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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435009 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 03/30/2016 |
| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MILBANK | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1103 SOUTH SECOND STREET MILBANK, SD 57252 | |
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| F 000 | INITIAL COMMENTS Surveyor: 26180 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/29/16 through 3/30/16. Areas surveyed included Nursing Services and Quality of Care/Treatment. Golden LivingCenter - Milbank was found not in compliance with the following requirements: F309 and F356. | 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. This covers F309 & F356 | |
| F 309 SS=G | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on closed record review, interview, and policy review, the provider failed to appropriately assess, monitor, and make timely arrangements for transfer to a higher level of care for one of one sampled resident (4) who had a change in his medical condition after a fall. Findings include: 1. Review of resident 4's medical record revealed: *An admission date of 10/26/15. *Diagnoses of fractured right femur, osteoarthritis, anxiety, major depression, and chronic obstructive pulmonary disease (blocks | F 309 | F309 1. Resident #4 is no longer in the facility. Any resident with fall or other change of condition could be affected. 2. Per facility policy for falls the Change of Condition Report will be completed and documented on the assessment form. Fall Risk/Post Fall Assessment Process Algorithm will be followed thru the process. Falls with injury will have 911initiated if necessary. Falls with no injury will be reported | |

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

TITLE

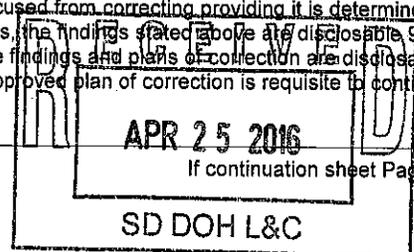
(X6) DATE

Andrew Payne

ED

4-21-16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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| F 309 | <p>Continued From page 1 airflow in the lungs). *He was alert and oriented (memory okay). *He had been participating in physical and occupational therapies to regain strength. *A physician's order dated 12/7/15 for: -"Oxygen at 2 liters per minute [lpm] per nasal cannula. Up to 4 lpm with activity." He had required the use of that oxygen continuously at 2 lpm. -Hydrocodone (pain medication) 5/325 milligrams (mg) 1 tablet orally (po) twice a day. He took those pills at 8:00 a.m. and 8:00 p.m. everyday. -Hydrocodone 5/325 mg 1-2 tablets po every 4 hours as needed (prn) for pain. *He had been able to walk short distances with the use of a wheeled walker (w/w). Attached to that w/w had been an oxygen tank. *On 12/20/15 at 12:40 p.m. he had been walking on his own and had fallen.</p> <p>Review of resident 4's 12/20/15 Post Fall Analysis/Plan revealed: *Fall details: "Lost strength." *Subjective or resident states: -"Headache." -"Dizziness/Faint." -"Discomfort in area of trauma." -"Resident had been ambulating in halls for exercise." *Physical assessment after fall: -"Anxious/irritable." -"Skin tear to his left shoulder, left side of face, left eyebrow." -"Redness/swelling/bruise, to left side of face, eye." -Range of motion to both arms and legs had been normal. -He had denied any pain. *The interdisciplinary care team had:</p> | F 309 | <p>to physician or designee on 1st clinic day following the fall. Falls will be reported to families immediately, the exception is if there is no injury with falls from 9pm to 7am then the fall will be reported to families at 7am. A resident with a change of condition will have emergent measures taken to stabilize, if unable to stabilize per use of standing orders then the primary or on call physician will be notified for further instructions and the event will be communicated to the physician or on call within 24 hours. The DON or designee will complete a post fall/change of condition review to determine further interventions within 24 hours. DON/designee review will be noted by the Medical Director monthly at QAPI. Staff Education on the process was held on 4/18.</p> | | |

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| F 309 | <p>Continued From page 2</p> <p>-Reviewed the fall on 12/21/15 at the stand-up meeting.</p> <p>-Recommended to monitor and assess any further events of dizziness.</p> <p>*His wife had been notified of the fall.</p> <p>*The certified nurse practitioner (CNP) had not been notified of the fall until 12/21/15. No time of day had been documented.</p> <p>Review of resident 4's nursing progress notes from 12/20/15 through 12/23/15 revealed on:</p> <p>*12/20/15:</p> <p>-He had fallen while walking on his own.</p> <p>-At 2:56 p.m. he had requested a hydrocodone for a pain level of ten (excruciating pain). That pain pill had been effective.</p> <p>-At 9:40 p.m. "Scheduled analgesics [pain medication] given at HS [hour of sleep] muscle pain all over, especially his upper chest area." No documentation to support the nurse had assessed his chest area for increased bruising, tenderness from touch, swelling, or abnormal lung sounds.</p> <p>*12/21/15:</p> <p>-1:15 a.m. "Resident c/o [complaining of] pain in the right side of his chest when he takes deep breaths. His O2 [oxygen] sats [saturation] were 88% [normal 90% or greater], so turn his O2 up to 4 lpm, and his sats went up to 92%. Lungs have ronchi [abnormal lung sounds] throughout on expiration. He stated he didn't know what to rate his pain at, but when I watched him take deep breaths his facial scale would be seven out of ten. He states he is still using the incentive spirometry [device to help keep lung airways open], but he can't get his lung volume as high as he could prior to the fall. Resident also states that it really hurt on the right side when he coughed. The resident is definitely weaker now than he was</p> | F 309 | <p>3. Post Fall Assessment and DON or designee review will be audited for completion of the assessment and notification of physician and family by ED or Designee weekly x4, bi-weekly x2, monthly x2, with results reported to QAPI.</p> <p>4.</p> | 5-19-16 AR | |

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| F 309 | Continued From page 3 prior to his fall. Requesting pain medication, he stated "I don't know what the pain rating would be" he stated his right upper chest hurt on inspiration [inhaling] since he fell." -1:15 a.m. "Hydrocodone 1 tablet given. Requesting pain medication, he stated "I don't know what the pain rating would be" he stated his R [right] upper chest hurt on inspiration since he fell. By facial scale he is seven out of ten." -1:55 a.m. "Tussin DM [cough syrup] requested for cough. He has a wet productive cough, have not seen what he is coughing up." -3:30 a.m. "PRN administration was ineffective. Resident stated his right side of his chest still hurt really bad, so I gave him another Hydrocodone. His pain scale he now rates at seven out of ten." -11:46 a.m. "O2 at 2 lpm up to 4 lpm with activity." -12:52 p.m. "Hydrocodone 2 tabs given prior to whirlpool for c/o right sided chest pain." -1:33 p.m. "[name of CNP] notified of resident fall and laceration. O2 small tanks have been ordered." -There was no documentation to support the CNP was notified of the resident's significant change in medical status. Those areas of change had been an increase in pain to his right side, productive cough with abnormal lung sounds, and a need for his oxygen level to have been increased from 2 lpm to 4 lpm. -2:35 p.m. He had continued to c/o right chest pain and was tender to the touch. The nurse had observed no bruising to that area. -8:48 p.m. "O2 90% with O2 on continuous at 4 lpm per nasal cannula. Resident complaining that chest and ribs hurt when coughing, PRN cough syrup given with some relief." -11:13 p.m. prn hydrocodone 1 tablet had been given for c/o rib pain from his fall. *12/22/15: | F 309 | | | |

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| F 309 | <p>Continued From page 4</p> <p>-1:47 a.m. the prn hydrocodone given at 11:13 p.m. was ineffective and another pain pill had been administered. "The resident has continued to be in pain. Follow-up pain scale was 7."</p> <p>-5:01 a.m. "Resident had wanted to see a doctor during the night because his ribs hurt, also wanting the ambulance called. Informed resident that writer would report pain in ribs to AM shift, so they can call doctor during clinic hours. Resident had hydrocodone 2 tabs at 3:38 a.m., and was c/o no relief at 4:15 a.m. Resident does rest at intervals, but says has not rested at all."</p> <p>-2:58 p.m. "Resident is currently at clinic seeing on call doctor for c/o rib and chest discomfort. O2 sats 85% today with oxygen at 4.5 liters, attempted to use incentive spirometer but unable to take very deep breaths. Faint bruise noted to left side of chest." There was no documentation to support the family had been notified of the physician visit.</p> <p>-There was no documentation to support the resident had received any pain medication after 4:15 a.m. or had been assessed for an increase in pain.</p> <p>-3:25 p.m. "Call received from clinic. Res [resident] being admitted to hospital with pneumonia."</p> <p>*12/23/15 at 12:05 p.m. "Res passed away at hospital this a.m."</p> <p>*There was no documentation to support the physician had been notified of the resident's change in his medical condition until 12/22/15 when he had been assessed in the clinic.</p> <p>Review of resident 4's December 2015 medication administration record revealed from: *12/1/15 through 12/19/15 he had received only two extra doses of hydrocodone for complaints of pain.</p> | F 309 | | | |

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| F 309 | <p>Continued From page 5</p> <p>*12/20/15 through 12/23/15 after his fall he had requested six extra doses of hydrocodone for complaints of pain.</p> <p>Interview on 3/29/16 at 1:40 p.m. with licensed practice nurse (LPN) A regarding resident 4 revealed:</p> <p>*She confirmed he had an intact memory, and his requests to the staff were appropriate.</p> <p>*She had taken care of the resident on 12/22/15, two days after his fall.</p> <p>*He had complained of rib pain that day but not shortness of breath.</p> <p>*She could not recall:</p> <p>-Giving him any extra pain medication to help decrease that pain.</p> <p>-Increasing the resident's O2 from 4 lpm to 4.5 lpm.</p> <p>-If she had notified the family but had called to set-up the clinic appointment for him.</p> <p>-Much about his condition that day or if his condition had worsened from the fall.</p> <p>Interview on 3/29/16 at 2:00 p.m. with the administrator revealed the director of nurses was not available, and questions should be directed to the Minimum Data Set (MDS) assessment coordinator.</p> <p>Interview on 3/29/16 at 2:40 p.m. with the MDS assessment coordinator regarding resident 4 revealed:</p> <p>*She had been working on 12/20/15, the day of the resident's fall, and been part of the initial post-fall assessment of him.</p> <p>*She confirmed the resident had a change in medical condition after his fall.</p> <p>*The resident's wife was aware he had fallen, because she came to visit while they were doing</p> | F 309 | | | |

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| F 309 | <p>Continued From page 6 the post-fall assessment. *The CNP had: -Been in the facility seeing other residents on 12/21/15 per her usual schedule. -Not seen the resident or assessed his condition after the fall. -Not been informed of the resident's change in condition on 12/21/15 when she had been in the facility. *The nursing staff should have contacted the physician on 12/21/15 after the nurse noted a change in his medical condition or he should have been seen by the CNP when she was in the facility. *She was not aware if the family had been notified of the resident's change in condition or of his physician's appointment on 12/22/15. *She agreed the nurses had failed to: -Appropriately assess the resident after his fall with his complaints of increased pain, productive cough, and increase in O2 needs. -Monitor and notify the physician and family in a timely manner of the resident's change in condition. -Notify the physician for an order to increase his O2 beyond 4 lpm.</p> <p>Interview on 3/30/16 at 7:00 a.m. with LPN B revealed: *She had worked the night shift after resident 4's fall. *She confirmed the resident had appeared to be in more pain after the fall. *Resident 4: -Had complained of increased rib pain and had requested to go to the hospital. -Had been assessed, and she had noted a bruised area on the left side of his chest. -Had not been assessed for any increase in pain</p> | F 309 | | | |

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| F 309 | <p>Continued From page 7</p> <p>from touch or increased congestion in his lungs. *She did not feel based on her observations and assessments he required hospitalization. *During the night they try to wait until the next day for the residents to see their physicians. *She stated "[resident name] wanted to go to the hospital many times during his care here. She had not always documented those requests to go to the hospital. As a nurse she should have assessed his pain and chest better." *The expectation of the nursing staff was they were to notify the physician and family with a fall or change in condition. *She agreed if the documentation was not there the assessment or task would had not have been considered completed.</p> <p>Interview on 3/30/16 at 7:30 a.m. with the administrator revealed: *He had arranged for all of the transportation in the facility. *He had arranged for resident 4 to be transported by their facility van on 12/22/15. *The maintenance supervisor drove the resident to his physician's appointment that day. *No staff or family had gone along with the resident in the van. That had not been an uncommon occurrence. *The families had not always been notified of all physicians' visits. *If the resident had been their own power-of-attorney (POA) they were not required to notify the families. *He was not surprised the family had not been notified of the clinic appointment, because he did not have a POA and could act on his own behalf. *When he arranged the transportation for resident 4 he had not been aware the resident had: -A change in condition since his fall on 12/20/15.</p> | F 309 | | | |

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| F 309 | <p>Continued From page 8</p> <ul style="list-style-type: none"> -Increased pain. -The need for his O2 to be increased significantly. -Requested an ambulance during the night. <p>Interview on 3/30/16 at 8:30 a.m. with registered nurse (RN) C regarding resident 4 revealed:</p> <ul style="list-style-type: none"> *She confirmed the resident had an intact memory and could make his needs known to the staff. *The resident would become impatient with his requests, but his requests were accurate and justifiable. *She had been working the day he fell. *He had complained of right-sided rib pain after the fall. That area had been tender to the touch. *She had reported the fall and change in condition to the director of nursing. *She had not reported the fall or any change in condition of the resident to the family or physician. *She stated: "Well it was probably my responsibility to report to the physician. I didn't feel that he was that critical. I don't know why they did not notify the physician. I don't know when the physician was actually notified." *The nursing staff should have notified the physician when the resident had an increase in pain and increase in O2 needs. *She confirmed "If a resident requested an ambulance to be called they should have honored that request." <p>Interview on 3/30/16 at 10:15 a.m. with the clinic physician who had seen resident 4 on 12/22/15 revealed:</p> <ul style="list-style-type: none"> *He could not remember all of the details on the day the resident had visited the clinic. *He had been concerned the resident had a: -Change in status. | F 309 | | | |

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| F 309 | <p>Continued From page 9</p> <p>-Combination of not getting enough air and pain. *The x-ray had revealed significant pneumonia. *He had referred the surveyors to review his clinic assessment documentation.</p> <p>Review of resident 4's 12/22/15 physician's clinic report revealed: *History of present illness: "He is brought to the clinic today with increasing shortness of breath, cough, and rib pain after a fall at the nursing home on 12/20/15. He was a little light-headed, and he fell over and knocked the anterior chest wall against his oxygen tank. He is on supplemental O2 for his COPD with increased O2 requirement over the last two days." *Pain: "10/10 worst/intolerable." *Chest: "Lungs have diminished breath sounds with poor air movement." *Impression: "Pneumonia, right lung."</p> <p>Interview on 3/30/16 at 10:23 a.m. with the licensed social worker revealed: *The family and physician should have been notified when the resident had a change in condition. *Families should be notified with any physician visits/appointments. *It was a resident right to request an ambulance.</p> <p>Review of the provider's undated Long-Term Care Facilities Resident's Bill of Rights pamphlet revealed: *"A long-term care facility must notify you when your condition changes." *A facility must inform you, consult with your physician, and, if known, notify your legal representative or interested family member when any of the following occurs: -"You were injured in an accident and may</p> | F 309 | | | |

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| F 309 | <p>Continued From page 10</p> <p>potentially require a physician." -"Your physical, mental or psychosocial status changes significantly." -"Your treatment needs altered significantly." -"The facility decides to transfer or discharge you."</p> <p>Review of the provider's undated Deciding About Going to the Hospital policy revealed: *A copy of the policy was provided to the resident/family member upon admission to the facility. **Whether hospitalization can be prevented depends on the resident's condition, the ability of the staff to provide the care necessary in the nursing home, and the preferences of the resident and her or his family."</p> <p>The provider had no policy or procedure for post fall assessments when requested from this surveyor, and none were provided prior to exit.</p> <p>Review of the provider's 11/12/14 Notification of Change in Resident Health Status policy revealed: **"The center will consult the resident's physician, nurse practitioner or physician assistant, and if known notify the resident's interested family member when there is: -Notification: within 24 hours from the time an assessment has been made indicating there may be a potential for physician intervention. -Acute illness or a significant change in the resident's physical, mental, or psychosocial status. -A need to alter treatment significantly. -A decision to transfer or discharge the resident from the center."</p> | F 309 | | |

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

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FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435009 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 03/30/2016 |
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| F 309 | <p>Continued From page 11</p> <p>Review of the provider's 2/10/15 Pain Management Guideline policy revealed: **Guideline statement: "To provide guidance for consistent assessment, management and documentation of pain in order to provide maximum comfort and enhanced quality of life, in concert with the patient's/resident's plan of care and goals for pain management." **Following an acute change in condition when pain is suspected, and after any fall, the licensed nurse assesses the patient/resident for pain, using the appropriate pain scale and documents assessment findings. Discusses the findings with the patient's/resident's physician or provider, and receives any new orders for evaluation and treatment of pain."</p> <p>Review of the provider's 9/10/14 Charge Nurse RN job description revealed: **Responsible for the independent supervision of the delivery of care to a group of residents in a nursing unit. Assess resident needs, develop individual care plans, administer nursing care, evaluate nursing care." **Assure that effective quality nursing care is delivered which is outcome focused through utilization of the nursing process." **Identify needs and provide input for discharge planning and follow-up throughout length of stay." **Work in collaboration with the physician and/or other health care professionals by sharing information relevant to changing plan of care." **Deliver and maintain optimum resident care and comfort by demonstrating knowledge and skills of current nursing practices."</p> <p>Review of the provider's 3/29/13 Charge Nurse LPN job description revealed: **Responsible for the independent supervision of</p> | F 309 | | |
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| F 309 | Continued From page 12 the delivery of care to a group of resident in a nursing unit. Assess resident needs, develop individual care plans, administer nursing care, evaluate nursing care." *"Assure that effective quality nursing care is delivered which is outcome focused through utilization of the nursing process." *"Identify needs and provide input for discharge planning and follow-up throughout length of stay." *"Work in collaboration with the physician and/or other health care professionals by sharing information relevant to changing plan of care." *"Deliver and maintain optimum resident care and comfort by demonstrating knowledge and skills of current nursing practices." | F 309 | | | |
| F 356 SS=B | 483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. | F 356 | F356 1. 1. No resident affected. No resident care affected, may feel facility had not informed them of staffing. 2. The DON or Designee will complete the Posting of Nursing Hours form prior to the date. The night nurse will complete the census when midnight census is done. The Charge Nurses will adjust the form as changes occur during the date. Staff Education on the process completed by 4/30 3. ED or Designee will audit the form 3x weekly x2 weeks, 2x weekly x2 weeks, weekly x2 weeks and monthly x2 with results reported to QAPI. 4. | 5-19-16 AR | |

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| F 356 | <p>Continued From page 13</p> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, interview, and policy review, the provider failed to ensure the twenty-four (24) hour nursing staff information was completed and posted daily fourteen of twenty-nine days. Findings include:</p> <p>1. Random review and observation of the twenty-four hour nursing staff information revealed incomplete information on staffing was posted on fourteen days in March 2016: *3/2/16, 3/14/16, There were no hours recorded on the evening shift and the census was left blank. *3/4/16, 3/5/16, 3/9/16, 3/10/16, 3/19/16 and 3/28/16, There were no hours recorded on the evening shift. *3/8/16 and 3/22/16, There were no hours recorded on the day or evening shifts. *3/12/16 and 3/13/16, The census was left blank. *3/17/16, There were no hours recorded on the evening or night shifts. *3/21/16, There were no hours recorded on the night shift.</p> <p>Interview on 3/30/16 at 10:50 a.m. with the</p> | F 356 | | |

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| F 356 | <p>Continued From page 14</p> <p>administrator revealed the twenty-four hour nursing staff information should have been thoroughly completed every day. He confirmed that had not occurred.</p> <p>Review of the provider's 12/29/14 Nursing Staff Hours policy revealed: **Nursing staff hours will be posted in accordance with state and federal regulation in all facilities. *Posting: The following information shall be posted on a daily basis at the beginning of each shift. -Center/Location Name. -Current date. -Total number and actual hours worked by licensed and unlicensed staff responsible for resident care, including RNs [registered nurses, LPNs/LVNs [licensed practical nurses/licensed vocational nurses] and CNAs [certified nursing assistants]."</p> | F 356 | | |