <p>-The care plan did state to "encourage fluids."</p> <p>*The 8/16/16 extension care plan CNA worksheet revealed no mention of the fluid restriction.</p> <p>*Review of the posting at the kitchen window revealed notification the resident was on 1/2 sweets listing, but she was not listed on the fluid restriction listing.</p> <p>*Review of the sticker placed on the menu revealed a regular diet with 1/2 sweets with no mention of the fluid restriction.</p> <p>Interview on 8/22/16 at 9:50 a.m. with the dietary manager revealed if she had been aware of the fluid restriction it would have been on the posting and the menu sticker. It would also have been</p>	F 280	<p>the Registered Nurse Assessment Coordinator (RNAC) and Interdisciplinary team according to the RAI process.</p> <p>All licensed nurses and department heads will remain responsible for care plan revision according to changes in resident preference or changes in condition. All staff is responsible for communicating resident physical care changes or preferences to the Licensed Nurses and/or department heads</p> <p>The Care Plan Policy and Procedure was reviewed by the Interdisciplinary team. All CNA care sheets and resident eMAR/eTAR will be considered part of the care plan.</p> <p>The care planning process will be inclusive of Facility protocols, the RAI manual, and other accepted standards of practice. Care plans will contain individualized interventions based on the individual resident needs and desires.</p> <p>Lippincott Nursing Manuals were received and placed at the Nurses</p>	

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F 280	Continued From page 35 care planned.  Review of resident 18's wound care plan revealed it had conflicting information. *Review of the 7/18/16 Pressure ulcer care plan revealed a pressure ulcer present on the right buttock and an open area to the left lower leg. *Review of the 7/18/16 Pain management care plan revealed a wound to the left lower extremity and a sacral ulcer. Neither of these care plans indicated the treatment to be done to the wounds. Refer to F281, finding 4.  Surveyor: 32355 3. Review of resident 13's medical record revealed: *He had been admitted on 7/22/16. *Diagnoses included a left below-the-knee amputation, Type II diabetes, pressure ulcers, high blood pressure, and a history of blood clots. *He had been: -Admitted with multiple wounds. -Dependent upon the staff to assist him with activities of daily living (ADL). -Weak and was working with the therapy department on strengthening. -Having a problem with his blood pressure dropping when he was out of bed for any length of time. -Assisted out of his bed with the therapy department once a day because of his blood pressure problems. *He had good memory recall. *His blood pressure medication had been discontinued on 8/9/16. *His blood pressure was to have been checked every day.	F 280	station, and DNS office office on September 7, 2016.  Education will be provided to all staff regarding communicating resident needs and preferences; provision of care according to the Care Plan/CNA Care sheet and Licensed Nurses/department personnel on development/revision of a care plan by the Multi-site Director of Clinical Education by September 14, 2016.  The Director of Nursing (DNS) or designee will audit appropriateness of Interim care plans within 72 hours of admission for all new residents.  All current residents will have their comprehensive care plans audited for completion and accuracy by the DNS or designee with the completion of the next required MDS.  Then the DNS or designee will complete audits of 4 of the residents due to have a comprehensive MDS completed for accuracy of the Care plan quarterly X 2.		

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F 280	<p>Continued From page 36</p> <p>Observation and interview on 8/22/16 at 4:00 p.m. with resident 13 revealed: *He had been laying in his bed watching television. *He had already been out of his bed for the day. -The therapy department had assisted him earlier in the day with getting out of bed. *He planned to eat supper in his room. -He ate all of his meals in his room per his choice.</p> <p>Interview on 8/23/16 at 9:20 a.m. with the occupational therapy department confirmed the above medical record review and interview with resident 13.</p> <p>Review of the undated certified nursing assistant (CNA) resident care sheets regarding resident 13 revealed: *No documentation to support: -He had been having problems with his blood pressure. -His blood pressure was to have been checked every day. -He had been getting out of bed once a day with the assistance of the therapy department. -Where he had been eating his meals.</p> <p>Review of resident 13's revised 7/22/16 care plan revealed: *Focused area: "Impaired Cardiovascular status related to hypertension, chronic venous stasis, and lymphedema." -Intervention under that focused area revealed no documentation to support: --His blood pressure medication had been discontinued. --How often his blood pressure was to have been</p>	F 280	<p>The results of these audits will be presented by the DNS or Designee to the QAPI committee monthly for further review and recommendations.</p>		

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F 280	<p>Continued From page 37 checked.</p> <p>--He was assisted out of bed once a day with the therapy department due to his blood pressure problems.</p> <p>*Focused area: "Altered skin integrity non pressure related to: Diabetic ulcer, surgical wound, pressure ulcer to right heel, right buttock and coccyx, lymphedema."</p> <p>-Intervention under that focused area revealed: --"Conduct weekly skin inspection." --"Weekly wound assessment." -No documentation to support if there should have been a treatment completed on his wounds.</p> <p>Review of resident 13's weekly skin review sheets from 7/26/16 through 8/10/16 revealed no documentation to support his skin had been checked after 8/10/16.</p> <p>Review of resident 13's weekly wound evaluation flow sheets from 7/22/16 through 8/23/16 revealed: *On 7/22/16 the wound to his coccyx had been assessed. -No other wounds had been documented on or assessed. *No documentation to support his: -Coccyx had been assessed after 7/22/16. -Other wounds had been assessed during his stay in the facility from 7/22/16 to present.</p> <p>4. Review of resident 14's medical record revealed: *She had been readmitted to the facility on 7/5/16 from an acute care hospital. *Diagnoses were: amyotrophic lateral sclerosis (ALS), failure to thrive, reflux disease, pain, and history of pneumonia. *She had:</p>	F 280			

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F 280	<p>Continued From page 38</p> <ul style="list-style-type: none"> <li>-No muscle control and required assistance from the staff for positioning and transfers.</li> <li>-Required the use of a transfer aide to assist her with transfers in and out of bed.</li> <li>-The staff assisted her out of bed once or twice a week per her choice.</li> <li>-Been incontinent of both urine and bowel.</li> <li>-Wounds to her sacral area.</li> <li>-Been placed on a fluid restriction upon this readmission.</li> <li>-A significant weight loss prior to her admission.</li> <li>-Received bed baths and not showers or baths.</li> </ul> <p>Review of the undated CNA resident care sheets regarding resident 14 revealed:</p> <ul style="list-style-type: none"> <li>*No documentation to support she had: <ul style="list-style-type: none"> <li>-Been on a fluid restriction.</li> <li>-Been incontinent of both urine and bowel.</li> <li>-Any skin issues.</li> </ul> </li> <li>*She was to have: <ul style="list-style-type: none"> <li>-Eaten her meals in the dining room.</li> <li>-Received a bath or shower twice a week.</li> </ul> </li> <li>*No documentation to support how often she should have been weighed.</li> </ul> <p>Interview on 8/23/16 at 2:25 p.m. with CNA A revealed:</p> <ul style="list-style-type: none"> <li>*She had confirmed the resident care sheets were: <ul style="list-style-type: none"> <li>-What the CNAs had followed to ensure the residents received the appropriate care they required.</li> <li>-Not accurate, complete, and up-to-date for resident 14.</li> </ul> </li> <li>*She had not been aware resident 14 had been on a fluid restriction.</li> <li>*She would have expected to find the fluid restriction concern documented on the resident care sheets.</li> </ul>	F 280			

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F 280	<p>Continued From page 39</p> <p>*She had not been aware of who updated the resident care sheets or how often.</p> <p>Review of resident 14's revised 8/22/16 care plan revealed:</p> <p>*Focused area: "Pressure ulcer actual sacrum, assistance required in bed mobility, bed fast." -Intervention under that focus area revealed no documentation to support: --Weekly skin inspection and wound assessments should have been completed. --If there should have been a treatment completed on her sacrum wounds.</p> <p>*Focused area: "Swallowing difficulty as related to ALS." -Intervention under that focus area revealed she should have been weighed weekly.</p> <p>Review of resident 14's weight documentation form revealed she had not been weighed since her readmission on 7/5/16. She had weighed 113.96 pounds on that date.</p> <p>Interview on 8/24/16 at 9:15 a.m. with the field services clinical director and MDS assessment coordinator revealed:</p> <p>*The interdisciplinary care team and nursing staff had been responsible for reviewing and revising the care plans. *They confirmed the CNA resident care sheets had been an extension of the care plans. -The staff used them to guide their care for the residents. *They agreed: -All of the above areas of concerns for residents 13 and 14 should have been found on their care plans and care sheets. -The care plans and care sheets should have been updated to reflect the current level of care</p>	F 280			

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F 280	<p>Continued From page 40 they had required.</p> <p>Surveyor: 32333</p> <p>5. Interview on 8/17/16 at 9:05 a.m. with the local ombudsman regarding his interview with resident 8 who was admitted on 6/30/16 and the director of nursing (DON) during his monthly visit on 7/13/16 revealed:</p> <ul style="list-style-type: none"> <li>*He voiced that his pressure ulcer had not been looked at.</li> <li>*He did not have the strength to use a bedpan, and they did not have a sling to transfer him to the commode.</li> <li>*His family took him home once per week to have a bowel movement.</li> <li>*The DON confirmed: <ul style="list-style-type: none"> <li>-She had not assessed the resident's pressure ulcer.</li> <li>-They could not find the correct Hoyer lift sling to toilet the resident.</li> </ul> </li> <li>*The resident's family took him home one time a week to toilet him, so he could have a bowel movement.</li> </ul> <p>Review of resident 8's 6/30/16 care plan revealed:</p> <ul style="list-style-type: none"> <li>*Focus area: a pressure ulcer stage 2 to coccyx.</li> <li>*Interventions included: <ul style="list-style-type: none"> <li>-Conduct weekly skin assessments.</li> <li>-Skin assessment to be completed per LivingCenter policy.</li> <li>-Weekly wound assessment.</li> </ul> </li> <li>*No mention of a toileting schedule.</li> <li>*No mention of the resident's preferences regarding toileting.</li> </ul> <p>Interview on 8/17/16 at 11:15 a.m. with the DON regarding resident 8 revealed:</p> <ul style="list-style-type: none"> <li>*A wound care assessment sheet had not been</li> </ul>	F 280			

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F 280	<p>Continued From page 41 initiated.</p> <ul style="list-style-type: none"> <li>*Weekly skin assessments had not been completed.</li> <li>*There had been no toileting sling for the resident.</li> <li>*The resident did not feel secure with the regular Hoyer lift sling.</li> <li>*The resident felt more comfortable going home to use the toilet.</li> <li>*They had not care planned his toileting preferences.</li> <li>*They had not followed their care plan regarding his pressure ulcer.</li> <li>*They had not followed their pressure ulcer policies.</li> </ul> <p>6. Review of resident 2's complete medical record revealed:</p> <ul style="list-style-type: none"> <li>*She was admitted on 12/17/15 with four pressure ulcers.</li> <li>*On 1/16/16 a skin tear had been identified.</li> <li>*On 6/19/16 she acquired a pressure ulcer on her left lower hip area.</li> <li>*Her wound evaluation flow sheets and weekly skin assessments were incomplete or had not been completed from admit through 8/18/16.</li> <li>*Her care plan had not been updated: <ul style="list-style-type: none"> <li>-When she had changes in her skin condition.</li> <li>-To reflect her current skin integrity.</li> <li>-From that incomplete documentation there was know way to know the current status of her wounds.</li> </ul> </li> </ul> <p>7. Review of resident 10's complete medical record revealed:</p> <ul style="list-style-type: none"> <li>*He was admitted on 5/24/16.</li> <li>*He had been identified as a fall risk.</li> <li>*He had a diagnosis of dementia.</li> <li>*He had sixteen falls from in the eighty days from</li> </ul>	F 280			

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F 280	<p>Continued From page 42 admission through 8/11/16</p> <p>Review of resident 10's 7/29/16 revised care plan revealed: *Focus area: at risk for falls. *Intervention: "Needs to be at nurses station or activity programs; can not be left alone in his room unless going to bed." *Intervention: "Resident will be laid down after meals to rest." *Intervention: "Staff must anticipate needs, resident is not able to verbalize when he needs assistance due to his short term memory loss." *Intervention: "Will toilet before and after meals, before laying down for a nap, at hs, once during the night, and as needed."</p> <p>Observation on 8/18/16 at 9:00 a.m. and at 9:05 a.m. of resident 10 after his breakfast revealed: *At 9:00 a.m. he was sitting in his wheelchair in his room by himself. *At 9:05 a.m. he was in his bathroom alone trying to self-transfer himself to the toilet.</p> <p>Review of resident 10's Post Fall Analysis/Plan forms from 5/26/16 through 7/21/16 revealed: *He had no reports for the following dates: 5/27/16, 6/1/16, 7/29/16, 8/3/16, 8/11/16. *The forms that had been initiated were incomplete. *There was no interdisciplinary review or recommendations.</p> <p>Interview on 8/18/16 at 9:40 a.m. with the administrators preceptor revealed she was unsure what the fall communication system was.</p> <p>Interview on 8/23/16 at 9:00 a.m. with an anonymous CNA revealed:</p>	F 280		

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F 280	<p>Continued From page 43</p> <p>*There were no activities.</p> <p>*The activities director had quit approximately a month and a half to two months ago.</p> <p>Surveyor: 23059</p> <p>8. Review of resident 5's revised 8/12/16 care plan revealed she had a stage four pressure ulcer on her left ischium. The goal with a 11/4/16 target date was it would heal without complication. The interventions for that stage 4 pressure ulcer were:</p> <ul style="list-style-type: none"> <li>*Conduct weekly skin inspections.</li> <li>*Provide pressure reduction/relieving mattress.</li> <li>*Provide thorough skin care after incontinent episodes and apply barrier cream.</li> <li>*Weekly wound assessment.</li> </ul> <p>Review of resident 5's nurse's progress notes revealed she had surgery on 4/14/16 to repair that pressure ulcer. Review of her 5/12/16 hospital wound care progress notes revealed it had healed at that time. She was to have:</p> <ul style="list-style-type: none"> <li>*Minimal time sitting in her chair. Limited to 30 to 40 minutes three times daily.</li> <li>*Not to elevate the head of her bed more than 30 degrees.</li> </ul> <p>Review of the resident's wound evaluation flow sheet revealed the last entry regarding the stage 4 pressure ulcer was on 3/23/16. At that time it measured 1.4 centimeters (cm) long by 0.4 cm wide and 0.1 cm deep. Current prevention strategies at that time were a pressure redistribution mattress and a wheelchair cushion. That documentation indicated the care plan had not been reviewed at that time. No further wound documentation was found.</p> <p>Review of resident' 5's 5/16/16 weekly skin review revealed her skin was intact. Subsequent skin</p>	F 280			

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F 280	Continued From page 44 reviews revealed no indication of a stage four pressure ulcer.  Interview on 8/24/16 at 9:10 a.m. with the Minimum Data Set (MDS) coordinator regarding resident 5 revealed she confirmed her care plan had not been updated to reflect : *Her stage 4 pressure ulcer had healed. *She should only have been up in her wheelchair 30 to 40 minutes three times a day. *She should not have the head of her bed elevated past 30 degrees.  Surveyor: 32572 Review of the provider's 11/13/13 resident assessment instrument (RAI) policy revealed "LivingCenters adhere to all CMS [Centers for Medicare and Medicaid Services] regulations which are considered the definitive source in completion of the RAI process. This includes coding the MDS [Minimum Data Set], completion of Care Area Assessments (CAA's) and the development of the comprehensive plan of care."  Interview on 8/17/16 at 10:10 a.m. with the director of nursing confirmed the responsibility for keeping care plans current was: *The MDS nurse for the immediate plan of care and the comprehensive care plan. *The interdisciplinary team for any changes occurring in the resident's status. *Anyone could update the care plan as deemed necessary.	F 280		
F 281 SS=I	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.	F 281		

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F 281	Continued From page 45  This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, record review, and policy review, the provider failed to ensure: *Weekly skin reviews and wound documentation had occurred for 7 of 7 sampled residents (2, 4, 5, 8, 13, 14, and 18). *Physicians' orders were in place for wound treatment for 1 of 6 sampled residents (14). *The correct wound treatment had been completed by 1 of 1 licensed practical nurse (LPN) (D) on 1 of 4 sampled residents (13) who required a daily dressing change for a pressure ulcer. *Physician's order to hold a medication was in the medical record for 2 of 21 sampled residents (2 and 7). Findings include:  1a. Review of resident 13's medical record revealed: *He had been admitted on 7/22/16. *Diagnoses included left below-the-knee amputation, Type II diabetes, pressure ulcers, high blood pressure, and history of blood clots. *He had good memory recall. *His blood pressure medication had been discontinued on 8/9/16. *His blood pressure was to have been checked every day. *He had been admitted with multiple wounds. Those wounds had been: -A surgical wound to his left knee. -A stage II pressure ulcer to his coccyx. -A stage II pressure ulcer to his right buttock. -An unstageable pressure ulcer to his right heel.	F 281	<b>F281 Services provided meet professional standards.</b>  Resident # 2 – Weekly skin assessments were not able to be recreated due to being outside the acceptable timeframe. The wound care order was reviewed and revised with the Primary Care Physician (PCP) on September 5, 2016.  Residents # 4, 5, 13, 18 – Weekly skin assessments were not able to be recreated due to being outside the acceptable timeframe.  Resident 7 - The Medication noted to be on-hold order will be reviewed and revised with the Consulting Physician (Oncologist) by September 14 , 2016.  Resident# 8 – Resident discharged on July, 31, 2016. Therefore, Weekly skin reviews and documentation were not able to be recreated.  Resident# 14 – Weekly skin reviews and documentation were not able to be recreated due to being outside the acceptable timeframe. The wound care	9/14/16	

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F 281	<p>Continued From page 46</p> <p>*He had been dependent upon the staff to assist him with activities of daily living (ADL).</p> <p>*Incomplete wound documentation.</p> <p>*A 7/29/16 physician's order for his skin to be assessed weekly.</p> <p>Review of resident 13's weekly skin review sheets from 7/22/16 through 8/10/16 revealed no documentation to support his skin had been assessed after 8/10/16. Those assessments had not been signed or dated by the licensed nurse.</p> <p>Review of resident 13's weekly wound evaluation flow sheets revealed: *On 7/28/16: -The wound on his coccyx had been assessed. -No other wounds had been assessed. *No documentation to support his wounds had been assessed for improvement, worsening, and healing after 7/28/16. *No date or signature from the licensed nurse who had completed the assessment on 7/28/16.</p> <p>Review for resident 13's nurses' progress notes from 7/22/16 through 8/23/16 revealed no documentation to support complete wound assessments had been done on all of his wounds after 7/22/16.</p> <p>b. Review of resident 14's medical record revealed: *She had been readmitted on 7/5/16 from an acute care hospital. *Diagnoses were: amyotrophic lateral sclerosis (ALS), failure to thrive, reflux disease, pain, and history of pneumonia. *She had: -No muscle control and required assistance from the staff for positioning and transfers.</p>	F 281	<p>order has been reviewed by the Primary Care Physician (PCP) and transcribed on September 6, 2016.</p> <p>All current residents remain at risk for care and services that do not reflect acceptable professional standards.</p> <p>The Executive Director, Director of Nursing, Interdisciplinary Team, a member of the Governing Board, and the Medical Director have reviewed and approved the use of the GLC- clean dressing and the policy and procedure for reviewing resident's skin on a weekly basis and as needed.</p> <p>All new hire licensed staff will complete a skills competency checklist during the orientation process.</p> <p>LPN D will be educated on correct wound treatments by September 14, 2016 by the Golden Living (GL) Registered Nurse (RN) Transitional leader.</p> <p>Licensed nursing staff have been re-educated on the procedures of completing a clean dressing change by</p>	

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F 281	<p>Continued From page 47</p> <p>-Required the use of a transfer aide to assist her with transfers in and out of the bed.</p> <p>-The staff assisted her out of bed once or twice a week per her choice.</p> <p>-Wounds to her sacral area.</p> <p>*An 8/18/16 physician's order to assess her skin every week on Wednesday.</p> <p>Review of resident 14's 7/5/16 admission skin condition assessment revealed:</p> <p>*Skin concern "Tiny open spot on right buttock."</p> <p>*No documentation to support the type of wound, size, and description of the wound to her right buttock.</p> <p>Review of resident 14's weekly skin review sheets from 7/5/16 through 7/25/16 revealed:</p> <p>*The description and documentation of the wound to her right buttock had been conflicting.</p> <p>*On:</p> <p>-7/5/16 and 7/13/16, a small open area to her right buttock.</p> <p>-7/18/16 and 7/24/16, "moisture to right buttock."</p> <p>-7/25/16, she had a skin tear to her sacral area.</p> <p>*No documentation weekly skin assessments had been completed after 7/25/16.</p> <p>*No date or signature from the licensed nurse who had completed the weekly skin sheets.</p> <p>Review of resident 14's weekly wound evaluation flow sheets 7/5/16 through 8/23/16 revealed on 8/16/16:</p> <p>*Site "Coccyx."</p> <p>*Type "Skin tear."</p> <p>*Stage "Unstageable."</p> <p>*Additional descriptions "Received skin tear when being transferred to gurney by EMS personal [personnel]."</p> <p>-Additional comments "Wound is not open, has</p>	F 281	<p>the by the Multi-site Director of Clinical Education on September 15, 2016.</p> <p>Nursing staff has been re-educated on the procedures of reviewing skin with the bathing schedule in partnership with a Licensed Nurse by the Multi-site Director of Clinical Education by September 14, 2016.</p> <p>Director of Nursing or designee will complete 5 random audits of licensed nurses clean dressing change technique, weekly skin review weekly x 4 weeks and then monthly x 2 months to ensure compliance.</p> <p>Director of Nursing will report the results of the audits at the monthly QAPI meetings for further review and recommendations.</p>		

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F 281	<p>Continued From page 48</p> <p>red edges, turning to white and has a dark center, suspecting deep tissue injury at this time. Patient is on a turn schedule but will refuse to reposition." *No documentation wound had been assessed prior to and after 8/16/16. That wound assessment had not been signed or dated by the licensed nurse.</p> <p>Review of resident 14's nurses' progress notes from 7/5/16 through 8/23/16 revealed no documentation a complete wound assessment had been done after her admission on 7/5/16.</p> <p>Surveyor: 32572 c. Review of resident 4's medical record revealed an 8/17/16 signed physician's order: -Wound care to the right foot daily on the evening shift and as needed (PRN). --That physician's order had been initiated 6/27/16. -Weekly skin assessments every Thursday. -Weekly skin reviews.</p> <p>The provider was unable to produce from the electronic medical record any weekly skin assessments for resident 4.</p> <p>Review of nurses progress notes from 6/23/16 through 8/22/16 revealed three progress notes about the wound dressing change on the right foot. There was no documentation to determine a complete wound assessment had been done.</p> <p>Review of the July and August 2016 Weekly Skin Reviews completed for resident 4 revealed: *7/7/16: He had a bruise on the abdomen from insulin injections and pre-existing open area on right toes with scab and dry red areas.</p>	F 281			

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F 281	<p>Continued From page 49</p> <p>*7/14/16: He had a bruise and open area. Under other it stated he had a PICC (special intravenous device) line in his left arm, amputated toes, multiple bruises on abdomen.</p> <p>*7/21/16: He had pre-existing dry skin and pre-existing open area on the right toes; "healing wounds due to post amputation of toes."</p> <p>*8/4/16: He had bruises from insulin shots on both upper arms and on his abdomen. He had a pre-existing "open area right toes (amputation of toes before admission)."</p> <p>*8/5/16: His skin was intact.</p> <p>No further weekly skin reviews were found.</p> <p>d. Review of resident 18's medical record revealed an admission date of 7/15/16 with a 7/21/16 signed physician's orders stating: -Weekly skin reviews every Thursday. -Those signed physician's orders did not include the admission order for : --Wound care to her LLE (left lower extremity). --Wound care to her right buttock.</p> <p>Review of resident 18's 7/15/16 admission nursing assessment of the skin conditions revealed: -No indication of where the wounds were on the pictures of the body. -A skin concern was documented for the LLL (left lower leg). An open area was observed on 7/15/16. --It did not indicate the stage of the wound or how the surrounding tissue appeared. --It was 4 cm (centimeters) by 2.5 cm but did not indicate how deep the wound was. -- It stated "open area R/T [related to] cellulitis [skin infection]; small amt [amount] of yellow drainage noted." -No other skin concerns were noted.</p>	F 281		

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F 281	<p>Continued From page 50</p> <p>Review of the resident 18's July and August 2016 Weekly Skin Review documentation revealed: *7/15/16: "Open area r/t cellulitis to left lower leg (lateral side) approx. 4cm L X 2.5 cm W. Small amount of yellow drainage noted. Cleansed with normal saline applied mepilex." *7/21/16: Her skin was dry with pre-existing redness and a pre-existing open area. -The open area was left lower leg stating "wound from fall that occurred before admission." *8/4/16: An open area that was pre-existing on the outer aspect of LLE due to cellulitis. And the "sacrum-open area due to sheer and moisture, barrier cream applied." *8/8/16: An open area on right thigh front. A skin tear measuring 4 inches by 0.5 inches.</p> <p>Review of the resident 18's Wound Evaluation Flow Sheet revealed: *A pressure ulcer on the coccyx measured 0.1 X 0.1 X 0.1 cm, a stage two, red wound bed was identified on 7/15/16 upon admission. There was a pain management plan in place for the wound. There were preventative measures in place of a pressure redistribution mattress and a turn/reposition schedule. The care plan had been reviewed. *That wound document was not signed or dated by the licensed nurse. *There was no other wound documentation.</p> <p>Interview on 8/24/16 from 9:07 a.m. through 10:10 a.m. with the field services clinical director confirmed she would have expected the weekly skin assessments to have included the wound length, width, depth, drainage, stage, surrounding tissue, and tunneling. The weekly skin reviews were to have been completed with baths to</p>	F 281		

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F 281	<p>Continued From page 51 monitor for potential skin issues.</p> <p>Surveyor: 32355 6. Review of resident 14's 8/8/16 nurse's progress note revealed "New orders for daily dressing changes with hydrogel please see TAR [treatment administration record]."</p> <p>Review of resident 14's physician's orders revealed no documentation an order had been noted by the licensed nurse who received the above treatment order change from the physician.</p> <p>7. Review of resident 2's 8/23/16 nurse's progress note revealed: ***Updated PCP [primary care provider] re: wound care today and residents wishes." ***PCP gives order to hold collagen powder for 2 days and then to restart."</p> <p>Review of resident 2's August 2016 TAR revealed: *She was to have collagen powder applied to her open wounds on her buttocks daily. *On 8/24/16 and 8/25/16 the above treatment to her wounds was to have been held.</p> <p>Review of resident 2's physicians' orders revealed no documentation to support an order had been noted by the licensed nurse who received the above treatment order change from the PCP.</p> <p>Interview on 8/24/16 at 9:20 a.m. with the field services clinical director confirmed she would have expected a physician's order to have been noted for the above wound treatment changes.</p> <p>8. Observation on 8/23/16 at 3:15 p.m. of LPN D with resident 13 revealed:</p>	F 281		

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F 281	<p>Continued From page 52</p> <p>*The nurse had: -Prepared to complete a dressing change to the resident's right heel. -Applied Betadine to his right heel wound.</p> <p>Review of resident 13's medical record revealed: *He had been admitted on 7/22/16. *He had been admitted with an unstageable pressure ulcer to his right heel. -The wound was to have been treated daily with Betadine. *On 8/16/16 the physician had changed the treatment to his right heel. -The Betadine had been discontinued and Santyl ointment was to have been applied to the wound.</p> <p>The licensed nurse had not been available for interview regarding the above observation.</p> <p>Interview on 8/24/16 at 9:25 a.m. with the field services clinical director confirmed the treatment orders for resident 13 had changed on 8/16/16. She would have expected the licensed nurse to have followed the current physician's order of Santyl ointment.</p> <p>Surveyor: 23059 e. Review of resident 5's physician's orders revealed a weekly skin assessment was to have been completed. That order had been initiated on 1/10/16 and discontinued on 7/28/16. She had been admitted 12/30/15 with a stage 4 pressure ulcer. Surgery had been performed on 4/14/16 to close that wound. She was at high risk for redevelopment of a pressure ulcer.</p> <p>Review of her weekly skin assessments from 3/3/16 through 8/23/16 revealed documented</p>	F 281		

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F 281	<p>Continued From page 53</p> <p>assessments had been completed on:</p> <p>*March: 3/30/16. *April: 4/13/16. *May: 5/16/16, 5/18/16. *June: 6/15/16, 6/22/16, 6/29/16. *July: 7/20/16. *August: 8/3/16, 8/10/16.</p> <p>Those skin assessments had not been completed weekly as ordered by the physician.</p> <p>Review of her weekly wound documentation from 3/3/16 through 8/23/16 revealed it had been completed:</p> <p>*3/10/16. *3/23/16.</p> <p>After that time no further wound documentation was found in her record.</p> <p>Interview on 8/24/16 at 9:10 a.m. with the field services clinical director and the Minimum Data Set (MDS) coordinator revealed their expectation was weekly skin reviews should have been documented per physician's orders until it had been discontinued on 7/28/16. Wound documentation should have been maintained and completed until the wound had healed completely. Both confirmed a surgical incision and repair would have been considered a wound and appropriate assessment and documentation should have occurred.</p> <p>10. Review resident 7's April, May, June, July, and August 2016 medication administration records (MAR) revealed:</p> <p>*A physician's order for Xtandi Capsule 160 mg by mouth one time a day. -April MAR indicated the medication was administered for the first twenty-seven days. -May MAR indicated the medication was held all</p>	F 281		

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F 281	<p>Continued From page 54 month. -June MAR indicated the medication was held all month. -July MAR indicated the medication was held all month.</p> <p>Review of the medical record revealed no physician's order to hold the medication for resident 7.</p> <p>Interview on 8/23/16 at 3:15 p.m. with the administrator preceptor confirmed there was no physician's order to hold the medication.</p> <p>Interview on 8/24/16 from 9:07 a.m. through 10:10 a.m. with the field services clinical director confirmed the expectation would have been to have a physician's order to hold the medication and to document the physician's order. She stated the provider was ordering a Lippincott Manual as the professional reference for nurses.</p> <p>Surveyor: 32333 11. Review of resident 8's complete medical record revealed: *He was admitted on 6/30/16. *He had a stage 2 pressure ulcer on his coccyx. *A 6/30/16 physician's order for a weekly skin review. *A wound care assessment sheet had not been initiated upon admit. *Weekly skin assessments had not been completed during that time. *He had two weekly skin assessments during his stay. *On 7/11/16 there was an incomplete weekly skin review with only: -Open area to coccyx.</p>	F 281		

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F 281	Continued From page 55 -No measurement of the area. Refer to 314, finding 4.  12. Review of resident 2's complete medical record revealed: *She was admitted on 12/17/15 with four pressure ulcers. *On 1/16/16 a skin tear had been identified. *On 6/19/16 she acquired a pressure ulcer on her left lower hip area. *Her wound evaluation flow sheets and weekly skin assessments were incomplete or had not been completed from admit through 8/18/16. *Her care plan had not been updated: -When she had changes in her skin condition. -To reflect her current skin integrity. -From that incomplete documentation there was know way to know the current status of her wounds. Refer to F314, finding 5.	F 281		
F 311 SS=F	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS  A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.  This REQUIREMENT is not met as evidenced by: Surveyor: 32355  Surveyor: 32572 Based on interview, record review, and policy review, the provider failed to ensure a restorative nursing program was in place for all residents living in the facility. Findings include:	F 311	F311 Treatment/Services to improve/maintain ADLS  Individual Residents affected were not identified in the 2567 therefore; we are unable to address their individual restorative needs.  The DNS or Designee will identify residents with needs that can be benefited by restorative nursing techniques. Individual programming will be discussed with the resident and or responsible party and care planned over the next quarter in conjunction with the MDS.	9/14/16

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F 311	<p>Continued From page 56</p> <p>1. Review of the provider's 7/21/16 Restorative Guideline policy revealed: *"The LivingCenter provides a Restorative Nursing program with interventions that promote the resident's/patient's ability to adapt and adjust to living as independently and safely as possible." ***Nursing Rehab/Restorative care includes nursing interventions that assist or promote the resident/patient's ability to maintain or improve his or her maximum functional status."</p> <p>Review of the admission packet given to all residents included a pamphlet entitled Long-Term Care Facilities Resident's Bill of Rights. That revealed: *"You are entitled to quality of life. A facility must provide care and an environment that contributes to your quality of life including: -A safe, clean, comfortable and home-like environment. -Maintenance or enhancement of your ability to preserve individuality, exercise self-determination and control every day physical needs. -Freedom from physical or chemical restraints used for purposes of discipline or convenience. -Freedom from theft of personal property; verbal, sexual, physical or mental abuse; and involuntary seclusion, neglect or exploitation imposed by any one."</p> <p>Review of a list of residents who were receiving skilled therapy services provided by the rehab team leader revealed nineteen of sixty-five residents were receiving skilled therapy services. The other forty-six residents had no programs in place to maintain current physical status.</p> <p>Review of a list provided by the Minimum Data Set nurse indicated twenty-seven residents had</p>	F 311	<p>All Nursing staff will be re-educated on the appropriate completion of Restorative Nursing interventions that will be provided to maintain or improve his or her abilities by the Multi-site Director of Clinical Education by September 14, 2016.</p> <p>The DNS or designee will audit resident restorative programs weekly X 4 and monthly X2 to assure the appropriate delivery of Restorative Nursing programs as well as resident participation.</p> <p>Director of Nursing will report the results of the audits at the monthly QAPI meetings for further review and recommendations.</p>	

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F 311	Continued From page 57 impairment with arms or legs. Of those twenty-seven residents, six were receiving skilled therapy services.  Surveyor: 32355 2. Interview on 8/23/16 at 9:25 a.m. with the occupational therapist revealed: *She had confirmed there was no restorative programs in place for those residents who were not currently receiving therapy services. *She had stated "There has not been a restorative program for the residents since I have been here. I have been working in the facility for 1 1/2 to 2 years. *She agreed the residents had the right to maintain their current function and capabilities through a restorative program. That had been the purpose of a restorative program. *She stated "The therapy department is for strengthening and improving function and capabilities. The restorative programs are designed to maintain those capabilities after we are done working with them."	F 311		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312	F312 - ADL Care provided for Dependent Residents  Resident #1, 2, 3, 4, 6, 7, 8, 9, 10, 13, 15, 16 and 17 have received bathing according to their preference of type provided and revised bathing schedule.	9/14/16

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F 312	<p>Continued From page 58</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355</p> <p>Surveyor: 23059 Based on record review, interview, and policy review, the provider failed to ensure baths were provided per policy and resident expectation for 13 of 21 sampled residents (1, 2, 3, 4, 6, 7, 8, 9, 10, 13, 15, 16, and 17). Findings include:</p> <p>1. Review of the provider's 8/16/16 daily certified nursing assistant (CNA) worksheets revealed all residents were to have showers or baths twice weekly. Each resident had designated days and either AM or PM bath times written on those worksheets.</p> <p>2. Interview on 8/16/16 at 2:50 p.m. with resident 9 revealed she was disappointed she only received one bath per week. She stated she was to receive two baths per week, and she had not been getting that. Interview with her on 8/17/16 at 9:10 a.m. revealed the last time she had a bath was on 8/9/16. She stated she preferred tub baths to showers, but sometimes the tub chair "had been broken." At those times she would need to take a shower that she did not like. She stated she was to have had a bath early in the morning before her TED hose were put on. If those were put on before she had received a bath she knew she would not get one that day.</p> <p>Review of resident 9's 7/1/16 through 8/12/16 bathing records revealed she had received during the weeks of: *7/1/16: one tub bath. *7/8/16: two showers.</p>	F 312	<p>CNA E was terminated from employment at the facility for falsification of records on August 24, 2016. A report was filed with the South Dakota Department of Health substantiating Abuse and Neglect following a lengthy investigation.</p> <p>All residents residing in the facility have the potential to be affected in a similar manner.</p> <p>Resident Bath and Showers – A Designated Team has been established to provide consistent completion of bathing activities for all residents.</p> <p>The Executive Director, Director of Nursing, and the Interdisciplinary team have reviewed and reestablished the Resident Care policies.</p> <p>All nursing staff members will be re-educated on providing necessary services to maintain good grooming and personal and oral hygiene by the Multi-site Director of Clinical Education on September 14, 2016.</p>	

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F 312	<p>Continued From page 59</p> <p>*7/15/16: one shower. *7/22/16: no shower or tub bath. *7/29/16: one shower. *8/5/16: one tub bath. *8/12/16: one shower.</p> <p>For the above seven weeks she should have received fourteen showers or tub baths. She had only received five showers and two tub baths.</p> <p>3. Interview on 8/18/16 at 9:25 a.m. with resident 1's daughter revealed her mother was to have received baths twice weekly. She stated she knew that was not getting done. She stated she had discussed her concern with the director of nursing and was advised "they would take care of it."</p> <p>Review of resident 1's 7/1/16 through 8/16/16 bathing records revealed she had received a tub bath or shower twice weekly until 7/27/16. She had been hospitalized from 7/31/16 until 8/3/16. She received a bed bath upon her return from the hospital on 8/3/16. There had been no documented bath or shower since that time.</p> <p>For the above seven weeks she should have received fourteen showers or tub baths. She had received six showers, one bed bath, and one tub bath.</p> <p>4. Review of resident 15's 6/29/16 through 8/23/16 bathing records revealed: *She had received a bed bath on 6/29/16 and 7/1/16. *Her next bath was a tub bath on 7/16/16. *She had received a shower on 7/23/16, 8/2/16, 8/9/16, 8/16/16, and 8/19/16.</p> <p>For the above eight weeks she should have</p>	F 312	<p>Executive Director or designee will complete 5 random interviews to include resident # 1, 2, 3, 4, 6, 7, 9, 10, 13, 15, 16, and 24 weekly X 4 weeks then monthly X2 months to ensure resident's are receiving bathing per their preference and established schedule.</p> <p>Executive Director will provide the results of the audits to the monthly QAPI meetings for further review and recommendations.</p>	

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F 312	<p>Continued From page 60</p> <p>received sixteen showers or tub baths. She had received five showers, two bed baths, and one tub bath.</p> <p>5. Review of resident 16's 6/29/16 through 8/23/16 bathing records revealed: *She had received a tub bath on 6/26/16, 7/13/16, and 7/20/16. *She had received a shower on 7/24/16, 7/27/16, and 7/31/16. *She had received another tub bath on 8/3/16. *No shower or tub bath had been documented since 8/3/16.</p> <p>For the above eight weeks she should have received sixteen showers or tub baths. She had received three showers and four tub baths.</p> <p>6. Review of resident 17's 6/29/16 through 8/23/16 bathing records revealed: *She had received a shower on 6/26/16, 7/10/16, 7/17/16, 7/29/16, and 8/16/16. *She had received a tub bath on 7/24/16 and 8/12/16. *No shower or tub bath had been documented since 8/16/16.</p> <p>For the above eight weeks she should have received sixteen showers or tub baths. She had received five showers and two tub baths.</p> <p>Surveyor: 32572</p> <p>7. Review of resident 3's medical record revealed she had been admitted on 7/6/16 and discharged on 8/10/16.</p> <p>Review of the CNA electronic documentation of baths completed for July and August 2016</p>	F 312		

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F 312	<p>Continued From page 61 revealed she had recieved:</p> <ul style="list-style-type: none"> <li>*7/8/16: a whirlpool bath.</li> <li>*7/15/16: a shower, and a resident refusal.</li> <li>*7/22/16: a whirlpool bath.</li> <li>*7/29/16: a shower.</li> </ul> <p>If she had received two baths per week as the facility standards stated she should have received seven baths during her stay at the facility. She had recieved two baths and two showers.</p> <p>8. Review of resident 4's medical record revealed he had been admitted on 5/5/16.</p> <p>Review of the CNA electronic documentation of baths completed for July and August 2016 revealed the weeks of:</p> <ul style="list-style-type: none"> <li>*7/1/16: There was no documentation a bath or shower had been given.</li> <li>*7/8/16: A partial bath was given.</li> <li>*7/15/16: A full bed bath was given, and a resident refusal.</li> <li>*7/22/16: There was no documentation of a bath or shower given.</li> <li>*7/29/16: A tub bath was given.</li> <li>*8/5/16: There was no documentation of a bath or shower given.</li> <li>*8/12/16: There was no documentation of a bath or shower given.</li> </ul> <p>Review of the 8/16/16 care plan extension CNA worksheet revealed he was to have received baths in the a.m. on Wednesdays and Sundays. If he had received two baths per week according to the facility standards he should have received fifteen baths, however he had only recieved two bed baths and one tub bath.</p> <p>9. Review of resident 6's medical record revealed</p>	F 312			

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F 312	<p>Continued From page 62</p> <p>she had been admitted on 7/1/16 and discharged on 7/31/16.</p> <p>Review of the CNA paper documentation of baths completed for July and August 2016 revealed she had a tub bath on 7/18/16. If she had received two baths per week according to the facility standards she should have received eight baths.</p> <p>10. Review of resident 7's medical record revealed he had been admitted on 4/14/15.</p> <p>Review of the CNA electronic documentation of baths completed for July and August revealed the weeks of:            *7/1/16: There was no documentation of a bath or shower.            *7/8/16: He had received a shower.            *7/15/16: He had received a whirlpool bath.            *7/22/16: He had received two showers.            *7/29/16: He had received a shower.            *8/5/16; He had received a shower.            *8/12/16: He had received a shower.</p> <p>Review of the 8/16/16 care plan extension CNA worksheet revealed he was to receive a bath in the a.m. on Tuesdays, Thursdays, and Saturdays. If he had received three baths per week per the resident's request he should have received twenty-two baths. He had recieved six showers and one bath.</p> <p>Surveyor: 32355</p> <p>11. Review of resident 13's medical record revealed:            *He had been admitted on 7/22/16.            *Diagnoses included a left below-the-knee amputation, Type II diabetes, pressure ulcers, high blood pressure, and a history of blood clots.</p>	F 312			

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F 312	<p>Continued From page 63</p> <p>*He had good memory recall. *He had been admitted with multiple wounds. That had been: -Surgical wound to his left knee. -Pressure ulcers to his coccyx and right heel. *He was to have received a bath or shower twice a week on Wednesdays and Sundays.</p> <p>Review of the CNA electronic documentation of baths completed for July and August 2016 revealed: *He had received a shower on 8/7/16 and on 8/10/16. *According to his bathing schedule he should have received a total of nine baths during his stay in the facility.</p> <p>Surveyor: 32333 12. Interview on 8/16/16 at 4:45 p.m. with resident 2 revealed: *She was supposed to have a bath every Tuesday, Thursday, and Saturday. *It had been well over two weeks since she had a bath.</p> <p>Review of resident 2's Shower Evaluation form from 7/1/16 through 8/15/16 revealed she had one form completed on 7/16/16.</p> <p>Review of the 8/16/16 care plan extension CNA worksheet for resident 2 revealed she should have had nineteen baths from 7/1/16 through 8/15/16.</p> <p>13. Interview on 8/23/16 at 8:47 a.m. with resident 8's father revealed: *He was admitted on 6/30/16 and discharged on 7/29/16.</p>	F 312			

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F 312	<p>Continued From page 64</p> <p>*He had only received two showers while he was a resident at the facility.</p> <p>*He had never refused to take a shower.</p> <p>Review of resident 8's Shower Evaluation form for 7/1/16 through 8/15/16 revealed he had one form completed on 7/18/16.</p> <p>Review of the provider's standard of practice revealed resident 8 should have received at a minimum eight baths.</p> <p>14. Review of resident 10's Shower Evaluation form for July 2016 through 8/15/16 revealed he had no forms.</p> <p>Review of the 8/16/16 care plan extension CNA worksheet for resident 10 revealed he should have had thirteen baths from 7/1/16 through 8/15/16.</p> <p>Surveyor: 32572</p> <p>15. Review of the provider's 11/17/15 Preventing, Investigating, and Reporting Alleged Sexual Assault and Abuse Violation policy revealed: *"It is the policy of this center to take appropriate steps to prevent the occurrence of neglect." *Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness."</p> <p>Review of the 8/24/16 bathing assistance needed report from the Minimum Data Set nurse revealed thirty-four residents required at least one staff person for physical assististance with bathing.</p> <p>Interview on 8/17/16 with CNA E revealed if she was unable to get her assigned baths completed she would document the resident had refused.</p>	F 312		

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F 312	Continued From page 65 She would also tell the oncoming staff and the charge nurse which baths she was unable to complete.  Review of the 8/15/16 Staff Huddle notes revealed: *Today's Hot Topics: -"Bathing - need to be charted in care tracker." -"Need a bath sheet signed by nurse." -"Review to be done on Friday." -"Employees affected will receive write up." -"If they have S.A. [skin assessment] by their names the nurse need to see them."  Review of the provider's 1/4/16 Bath, Shower policy revealed "Documentation may include: *Amount of assistance required. *Reports of unusual observations to the charge nurse. *Signature and title."  Interview on 8/24/16 from 9:07 a.m. through 10:10 a.m. with the field services clinical director revealed she confirmed the provider's standard of practice was residents were to receive two baths per week or per the resident's request.	F 312			
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.	F 314	F314 Treatment/Services to Prevent/Heal Pressure Sores  Resident 2 - met with the Field Services Clinical Director (FSCD) and an additional staff member on September 1, 2016 for her scheduled care conference. An agreement was negotiated for her ordered wound care and subsequent out of bed and repositioning schedules to allow her to	9/14/16	

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F 314	Continued From page 66  This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, record review, and policy review, the provider failed to assess, implement interventions, and follow their policy to prevent or ensure worsening of pressure ulcers had not occurred for six of six sampled residents (2, 4, 8, 13, 14, and 18). Findings include:  1. Random observations of resident 13 on 8/22/16 from 4:00 p.m. through 6:20 p.m., on 8/23/16 from 8:00 a.m. through 11:10 a.m., and 1:50 p.m. through 4:00 p.m. revealed: *He been laying in his bed. *He had a pressure relieving air mattress device on his bed. *Head of bed was in the up position. *He had been positioned on his back and down far in the bed. *His right foot/heel had been positioned up against the foot board of the bed. -That foot board was a hard surface. *The back of his right heel and ankle had been positioned directly on the air mattress. -No pressure relieving device (pillows, wedges) was placed underneath that area to ensure no increase in pressure on it had occurred. *He had remained in that position during all the above time frames.  Review of resident 13's medical record revealed: *He had been admitted on 7/22/16. *Diagnoses included left below-the-knee amputation, Type II diabetes, pressure ulcers, high blood pressure, and history of blood clots. *He had good memory recall.	F 314	eat meals in the Dining Room and participate in the daily activities throughout the facility. Has been assessed by a Registered Nurse and all wounds have been documented on August 30, 2016. Her Care plan was revised on September 1, 2016. Care Plan has continued to be revised through September 7, 2016 per resident wishes.  Resident #4 has been assessed by a Registered Nurse and all wounds have been measured and documented on September 9, 2016. The wound care center has been communicated as to the current status of his wounds and an appropriate wound care treatment plan re-established. His Care plan has been reviewed and appropriate interventions for pressure relieving devices and repositioning implemented as per the above assessment.  Resident #8 – Has discharged from the facility so we are unable to reassess wounds or reestablish an appropriate treatment plan.		

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F 314	<p>Continued From page 67</p> <p>*His blood pressure medication had been discontinued on 8/9/16.</p> <p>*He had been admitted with multiple wounds. Those wounds had been:</p> <ul style="list-style-type: none"> <li>-A surgical wound to his left knee.</li> <li>-A stage 2 pressure ulcer to his coccyx.</li> <li>-A stage 2 pressure ulcer to his right buttock.</li> <li>-An unstageable pressure ulcer to his right heel.</li> </ul> <p>*His 8/2/16 Braden Risk Assessment Scale score had been a 15.</p> <ul style="list-style-type: none"> <li>-That score made him at high risk for developing pressure ulcers.</li> </ul> <p>*He had been dependent upon staff to assist him with activities of daily living (ADL).</p> <p>*A 7/29/16 physician's order for a weekly skin assessment.</p> <p>*He had been:</p> <ul style="list-style-type: none"> <li>-Dependent upon staff to assist him with ADLs.</li> <li>-Weak and was working with the therapy department on strengthening.</li> <li>-Having a problem with his blood pressure dropping when he was out of bed for any length of time.</li> <li>-Assisted out of his bed with the therapy department once a day because of his blood pressure problems.</li> </ul> <p>*On 8/16/16 staff had faxed the physician requesting a change in treatment for his right heel due to worsening.</p> <ul style="list-style-type: none"> <li>-There was no documentation in his medical record that the request to the physician had been made.</li> </ul> <p>*Incomplete wound documentation and assessments from 7/22/16 admission through 8/23/16.</p> <p>Observation and interview on 8/23/16 at 3:15 p.m. with licensed practical nurse (LPN) D with resident 13 revealed:</p>	F 314	<p>Resident # 13 - Has been assessed by a Registered Nurse and all wounds have been measured and documented on September 5, 2016. His PCP has been updated as to the current status of his wounds and an appropriate wound care treatment plan re-established. His Care plan has been reviewed and appropriate interventions for pressure relieving devices and repositioning implemented as per the above assessment.</p> <p>Resident # 14 - Has been assessed by a Registered Nurse and all wounds have been measured and documented on September 5, 2016. Her PCP has been updated as to the current status of her wounds and an appropriate wound care treatment plan reestablished. Her Care Plan has been reviewed and appropriate interventions for pressure relieving devices and repositioning as per the above assessment.</p> <p>Resident # 18 has been assessed by a Registered Nurse and all wounds have been measured and documented on September 5, 2016. Her PCP has been</p>	

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F 314	<p>Continued From page 68</p> <p>*She had prepared to change the dressing on his right heel.</p> <p>*His right heel wound:</p> <ul style="list-style-type: none"> <li>-Was dark brown/black in color.</li> <li>-Encompassed the entire base of heel and extended up the back area of his ankle.</li> </ul> <p>*She could not identify if the wound had worsened since his admission.</p> <p>*She had not performed a formal wound assessment during the entire dressing change.</p> <p>2. Review of resident 14's medical record revealed:</p> <p>*She had been readmitted on 7/5/16 from an acute care hospital.</p> <p>*Diagnoses included amyotrophic lateral sclerosis (ALS), failure to thrive, reflux disease, dysphagia, pain, and history of pneumonia.</p> <p>*She had:</p> <ul style="list-style-type: none"> <li>-No muscle control and required assistance from staff for positioning and transfers.</li> <li>-Required the use of a transfer aide to assist her with transfers in and out of the bed.</li> <li>-Required staff assistance to get her out of bed once or twice a week per her choice.</li> <li>-Been incontinent of both urine and bowel.</li> <li>-Wounds to her sacral area.</li> </ul> <p>*An 8/18/16 physician's order to assess her skin every week on Wednesday.</p> <p>Random observations of resident 14 on 8/22/16 from 4:15 p.m. through 6:00 p.m. and on 8/23/16 from 8:05 a.m. through 4:00 p.m. revealed:</p> <p>*She had been laying in bed that had a pressure relieving air mattress on it.</p> <p>*She appeared very thin and weak.</p> <p>*Her bones were easily noticed through her skin.</p> <p>*The head of her bed had been in the upright position.</p>	F 314	<p>communicated with as to the current status of her wounds and an appropriate wound care treatment plan reestablished. Her Care plan has been reviewed and appropriate interventions for pressure relieving devices and repositioning implemented as per the above assessment.</p> <p>CNA G no longer works at the facility and further interview or re-education could not be completed.</p> <p>RN E was terminated from employment on August 24, 2016 thus re-education on Abuse and Neglect was not provided. A report was filed with the South Dakota Board of Nursing.</p> <p>LPN F was terminated from employment on August 24, 2016 thus re-education on Abuse and Neglect was not provided. A report was filed with the South Dakota Board of Nursing.</p> <p>The DNS was terminated from employment on August 24, 2016 and thus re-education was not provided. A report was filed with the South Dakota Board of Nursing.</p>		

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F 314	<p>Continued From page 69</p> <p>*She had been positioned on her back and down far in the bed.</p> <p>*Her left foot had been positioned up against the hard surface of the beds foot board.</p> <p>*The back of her heels and ankle had been positioned directly on the air mattress.</p> <p>-She could not move her legs without staff assistance.</p> <p>-No pressure relieving devices were placed underneath of her feet/legs to ensure no increase in pressure on them had occurred.</p> <p>*She had remained in that position during all the above time frames.</p> <p>Observation and interview on 8/23/16 at 4:05 p.m. with LPN D with resident 14 revealed:</p> <p>*She had prepared to change the dressing to the sacral area.</p> <p>*That wound was approximately 2 centimeters (cm) by 2 cm in diameter and red with areas of yellow in it.</p> <p>*It started as a small skin tear from the ambulance gurney.</p> <p>*She confirmed the wound had worsened significantly.</p> <p>*The resident had a small opening/slit below the sacral wound on her right buttock.</p> <p>-It was a new area identified on 8/22/16 as another skin tear.</p> <p>*She had not performed a formal wound assessment during the entire dressing change on either of the wounds.</p> <p>Review of the provider's 2011 manufacturer's MicroAir air mattress user manual revealed no documentation when it was in-use that:</p> <p>*Pressure relieving devices were not required.</p> <p>*Residents had not required repositioning in bed.</p>	F 314	<p>A Wound Rounds team has been re-established and weekly measurements and treatment review was started on September 8, 2016 members include DNS or designee, Physical Therapist, Occupational Therapist, and ad hoc facility staff.</p> <p>An inventory review of the current wound care products will be conducted before September 30, 2016 to assure we are providing the latest wound care products for optimal resident prevention and/or healing.</p> <p>The Executive Director, Director of Nursing, Interdisciplinary Team, a member of the Governing Board; and the Medical Director have reviewed and approved the use of the GLC- clean dressing policy.</p> <p>All new hire licensed staff will complete a skills competency checklist during the orientation process to include the Skin Integrity Guideline.</p> <p>Licensed nursing staff will be re-educated on the procedures of</p>	

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F 314	<p>Continued From page 70</p> <p>3. Interview on 8/24/16 at 9:15 a.m. with the Minimum Data Set (MDS) assessment coordinator and field services clinical director confirmed:</p> <ul style="list-style-type: none"> <li>*The above medical record reviews for residents 13 and 14.</li> <li>*When using the MicroAir mattress: <ul style="list-style-type: none"> <li>-The residents should have continued to be repositioned.</li> <li>-Pressure relieving devices should have been utilized.</li> </ul> </li> </ul> <p>Refer to F281, finding 2.</p> <p>Surveyor: 32333</p> <p>4. Review of resident 8's complete medical record revealed:</p> <ul style="list-style-type: none"> <li>*He was admitted on 6/30/16.</li> <li>*He had a stage 2 pressure ulcer on his coccyx.</li> <li>*A 6/30/16 physician's order for a weekly skin review.</li> <li>*A wound care assessment sheet had not been initiated upon admit.</li> <li>*Weekly skin assessments had not been completed during that time.</li> <li>*He had two weekly skin assessments during his stay.</li> <li>*On 7/11/16 there was an incomplete weekly skin review with only: <ul style="list-style-type: none"> <li>-Open area to coccyx.</li> <li>-No measurement of the area.</li> </ul> </li> </ul> <p>Interview on 8/17/16 at 9:05 a.m. with the local ombudsman regarding his interview with resident 8 and the director of nursing (DON) during that monthly visit on 7/13/16 revealed:</p> <ul style="list-style-type: none"> <li>*The resident voiced his pressure ulcer had not been looked at.</li> <li>*The director of nursing (DON) confirmed she had not assessed his pressure ulcer.</li> </ul>	F 314	<p>completing a clean dressing change by the Multi-site Director of Clinical Education on September 14, 2016.</p> <p>Director of Nursing or designee will complete 5 random audits of licensed nurses clean dressing change technique and wound healing weekly x 4 weeks and then monthly x 2 months to ensure compliance.</p> <p>Director of Nursing will report the results of the audits at the monthly QAPI meetings for further review and recommendations.</p>	

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F 314	<p>Continued From page 71</p> <p>Review of resident 8's 6/30/16 care plan revealed: *Focus area: of a pressure ulcer, stage 2, coccyx. *Interventions included: -Conduct weekly skin assessments per LivingCenter policy. -Weekly wound assessments.</p> <p>Interview on 8/17/16 at 11:15 a.m. with the DON regarding resident 8 revealed: *A wound care assessment sheet had not been initiated upon his admission. *Weekly skin assessments had not been completed. *They had not followed their care plan regarding his pressure ulcer. *They had not followed their pressure ulcer policy.</p> <p>5. Review of resident 2's complete medical record revealed: *She was admitted on 12/17/15 with four pressure ulcers. *On 1/16/16 a skin tear had been identified. *On 6/19/16 she acquired a pressure ulcer on her left lower hip area. *Her wound evaluation flow sheets and weekly skin assessments were incomplete or had not been completed from admit through 8/18/16. *Her care plan had not been updated: -When she had changes in her skin condition. -To reflect her current skin integrity. -From that incomplete documentation there was know way to know the current status of her wounds.</p> <p>Interview on 8/16/16 at 4:45 p.m. with resident 2 revealed: *Her call light response from staff at times could</p>	F 314		

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F 314	<p>Continued From page 72</p> <p>be up to an hour.</p> <p>-Usually that happened in the mornings.</p> <p>*She had a wound on her bottom.</p> <p>*Sometimes her bed would be soaked from her catheter leaking.</p> <p>-Staff told her they would change her bed when the nurse came in to do her dressing change.</p> <p>-Sometimes staff would only change the turn sheet instead of all of the bedding.</p> <p>-The last time it happened was that morning.</p> <p>*Some days she had to lay in bed until 10:30 a.m.</p> <p>-She had asked to get up earlier between 8:00 a.m. and 9:00 a.m.</p> <p>-She had been told she could not get up until the nurse had come in to do her dressing change.</p> <p>*She was told they were short staffed.</p> <p>*She was supposed to have a bath every Tuesday, Thursday, and Saturday.</p> <p>*It had been well over two weeks since she had a bath.</p> <p>Interview on 8/17/16 at 8:05 a.m. with certified nursing assistant G regarding resident 2 revealed:</p> <p>*She wanted to get up earlier.</p> <p>*They could not get her up for the day until the nurse changed her dressings.</p> <p>*She had observed a couple of nurses just changed the turn sheet when the bedding had been soaked with urine.</p> <p>Interview on 8/17/16 at 10:16 a.m. with a CNA who wished to remain confidential revealed LPN F would not change resident 2's sheets when they were wet.</p> <p>Interview on 8/17/16 at 10:55 a.m. with the director of nursing revealed:</p> <p>*LPN F and RN E were responsible for wound</p>	F 314		

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F 314	<p>Continued From page 73 care. *The wound care documentation was incomplete and inaccurate.</p> <p>Surveyor: 32355 Refer to F241, finding 3. Refer to F281, finding 7. Surveyor: 32572 5. Review of resident 4's medical record revealed: *He had been admitted on 5/5/16 with a bone infection. *He also had a surgical wound on the right foot. *Refer to F281, finding 3.</p> <p>6. Review of resident 18's medical record revealed: *She had been admitted on 7/15/16 with pressure ulcer on her right buttock. *She had also been admitted with a wound on her left lower extremity.</p> <p>Review of resident 18's 7/18/16 care plans revealed conflicting information as to where the pressure ulcer was. *The pressure ulcer care plan indicated on the right buttock. *The pain management care plan indicated on the sacrum (tailbone area). Neither care plan indicated the treatment that was to have been done to those areas. *Refer to F281, finding 4.</p> <p>7. Review of the provider's undated Skin Integrity Guideline policy revealed: *The purpose was to: -"Provide a comprehensive approach for monitoring skin conditions. -Decrease pressure ulcer and/or wound formation</p>	F 314		

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F 314	Continued From page 74 by identifying those patients/residents who are at risk, and implementing appropriate interventions. -Promote healing of wounds of any etiology, whether admitted or acquired." *The objectives of the policy were to: -"Decrease the prevalence and incidence of patients/residents who develop pressure ulcers. -Provide a guideline for optimal care to promote healing to patients/residents with all identified alterations in skin integrity (i.e. surgical incisions, skin tears, bruising, etc.)." *General Guidelines were: -"Patients/Residents will be assessed or observed for risk of skin breakdown within 24 hours of admission or readmission, quarterly, before transfer or discharge to any setting (unless emergent nature of transfer does not allow), and as necessitated by change in condition." -"Living Center develops a routine schedule to review patients/residents with wounds or at risk on a weekly basis and will document findings." -"DNS or designee will be responsible to implement and monitor the skin integrity program. Wound status is monitored on a weekly basis." -"The interdisciplinary plan of care will address problems, goals and interventions directed toward prevention of pressure ulcers and/or skin integrity concerns identified."	F 314			
F 323 SS=G	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.	F 323	F323- Free of Accident Hazards/Supervision/Devices  Resident #6 was discharged. We are unable to update her care plan to reflect appropriate fall interventions.	9/14/16	

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F 323	<p>Continued From page 75</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, record review, interview, and policy review, the provider failed to ensure the safety of 2 of 21 sampled residents (6 and 10) who had multiple falls with injury. Findings include:</p> <p>1. Review of resident 10's complete medical record revealed: *He was admitted on 5/24/16. *He was identified as a fall risk. *He had a diagnosis of dementia. *He had sixteen falls in the eighty days from admission on 5/24/16 through 8/11/16 for the following: -May: 5/25/16, and two on 5/27/16. -June: 6/1/16, 6/9/16 that resulted in a left hip fracture, 6/15/16, 6/17/16, 6/21/16, 6/23/16. -July: 7/8/16, 7/14/16, 7/19/16, 7/21/16, 7/29/16. -August: 8/3/16, 8/11/16.</p> <p>Interview with an anonymous CNA on 8/17/16 at 10:16 a.m. revealed: *They were short staffed. *There had been only one traveling CNA during a shift on 8/14/16. *When they were short staffed management would not help them. *Resident 10 always tried to self-transfer "There are not enough staff to watch him."</p> <p>Observation on 8/18/16 at 9:00 a.m. and 9:05 a.m. of resident 10 after breakfast revealed: *At 9:00 a.m. he was sitting in his wheelchair in</p>	F 323	<p>Resident # 10 We are unable to recreate the post fall assessments. We will update his Fall Risk assessment and care plan by September 10, 2016</p> <p>All residents remain who have been identified to be a risk for falls have the potential to be affected. Those care plans and CNA care sheets will be updated to reflect their current individualized interventions by September 10, 2016.</p> <p>Education of all Nursing staff will be provided on the Falls Management Guidelines policy by September 14, 2016.</p> <p>All new employees will be educated to the Falls Management Guideline during orientation on-going.</p> <p>The Executive Director, Director of Nursing, Interdisciplinary Team, a member of the Governing Board and the Medical Director have reviewed and approved the use of the Falls Management Guideline policy by September 14, 2016.</p>	

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F 323	<p>Continued From page 76 his room by himself. *At 9:05 a.m. he was in his bathroom alone trying to self-transfer himself to the toilet.</p> <p>Review of resident 10's 7/29/16 revised care plan revealed: *Focus area: at risk for falls. *Intervention stated: "Needs to be at nurses station or activity programs; can not be left alone in his room unless going to bed." *Intervention stated: "Resident will be laid down after meals to rest." *Intervention stated: "Staff must anticipate needs, resident is not able to verbalize when he needs assistance due to his short term memory loss." *Intervention stated: "Will toilet before and after meals, before laying down for a nap, at hs, once during the night, and as needed."</p> <p>Review of resident 10's Post Fall Analysis/Plan forms from 5/26/16 through 7/21/16 revealed: *He had no report for the following dates: -5/27/16 -6/1/16 -7/29/16 -8/3/16 -8/11/16 *The forms that had been initiated for other falls were incomplete. *There was no interdisciplinary review or recommendations on any of those forms.</p> <p>Interview on 8/18/16 at 9:40 a.m. with the administrator's preceptor revealed she was unsure what the fall communication system was.</p> <p>Interview on 8/23/16 at 9:00 a.m. with an anonymous CNA revealed: *Their were no activities.</p>	F 323	<p>The Director of Nursing or designee will complete falls audits on 5 random residents including resident # 10 weekly x 4 weeks then monthly x 2 months to ensure falls are monitored during daily clinical meetings and during the Weekly at Risk meetings on-going.</p> <p>The Director of Nursing or designee will present the results of the falls audits to the QAPI meeting for further review and recommendations.</p>		

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F 323	<p>Continued From page 77</p> <p>*The activities director quit approximately a month and a half to two months ago.</p> <p>Surveyor: 32572</p> <p>2. Review of resident 6's medical record revealed: *She had been admitted on 7/1/16. *She had fallen five times in July. *Refer to F280, finding 1.</p> <p>3. Review of the provider's Monthly Event Log revealed: *For July 2016 there were forty-two resident falls. *For August 1 through 16 there were thirteen resident falls.</p> <p>Review of the provider's 8/10/16 Falls Management Guideline policy revealed: **"At risk residents are identified through a 'fall alert' communication system to care givers. -During orientation new employees are educated to the fall management system." **Following a resident's fall: -Appropriate interventions are implemented. -Care plan is updated." **"QAPI [quality assurance process improvement] committee minutes reflect data analysis using the information driven by the Quality Control Event Reporting System to identify systemic trends and patterns related to resident falls and appropriate plans of action." *For monitoring/Compliance "the following elements are in place for the center to demonstrate satisfactory compliance with the guide: -Residents are evaluated for fall risk. -Communication system to identify the residents</p>	F 323			

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F 323	Continued From page 78 at risk for falls. -Residents at risk for falls are care planned with individualized interventions. -The IDT [interdisciplinary team] evaluation is completed on the Change of Condition Report-Post Fall and validation of individualized interventions."  Interview on 8/23/16 at 9:10 a.m. with the field services clinical director revealed: *The provider did not have a fall alert communication system. *The Quality Control Event Reporting System was not used to track and trend resident falls.  Interview on 8/24/16 from 9:07 a.m. through 10:10 a.m. with the field services clinical director revealed there was no formal activity program. The only activities were provided by volunteers, such as church and bingo. Those activities were not documented in the resident medical record. The activity director had resigned approximately two months ago causing the residents to have nothing to do and increasing the risk of falls.	F 323			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE  Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325	F 325 – Maintain Nutrition Status Unless Unavoidable Resident #14 and #18 have been weighed.  Residents residing in the facility have the potential to be affected in a similar manner.  Residents residing in the facility have had a weight obtained and documented in the medical record.	9/14/16	

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F 325	Continued From page 79  This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, record review, and policy review, the provider failed to weigh 2 of 25 sampled residents (14 and 18) according to their policy. Findings include:  1. Observation on 8/22/16 at 4:15 p.m. of resident 14 revealed: *She had been laying in bed sleeping. *She had pressure relieving devices in her bed and in her wheelchair. *She appeared very thin and weak. *Her bones were easily noticed through her skin.  Review of resident 14's medical record revealed: *She had been readmitted on 7/5/16 from an acute care hospital. *Diagnoses included amyotrophic lateral sclerosis (ALS), failure to thrive, dysphagia, reflux disease, pain, history of weight loss, and a history of pneumonia. *She had: -No muscle control and required assistance from staff for positioning and transfers. -Required the use of a transfer aide to assist her with transfers in and out of the bed. -Required assistance from staff to get her out of bed once or twice a week per her choice. -Wounds to her sacral area. -Required her fluids to be thickened to nectar consistency. -Been dependent upon staff to assist her with eating. -An 1800 cubic centimeter fluid restriction. *She had been weighed on the 7/5/16	F 325	Any variances in weight will be reported to the Registered Dietician and a nutritional assessment has been completed with recommended interventions implemented and care planned by September 14, 2016.  The Executive Director, Director of Nursing, Interdisciplinary Team, a member of the Governing Board and the Medical Director have reviewed and approved the use of the GLC-weight policy.  Nursing staff will be re-educated on the weight policy by the Multi-site Director of Clinical Education by September 14, 2016.  Weights will be monitored during daily clinical start up and during the Weekly at Risk meetings to ensure weight accuracy and appropriate referrals have been made to Registered Dietician with nutritional assessment completed, interventions implemented, and care plans have been revised.		

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F 325	<p>Continued From page 80 readmission. -She weighed 113.9 pounds.</p> <p>Review of resident 14's 7/20/16 care plan revealed: *Focus area: "Swallowing difficulty as related to ALS." *Two goals for that focus area: -"Will tolerate food texture and fluid texture and fluid consistency without choking episodes." -"Maintain nutritional status and body weight." *Intervention: She should have been weighed monthly.</p> <p>Review of her medical record revealed she had not been weighed since her readmission to the facility on 7/5/16.</p> <p>Interview on 8/24/16 at 9:15 a.m. with the Minimum Data Set assessment coordinator and field services clinical director regarding resident 14 revealed: *They confirmed: -The above medical record review. -With the resident's diagnoses and history of weight loss she had been at risk for continued weight loss. -Their policy was to weigh residents monthly. -The staff had not weighed her according to their policy and standard. *They agreed she had been at high risk for continued weight loss and should have been weighed more than monthly. -No confirmation on how often she should have been weighed was stated. *They had: -No nutritional-at-risk meetings or committee. -A weight loss committee. The resident had been identified at those meetings.</p>	F 325	<p>The Director of Nursing or designee will complete weight audits on 5 random residents including resident # 14 and 18 weekly x 4 weeks then monthly x 2 months to ensure weights are monitored during daily clinical start up and during the Weekly at Risk meetings and that weights are reflected accurately and appropriate referrals have been made to Registered Dietician with nutritional assessment completed, interventions implemented, and care plans have been revised.</p> <p>Director of Nursing will report the results of the audits at the monthly QAPI meetings for further review and recommendations.</p>	

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F 325	Continued From page 81 *No documentation to support: -When and how often the weight loss committee met. -What staff had been a part of the weight loss committee. -What residents had been identified and discussed at those meetings.  Surveyor: 32572 2. Review of resident 18's medical record revealed: *Admission on 7/15/16. *Diagnoses of diabetes mellitus, congestive heart failure, gastro-esophageal reflux, and wound on her left lower extremity. *She had been weighed upon admission and had not been weighed since then.  Review of the 7/25/16 care plan revealed she was to have been weighed monthly.  Interview on 8/24/16 from 9:07 a.m. through 10:10 a.m. with the field services clinical director confirmed it was standard practice to weigh residents monthly.  3. Review of the provider's 12/17/15 Weight Monitoring policy revealed: **"Weight is recorded by the Nursing department upon admission, monthly and more often if risk is identified." **"Each LivingCenter will have a Nutrition Risk Committee. This committee should meet regularly to determine possible reasons for weight loss or gains and to make recommendations to prevent further unplanned changes."	F 325		
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS	F 328		

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F 328	<p>Continued From page 82</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on observation, interview, policy review, and record review, the provider failed to ensure oxygen (O2) was provided and maintained continuously for six of six sampled residents (1, 15, 16, 17, and 18) using O2. Findings include:</p> <p>1. Observation on 8/17/16 at 4:45 p.m. revealed resident 17's portable O2 tank was empty. That was confirmed by a random certified nursing assistant (CNA). The O2 tank was replaced at that time.</p> <p>2. Interview on 8/18/16 at 9:25 a.m. with resident 1's daughter revealed her mother had a diagnosis of chronic obstructive lung disease and required constant oxygen. She had recently been hospitalized from 7/31/16 through 8/3/16 with pneumonia. On the day she was admitted to the hospital she had been found in her room unresponsive. She was dusky, cold, and had a respiration rate of eight breaths per minute. She was on O2 at 2 liters (L) per minute per nasal</p>	F 328	<p><b>F328 – Treatment/Care for Special Needs</b></p> <p>Residents #1, 15, 16, 17 and 18 oxygen tanks and physician orders were immediately verified and corrected upon notification of concern. Care plans were also reviewed and revised to ensure they accurately reflected each resident's current need.</p> <p>Residents residing in the facility who use oxygen have the potential to be affected in a similar manner.</p> <p>Residents residing in the facility who use oxygen have had oxygen tanks and physician orders verified and corrected when required. Care plans were also reviewed and revised to ensure accurately reflected each resident's current need.</p> <p>The Executive Director, Director of Nursing, Interdisciplinary Team, a member of the Governing Board and the Medical Director have reviewed and approved the use of the GLC-oxygen policy.</p>	9/14/16

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F 328	<p>Continued From page 83</p> <p>cannula (nc). The ambulance and the daughter were called. When the ambulance crew arrived her O2 saturation rates were "in the low 80s" which was below the recommended rate of 90% or above. She returned from the hospital with a physician's order for her O2 to run continuously at 3L. The daughter stated she came to visit her mother at least once every day. She stated she had come in several times and her O2 was set at 2L. She placed a sign on the back of her mother's wheelchair stating O2 was to be on at 3L. She stated she came in on 8/13/16 and her O2 tank was empty. The O2 flow rate had been set at 1.5 L. The CNA who had been working at that time confirmed the O2 tank had been empty.</p> <p>3. Observation on 8/22/16 at 3:30 p.m. revealed resident 15 had been seated in her wheelchair in her room. Her portable O2 tank was empty. The field services clinical director was notified, and the O2 tank was refilled. The resident was not aware the tank was empty.</p> <p>*Observation on 8/23/16 at 3:50 p.m. revealed resident 15 was seated in her wheelchair in her room. Her portable O2 tank was empty. That tank was immediately refilled by the administrative preceptor.</p> <p>4. Observation on 8/22/16 at 4:37 p.m. revealed resident 16 was seated in her wheelchair in the dining room. Her portable O2 tank was empty. The administrative preceptor was notified and the O2 tank was refilled. Interview with the preceptor at that time revealed staff had been instructed the prior week when the survey team had been there to ensure the O2 containers were filled. She stated she was upset staff had not followed through on those directions.</p>	F 328	<p>A system has been developed and implemented to ensure reserve oxygen tanks are readily available, oxygen equipment is checked and cleaned; oxygen liter flow and contents are checked at regular intervals.</p> <p>Nursing staff will be re-educated on the oxygen policy by the Multi-site Director of Clinical Education by September 14, 2016.</p> <p>The Director of Nursing or designee will complete oxygen audits on 5 random residents including residents # 1, 15, 16, 17, and 18 weekly x 4 weeks then monthly x 2 months to ensure reserve oxygen tanks are readily available, oxygen equipment is checked and cleaned; oxygen liter flow and contents are checked at regular intervals.</p> <p>Director of Nursing or designee will report the results of the audits at the monthly QAPI meetings for further review and recommendations.</p>		

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F 328	<p>Continued From page 84</p> <p>Surveyor: 32572</p> <p>5. Review of resident 18's medical record revealed: *Admission on 7/15/16 *Diagnosis of congestive heart failure. *A signed telephone physician's order for O2 at 2 L/NC .</p> <p>Review of the 7/25/16 comprehensive care plan did not reveal O2 use.</p> <p>Review of the care plan extension CNA worksheet revealed O2 at 2LPM.</p> <p>Random observations on 7/16/16 2:30 p.m. through 7/18/16 12 noon and 7/22/16 8:00 a.m. through 7/23/16 12 noon revealed resident 18's O2 portable canister had been empty every time it has been observed.</p> <p>7. Interview on 8/16/16 at 5:27 p.m. with CNA B revealed the portable O2 tanks were refilled every night.</p> <p>Interview on 8/16/16 at 5:30 p.m. with CNA C revealed the portable O2 tanks were monitored when the resident was put into their wheelchair and every night.</p> <p>Surveyor:23059</p> <p>Review of the provider's 1/26/15 Oxygen Administration policy revealed: *The purpose was to administer O2 to the resident when insufficient O2 was being carried in the blood to tissues. *The physician's orders were to have been checked for liter flow and method of administration.</p>	F 328		

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F 328	Continued From page 85 *A reserve O2 tank should have been available to provide continuity of care. **"At regular intervals" the O2 equipment should have been checked and cleaned. **"At regular intervals" the O2 liter flow and contents of the oxygen cylinder should have been checked."	F 328			
F 353 SS=I	<b>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</b>  The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.  The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:  Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.  Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.  This REQUIREMENT is not met as evidenced by: Surveyor: 32333  Surveyor: 32572	F 353	<b>F353 Sufficient 24-hour Nursing Staff per Care Plans</b>  Staffing ratios were immediately reviewed upon notification of concern.  Residents residing in the facility have the potential to be affected in a similar manner.  Additional supplemental staff including RNs, LPNs, CNAs, CDM and LSW have been contracted to provide the highest level of quality of care to each resident to ensure needs are being met. Robust recruitment plan has been developed and implemented to recruit permanent facility staff. The facility is contracted with Professional Placement Resources (PPR) group to recruit for open positions.  Executive Director, Director of Nursing, Field Service Clinical Director and Area Vice President will review staffing on a	9/14/16	

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F 353	<p>Continued From page 86</p> <p>Based on interview, schedule review, time card punch records, and policy review, the provider failed to ensure staffing was adequate to provide the necessary care and services for all 65 of the residents. Findings include:</p> <p>1. Interview on 8/16/16 at 5:00 p.m. with resident 5 revealed there was never enough help. Interview with certified nursing assistant (CNA) G revealed there was a staffing shortage. Residents were not getting their baths because of that staff shortage.</p> <p>Refer to F312.</p> <p>2. Review of the working nursing schedule revealed Sunday 8/14/16 three of the four scheduled CNAs had called off shift for the 6:00 a.m. until 2:00 p.m. time period. Review of the time card punches for that day revealed one CNA had worked from 6:00 a.m. until 10:00 p.m. There was a light duty CNA on duty from 6:00 a.m. until 9:30 a.m. The director of nursing was written in from 6:00 a.m. until 3:30 p.m. along with the manager on duty from 7:00 a.m. until 3:30 p.m.</p> <p>3. Interview on 8/17/16 at 3:30 p.m. with a confidential CNA revealed the administrative staff was in the building but did not assist with resident care. She stated they were on the phone the whole time.</p> <p>Surveyor: 32333</p> <p>4. Interview on 8/16/16 at 4:45 p.m. with resident 2 revealed: *Her call light times could be up to an hour. *She was told they were short staffed. Refer to F241, finding 1.</p>	F 353	<p>daily basis. Evidence of appropriate staffing levels will be reflective in the collective audits in this plan of correction.</p> <p>The QAPI committee will continually review the staffing levels and make appropriate recommendations for identified needs.</p>		

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F 353	<p>Continued From page 87</p> <p>5. Interview with an anonymous CNA on 8/17/16 at 10:16 a.m. revealed: *They were short staffed. *There had been only one traveling CNA during the a.m. shift on 8/14/16. *When they were short staffed management will not help them. *Resident 10 always tried to self-transfer, "There are not enough staff to watch him." Refer to F323, finding 1.</p> <p>6. Interview on 8/17/16 at 1:10 p.m. with an anonymous staff member revealed: *They were short on CNAs. *Residents sat in their chairs in the hallways and dining room. -Staff did not come and get them out of the dining room. *Other staff and management could pitch in and help, but they did not. *Residents' hair and hygiene needs were not being met.</p> <p>7. Interview on 8/17/16 at 1:20 p.m. with CNA H revealed there had been a short staffing issue here.</p> <p>Surveyor: 32572</p> <p>8. Review of the provider's undated Golden Living Scheduling Guide policy revealed "Appropriate scheduling is the foundation to successfully managing your workforce."</p> <p>Review of the 10/14/15 emergency permit holder (EPH) job description revealed: *The provider had given the survey team the Executive Director job description for the EPH job description. *The general purpose of that job was "To lead</p>	F 353		

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F 353	Continued From page 88 and direct the overall operations of the facility in accordance with customer needs, government regulations and Company policies, with focus on maintaining excellent care for the residents/patients while achieving the facility's business objectives. Serve as a mentor to guide and support all other assigned facilities."  Review of the 10/16/14 DON job description revealed the general purpose was to "Plan, coordinates, and manages the nursing department. Responsible for the overall direction, coordination and evaluation of nursing care and services provided to residents. Maintains quality of care that is consistent with company and regulatory standards. Assumes responsibilities of daily operation in the absence of the Executive Director."  For the necessary care and services that had not been provided refer to: F223, F225, F226, F241, F248, F280, F281, F311, F312, F314, F323, F325, F328, and F441.	F 353		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441	F 441 Infection Control  Licensed Practical Nurse (LPN-D) has been re-educated on the procedures of completing a clean dressing change.  Certified Nursing Assistant (CNA-F) no longer works at the facility so re-education was not completed.	9/14/16

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F 441	<p>Continued From page 89 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, and policy review, the provider failed to ensure infection control practices were maintained during: *Dressing changes for four of four sampled residents (2, 13, 14, and 18) by one of one licensed practical nurse (LPN) D. *Personal care for one of one sampled resident (15) by one of one certified nursing assistant (CNA) F. *The storage and removal of soiled linens for one of one sampled resident (21).</p>	F 441	<p><b>Residents residing in the facility have the potential to be affected in a similar manner.</b></p> <p>The Executive Director, Director of Nursing, Interdisciplinary Team, a member of the Governing Board, and the Medical Director have reviewed and approved the use of the GLC- clean dressing, providing personal cares, storage and removal of soiled linens and hand washing guidelines and/or policies.</p> <p>Licensed nursing staff will be re-educated on the procedures of completing a clean dressing change by the Multi-site Director of Clinical Education by September 14, 2016.</p> <p>Certified Nursing Assistants will be re-educated on the procedures of completing personal care and storage and removal of soiled linens by the Multi-site Director of Clinical Education by September 14, 2016.</p> <p>All staff will be re-educated in the procedure of hand washing by the Multi-site Director of Clinical Education by September 14, 2016.</p>	

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F 441	<p>Continued From page 90 Findings include:</p> <p>1. Observation on 8/23/16 at 10:22 a.m. with LPN D during a dressing change for resident 2 revealed: *She had gathered supplies to provide wound care for the resident that consisted of: -A medication cup with medication to be applied to the wounds. -Several unopened 4 by 4 gauze packages. -Three unopened abdominal gauze dressings. -Several gloves removed from a box. -A small tube of normal saline. *Without washing or sanitizing her hands she put on a clean pair of gloves. *While LPN D had her gloves on she: -Adjusted the bed by using the hand control. -Repositioned the resident onto her left side by using the repositioning sheet underneath her. -She had several open wounds to her bottom. Those wounds were not all covered. -There was a significant amount of green/brown colored drainage on that sheet from those wounds. -Adjusted the Foley catheter tubing and drainage bag. -Removed a heavily soiled dressing from her bottom. *She changed her gloves without washing her hands between glove use. *With those gloves on she: -Opened several packages of gauze and laid them on the protective barrier. -Opened the abdominal gauze packages and laid one of the clean dressings directly on top the bed sheet. That area was where the soiled repositioning sheet had been. -Cleansed the wound with the normal saline and several 4 by 4 gauze dressings.</p>	F 441	<p>Director of Nursing or designee will complete 5 random audits of licensed nurses including LPN D's clean dressing change technique, CNA providing personal care and storage and removal of soiled linens weekly x 4 weeks and then monthly x 2 months to ensure compliance.</p> <p>Director of Nursing will report the results of the audits at the monthly QAPI meetings for further review and recommendations.</p>	

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F 441	<p>Continued From page 91</p> <p>*She changed her gloves without washing her hands between glove use.</p> <p>*With those gloves on she:</p> <ul style="list-style-type: none"> <li>-Applied the medication.</li> <li>-Covered those wounds with the abdominal gauze dressings that had been laying directly on the bed sheet.</li> </ul> <p>*The resident requested the dressing to be removed and the medication to be washed off.</p> <ul style="list-style-type: none"> <li>-The medication was irritating to her wounds.</li> </ul> <p>*Without changing her gloves she removed the dressings per the resident's request.</p> <p>*With those same gloves on she:</p> <ul style="list-style-type: none"> <li>-Took keys from her pocket, gave them to another nurse, and that nurse left the room to get more supplies.</li> <li>-Opened several gauze packages the other nurse had given her.</li> <li>-Used those gauze dressings and the normal saline to cleanse the wound again.</li> <li>-Covered the wounds with abdominal gauze dressings.</li> </ul> <p>*She removed her gloves and without washing her hands she:</p> <ul style="list-style-type: none"> <li>-Took the garbage from the garbage can, left the room, went to the soiled utility room, and disposed of the garbage.</li> <li>-Washed her hands.</li> </ul> <p>*That had been the only time she was observed washing her hands during the entire dressing change.</p> <p>2. Observation on 8/23/16 at 3:15 p.m. with LPN D during a dressing change for resident 13 revealed:</p> <ul style="list-style-type: none"> <li>*She gathered supplies for his wound care.</li> <li>*Those supplies had consisted of: <ul style="list-style-type: none"> <li>-Betadine swabs.</li> <li>-Several gauze dressings.</li> </ul> </li> </ul>	F 441			

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F 441	<p>Continued From page 92</p> <ul style="list-style-type: none"> <li>-A small tube of normal saline.</li> <li>-A roll of kerlix.</li> <li>*Without washing her hands she put on a clean pair of gloves.</li> <li>*While she had her gloves on she:             <ul style="list-style-type: none"> <li>-Emptied the half-full urinal into the toilet.</li> <li>-Removed the sock from his right foot.</li> <li>-Applied lotion to his leg.</li> <li>-Dug in her pocket for a pair of scissors.</li> </ul> </li> <li>*She removed her gloves and left the room without washing her hands to get a pair of scissors.</li> <li>*She returned to the room and without washing her hands put on gloves.</li> <li>*With those gloves on she:             <ul style="list-style-type: none"> <li>-Opened the package of Betadine swabs.</li> <li>-Opened several packages of 4 by 4 gauze dressings.</li> <li>-Opened the package of kerlix.</li> <li>-Removed the soiled dressing with a small amount of brown drainage on it with the scissors.</li> </ul> </li> <li>*She changed her gloves without washing her hands and she:             <ul style="list-style-type: none"> <li>-Cleansed the wound with the saline and Betadine swabs.</li> <li>-Applied a 4 by 4 gauze dressing.</li> <li>-Wrapped the wound with the kerlix.</li> <li>-Put his sock back on.</li> </ul> </li> <li>*She removed her gloves and without washing her hands she:             <ul style="list-style-type: none"> <li>-Took the garbage from the garbage can, left the room, went to the soiled utility room, and disposed of the garbage.</li> <li>-Washed her hands.</li> </ul> </li> <li>*That had been the only time she was observed washing her hands during the entire dressing change.</li> </ul> <p>3. Observation on 8/23/16 at 4:05 p.m. of LPN D</p>	F 441		

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F 441	<p>Continued From page 93</p> <p>during a dressing change for resident 14 revealed:</p> <ul style="list-style-type: none"> <li>*She had gathered supplies to provide wound care for the resident that consisted of:               <ul style="list-style-type: none"> <li>-A medication cup containing the medication to be applied to her wound.</li> <li>-Several 4 by 4 gauze packages.</li> <li>-A small tube of normal saline.</li> </ul> </li> <li>*Without washing she put on a clean pair of gloves.</li> <li>*With those gloves on she:               <ul style="list-style-type: none"> <li>-Adjusted the bed by using the hand control.</li> <li>-Repositioned her onto her left side.</li> <li>-Removed her soiled incontinent brief.</li> </ul> </li> <li>*She had a large wound to her sacral area and a smaller wound directly underneath her right buttock.</li> </ul> <p>Those wounds had not been covered with dressings.</p> <ul style="list-style-type: none"> <li>*She changed her gloves without washing her hands and repeated the same process for cleaning and applying a dressing to the wounds as observed above with the other residents.</li> <li>*She removed her gloves and without washing her hands she:               <ul style="list-style-type: none"> <li>-Took the garbage from the garbage can, left the room, went to the soiled utility room, and disposed of the garbage.</li> <li>-Washed her hands.</li> </ul> </li> <li>*That had been the only time she was observed washing her hands during the entire dressing change.</li> </ul> <p>4. Interview on 8/23/16 at 4:30 p.m. with the field services clinical director confirmed:</p> <ul style="list-style-type: none"> <li>*The processes observed for all the above residents had not been performed in a sanitary manner.</li> <li>*Those residents had the potential for</li> </ul>	F 441		

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F 441	<p>Continued From page 94</p> <p>cross-contamination of bacterial germs to their wounds with the care provided above.</p> <p>Interview on 8/23/16 at 5:00 p.m. with LPN D revealed:                      *She had been the infection control nurse for the facility.                      *For the above residents' that had been her usual process for completing dressing changes.                      *She was not the wound nurse and did not routinely provide wound care.                      *She had stated "I am not steller at completing wound care."                      *She had not completed any audits of the wound care nurses completing any dressing changes. She stated "That is part of the educator's duties."                      *She had not been aware the process she used created the potential for cross-contamination of bacteria to the residents' wounds.</p> <p>Surveyor: 32572</p> <p>5. Observation on 8/23/16 at 4:45 p.m. with LPN D during a dressing change for resident 18 revealed:                      *She had gathered her supplies and taken them into the resident's room.                      *She then went and got the resident from the dining room.                      *She put on gloves without washing her hands and began the dressing change.                      *During the cleansing of the wound she rolled the gauze dressing up and wiped it through the wound three times, not changing the gauze between wiping.                      *She changed her gloves but did not wash her hands.                      *She then applied a kerlix dressing directly on the open wound with no absorbent dressing prior to the kerlix.</p>	F 441			

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F 441	<p>Continued From page 95</p> <p>*She then removed her gloves and left the room without washing her hands to get tape to secure the kerlix .</p> <p>*She returned to the room and applied the tape.</p> <p>*She then pushed the resident in her wheelchair out of the room and down the hallway. At that time she then used hand gel to sanitize her hands.</p> <p>Interview at that time with the LPN D revealed she was not the wound care nurse who routinely did that care. She was the infection control nurse and stated she understood infection control practices.</p> <p>Surveyor: 23059</p> <p>6. Observation on 8/23/16 at 4:25 p.m. of CNA F assisting resident 15 from the bed to the wheelchair revealed CNA F:</p> <p>*Did not wash her hands or use hand sanitizer upon entering the room or at any time while assisting the resident.</p> <p>*Used a gait belt to assist the resident from the bed to the chair.</p> <p>*Picked up the oxygen tubing and nasal cannula from the floor.</p> <p>*Did not cleanse the tubing or cannula prior to placing it in the resident's nose and securing the tubing behind her ears.</p> <p>*Communicated with the resident by using a whiteboard.</p> <p>*Did not wash her hands or use hand sanitizer prior to leaving the resident's room.</p> <p>*Wheeled the resident into the dining room.</p> <p>Interview with CNA F at 4:35 p.m. revealed all of the above was her usual practice. She stated there was nothing she felt she should have done differently other than getting a smaller gait belt.</p>	F 441		

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F 441	<p>Continued From page 96</p> <p>Interview on 8/24/16 at 9:30 a.m. with the field services clinical director revealed she would have expected: *Hand hygiene to have been completed before and after any care provided to the resident. *The nasal cannula to have been cleansed or replaced prior to placing it in the resident's nose.</p> <p>Surveyor: 32572 7. Review of the provider's undated Hand washing/Hand Hygiene policy revealed: **"This facility considers hand hygiene the primary means to prevent the spread of infections." **"All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections." **"The use of gloves does not replace handwashing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections."</p> <p>Review of the provider's July 2016 Nurse Skill Fair Packet revealed "Handwashing is done prior to and immediately after all clinical procedures."</p> <p>Surveyor: 32355 8. Random observations on 8/22/16 from 4:00 p.m. through 6:10 p.m. and on 8/23/16 from 8:00 a.m. through 4:00 p.m. of resident 21's room revealed there had been a pile of clothes laying directly on the floor by his bed. They had been there during all the observations.</p> <p>Interview on 8/23/16 at 4:00 p.m. with resident 21 revealed: *He was independent with his personal cares that</p>	F 441			

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F 441	Continued From page 97 included changing his clothes. *He would lay his soiled linens on the floor by his bed. *The staff were to have: -Picked up those clothes for him. -Taken those soiled linens to the laundry room for cleaning. *He confirmed those clothes had been there for two days. He stated "This is normal for my clothes to lay here for more than a day or two."  Interview on 8/23/16 at 4:35 p.m. with the field services clinical director regarding resident 21 revealed she would have expected the staff to take his soiled clothes in a sanitary and timely manner. She agreed the above process had not been completed in a timely manner.  Surveyor: 32572 Review of the provider's 4/6/15 Infection Control Program revealed "An infection control program is designed to provide and maintain a safe, sanitary and comfortable work environment and to help prevent the development or transmission of disease or infection will be established for all facilities."	F 441			
F 490 SS=J	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:	F 490	F 490 Effective Administration/Resident Well Being  The Executive Director and Director of Nursing were terminated from their positions after a thorough investigation was completed. An experienced Executive Director and Director of Nursing have been contracted to provide daily leadership of the facility.	9/14/16	

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F 490	<p>Continued From page 98 Surveyor: 32572 Based on observation, interview, record review, and policy review, the provider failed to ensure the facility was operated and administered in a manner that attained or maintained the highest practicable physical, mental, and psychosocial well-being of all sixty-five residents. Findings include:</p> <p>1. Interview on 8/17/16 at 3:00 p.m. with the emergency permit holder (EPH) and the director of nursing (DON) revealed they confirmed they were responsible for the overall management of the building.</p> <p>Review of the 10/14/15 EPH job description revealed: *The provider had given to the survey team the Executive Director job description for the EPH job description. *The general purpose of that job was "To lead and direct the overall operations of the facility in accordance with customer needs, government regulations and Company policies, with focus on maintaining excellent care for the residents/patients while achieving the facility's business objectives. Serve as a mentor to guide and support all other assigned facilities."</p> <p>Review of the 10/16/14 DON job description revealed the general purpose was to "Plan, coordinates, and manages the nursing department. Responsible for the overall direction, coordination and evaluation of nursing care and services provided to residents. Maintains quality of care that is consistent with company and regulatory standards. Assumes responsibilities of daily operation in the absence of the Executive Director."</p>	F 490	<p>Residents residing in the facility have the potential to be affected in a similar manner.</p> <p><b>Additional Consultant Support, i.e. RN Transitional Leader will be onsite in the facility 5 days per week for a minimum of one quarter and then as deemed necessary; the Field Service Clinical Director and/or Area Vice President will be onsite in the facility a minimum of one day per week for a minimum of one month and then as deemed necessary to ensure continued improvement in the highest quality of care for each resident.</b></p> <p>The Executive Director or designee will present the findings of all audits to the monthly QAPI committee and further recommendations followed.</p> <p>The RN Transitional Leader, Field Service Clinical Director and/or Area Vice President will attend the monthly QAPI meetings x 6 months to provide further recommendations as necessary to ensure the highest quality of care for each resident.</p>	

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F 490	Continued From page 99  Interviews, observations, record reviews, and policy reviews throughout the course of the extended survey from 8/16/16 through 8/18/16 and 8/22/16 through 8/24/16 revealed the administration had not ensured all residents attained and/or maintained their highest practicable physical, mental, and psychosocial well-being. Refer to F166, F223, F225, F226, F241, F248, F280, F281, F311, F312, F314, F323, F325, F328, F353, F441, and F520.	F 490	Recognizing all residents currently living with in the facility are at risk, the facility will not accept for admission any new residents for the next 90 days (December 13, 2016) and then it will be reviewed in conjunction with the South Dakota Department of Health.	
F 493 SS=J	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN  The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility  This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, record review, interview, and policy review, throughout the course of the survey from 8/16/16 through 8/18/16 and from 8/22/16 through 8/24/16 revealed the governing body had not ensured the safe management and necessary care and services for 65 of 65 residents. Findings include:  1. Review of the last licensure survey completed	F 493	F 493 Governing Body- Facility Policies/Appoint Administration  The Executive Director and Director of Nursing were terminated from their positions after a thorough investigation was completed. An experienced Executive Director and Director of Nursing have been contracted to provide daily leadership of the facility.  Residents residing in the facility have the potential to be affected in a similar manner.  Additional Consultant Support, i.e. RN Transitional Leader will be onsite in the facility 5 days per week and the Field Service Clinical Director and/or Area Vice President will be onsite in the	9/14/16

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NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - MEADOWBROOK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 ARROWHEAD DR</b> <b>RAPID CITY, SD 57702</b>		
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F 493	Continued From page 100 on 3/3/16 revealed the following deficiencies had been cited: F176, F241, F253, F280, F281, F325, F431, F441, F466, and F520.  Review of the complaint survey completed on 7/14/16 revealed the following deficiencies had been cited: F281 and F309.  The following had been cited and/or recited (*) for the current survey: F166, F223, F225, F226, *F241, F248, *F280, *F281, F311, F312, F314, F323, *F325, F328, F353, *F441, F490, F493, F501, and *F520.	F 493	facility a minimum of one day per week for a minimum of one quarter and then as deemed necessary to ensure continued improvement in the highest quality of care for each resident.  The RN Transitional Leader, Field Service Clinical Director and/or Area Vice President will attend the monthly QAPI meetings x 6 months to provide further recommendations as necessary to ensure the highest quality of care for each resident.		
F 501 SS=J	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR  The facility must designate a physician to serve as medical director.  The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility.  This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on interview and job description review, the provider failed to include the medical director in the implementation and/or coordination of residents care in the facility. Findings include:  1. Interview on 8/23/16 at 1:10 p.m. with the medical director revealed he had not been notified until approximately fifteen minutes ago the facility had been in an Immediate Jeopardy situation regarding resident abuse.	F 501	Recognizing all residents currently living with in the facility are at risk, the facility will not accept for admission any new residents for the next 90 days (December 13, 2016) and then it will be reviewed in conjunction with the South Dakota Department of Health.  F 501 Responsibilities of the Medical Director  The Medical Director was notified of the Immediate Jeopardy that occurred in the facility related to abuse and neglect.	9/14/16	

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F 501	Continued From page 101 Review of the 10/14/15 emergency permit holder (EPH) job description revealed: *The provider had given to the survey team the Executive Director job description for the EPH job description. *The general purpose of that job was "To lead and direct the overall operations of the facility in accordance with customer needs, government regulations and Company policies, with focus on maintaining excellent care for the residents/patients while achieving the facility's business objectives.  According to the Society for Post-Acute and Long-Term Care Medicine (AMDA-American Medical Directors Association) website accessed on 8/24/16 ( <a href="http://www.paltc.org/amda-white-papers-and-resolution-position-statements/nursing-home-medical-director-leader-manager">http://www.paltc.org/amda-white-papers-and-resolution-position-statements/nursing-home-medical-director-leader-manager</a> ) revealed there were functions that were relevant for all nursing home medical directors: *"Administrative-participates in administrative decision making and recommends and approves relevant policies and procedures. *Professional services-organizes and coordinates physician services and the services provided by other professionals as they relate to patient care. *Quality Assurance and Performance Improvement-participates in the process to ensure the quality of medical care and medically related care, including whether it is effective, efficient, safe, timely, patient-centered, and equitable. *Rights of Individuals-participates in establishing policies and procedures for assuring that the rights of individuals are respected.	F 501	The Executive Director and Director of Nursing were terminated from their positions after a thorough investigation was completed. An experienced Executive Director and Director of Nursing have been contracted to provide daily leadership of the facility.  Both the current Executive Director and Director of Nursing will be educated related to the inclusion of the Medical Director in the implementation and/or coordination of residents care in the facility by September 14, 2016.  When a permanent Executive Director and Director of Nursing have been identified, they will be educated related to the inclusion of the Medical Director in the implementation and/or coordination of residents care in the facility.  In collaboration with the Executive Director and the Director of Nursing, the Medical Director will review and implement the prepared plan of correction including the resident care policies.		
F 520	483.75(o)(1) QAA	F 520			

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F 520 SS=J	<p>Continued From page 102 <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 observation, record review, interview, and policy review throughout the survey, the provider failed to ensure an effective quality assurance (QA) program had been maintained to identify concerns, and to develop and implement corrective action. Findings include:</p> <p>1. Review of the previous complaint survey on</p>	F 520	<p>The Medical Director will be notified of the date and time of the monthly QAPI committee meetings.</p> <p>The Executive Director will ensure the Medical Director's attendance at a minimum of quarterly meetings. The Medical Director will receive monthly meeting minutes for those not attended.</p> <p>Recognizing all residents currently living with in the facility are at risk, the facility will not accept for admission any new residents for the next 90 days (December 13, 2016) and then it will be reviewed in conjunction with the South Dakota Department of Health.</p> <p>F 520 QAPI Committee</p> <p>The facility is unable to correct past administrative processes.</p> <p>Residents residing in the facility have the potential to be affected in similar manner.</p>	9/14/16

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F 520	<p>Continued From page 103 7/14/16 revealed the following deficiencies had been cited: F281, and F309.</p> <p>Review of the recertification survey on 3/3/16 revealed the following deficiencies had been cited: F176, F241, F253, F280, F281, F325, F431, F441, F466, F520.</p> <p>During the current survey the following deficiencies had been cited and/or recited (*): F166, F223, F225, F226, *F241, F248, *F280, *F281, F311, F312, F314, F323, *F325, F328, F353, *F441, F490, F493, F501, *F520.</p> <p>The provider did not have a quality assurance or quality assurance process improvement (QAPI) coordinator job description.</p> <p>Interivew on 8/24/16 from 9:07 a.m. through 10:10 a.m. with the field services clinical director confirmed the prior emergency permit holder (EPH) conducted the QA meetings. Unable to interview the EPH due to absent from the second part of the survey.</p> <p>Review of the QA minutes for June and July 2016 revealed: *No tracking and trending of resident falls. *In June they had identified concerns with: -Care planning and audits were initiated and continued to find the care plans were not accurate. Refer to F280. -Weights not being completed and stated they found complainace with weights. Refer to F325. -QAPI (quality assurance process improvement) had not included the past survey concerns for weights and infection control. Refer to F441. -Review of the falls that had occured within the facility for May, they were to "include a root cause</p>	F 520	<p>Executive Director, Director of Nursing Medical Director, and Interdisciplinary team will review the Quality Assurance and Performance Improvement Policy by September 14, 2016.</p> <p>The Quality Assurance Performance Improvement (QAPI) program will include review of deficiency, plan of correction audits as well as review of resident care concerns and plans, identify trends in the quality indicator measures, identify trends and tracking of infection prevention, control; identify trends and tracking of infection control, identify needs and issues with the electronic medical records; review admissions and discharges; discuss new and old policies and procedures; discuss monthly pharmacist reports, discuss incident and safety reports; discuss staff concerns and needs.</p> <p>QAPI Committee members will be educated on the QAPI process by the GL Vice President of Quality by September 14, 2016.</p>	

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F 520	Continued From page 104 analysis, review of causal factors specific to policy, procedure, people and physical plant." No findings for the above were identified. Refer to F323. *In July they had identified concerns with: -Care planning, and audits were initiated and continued to find the care plans were not accurate. Refer to F280. -Weights not being completed and stated yet they found compliance with weights. Refer to F325. -QAPI had not included the past survey concerns for weights and infection control. Refer to F325 and F441.	F 520	Staff members will be re-educated on the QAPI process by the Multi-site Director of Clinical Education by September 14, 2016.  When a permanent Executive Director and Director of Nursing have been identified, they will be educated on the QAPI process.  QAPI Committee meetings will be held at a minimum of quarterly, consisting of: the Executive Director, Director of Nursing, Medical Director and at least 3 other members of the facility staff.  The Area Vice President (AVP) or designee will audit QAPI minutes for 6 months to insure the facility is meeting the expectations of the prepared plan of correction, making necessary recommendations and continuing to work with staff to ensure regulatory compliance.	9-14-16	