

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/23/2016
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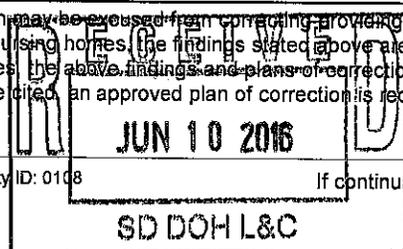
NAME OF PROVIDER OR SUPPLIER PRAIRIE VIEW HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 401 SOUTH FIRST AVENUE POST OFFICE BOX 68 WOONSOCKET, SD 57385
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F 000	<p><i>*Addendums noted with 6/1/16 per telephone with facility administrator and DON, JD PROUTIER</i></p> <p>INITIAL COMMENTS can asterisk per 6/1/16 per telephone with facility administrator and DON, JD PROUTIER</p> <p>Surveyor: 32333</p> <p>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted on 5/23/16. Areas surveyed included quality of care/treatment and nursing services. Prairie View Healthcare Community was found not in compliance with the following requirements: F279 and F281.</p>	F 000	<p>Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.</p> <p>F279</p> <ol style="list-style-type: none"> 1. Resident 3's care plan has been completed. Resident's 1 and 2 have their code status entered on their care plan. 2. All residents are at risk. 3. The Administrator, Director of Nursing (DON), Social Services, and interdisciplinary team, no later than 	
F 279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on record review, interview, and policy</p>	F 279		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Kayla Evans	TITLE Administrator, eph	(X6) DATE 6/8/16
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided 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 279	<p>Continued From page 1</p> <p>review, the provider failed to ensure care plans had been:</p> <ul style="list-style-type: none"> *Initiated for one of two sampled residents (3) who was newly admitted. *Completed to include the code status for three of seven sampled residents (1, 2, and 3). <p>Findings include:</p> <p>1. Review of resident 3's complete medical record revealed:</p> <ul style="list-style-type: none"> *He had been admitted on 5/17/16. *His code status was do not resuscitate (DNR). *There was no care plan in his medical record. <p>Interview on 5/23/16 at 2:50 p.m. with the Minimum Data Set (MDS) assessment coordinator revealed resident 3 did not have a care plan.</p> <p>Interview on 5/23/16 at 3:55 p.m. with the director of nursing (DON) revealed she would have expected resident 3 to have had an initial care plan.</p> <p>2. Review of resident 1's complete medical record revealed:</p> <ul style="list-style-type: none"> *He had been admitted on 5/13/16. *His code status was full code. *His code status was not reflected on his care plan. <p>Interview on 5/23/16 at 2:50 p.m. with the MDS coordinator revealed they did not indicate a residents code status on their initial care plan.</p> <p>Interview on 5/23/16 at 3:55 p.m. with the DON revealed she had no expectation to have a resident's code status reflected on their initial care plan.</p>	F 279	<p><i>JUNE</i> ^{ye} 16, 2016, will review the care plan policy and the requirement that the care plan is complete and accurate reflecting resident's current care needs, including Code status and have reviewed the cited deficiency. No later than 6-16-2016, the DON will educate nurses on ensuring the care plan is complete and accurate, includes code status, and all residents have immediate plan of care initiated within 24 hours of admission. Education provided on resident's preference for code status as well. Those not in attendance at education session will be educated prior to their first shift worked.</p> <p>4. The DON or designee will audit all care plans to ensure that all residents have their code status indicated on their care plan. After initial audit, the DON or designee will audit four care plans a week to ensure that the care plan is accurate and reflects the resident's care needs, including code status, and will audit all newly admitted residents to ensure an immediate plan of care is completed within 24 hours of admission. Audits will be weekly for four weeks and then monthly for three months. Audits will be discussed by the DON in monthly Quality Assurance Process Improvement (QAPI) for review and recommendations of continuation/discontinuation of audit.</p>	<p><i>#be</i> <i>10/30/2016/EL</i></p>
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F 279	Continued From page 2 3. Review of resident 2's complete medical record revealed: *He was admitted on 10/12/15. *His code status was full code. *His code status was not reflected on his care plan. Interview on 5/23/16 at 2:50 p.m. with the MDS coordinator revealed resident 2's code status should have been indicated on his care plan. Interview with the DON on 5/23/15 at 3:55 p.m. revealed she would have expected resident 2's code status to have been indicated on his care plan. 4. Review of the providers 11/6/15 Care Plans - Preliminary policy revealed "A preliminary plan of care to meet the resident's immediate needs shall be developed for each resident within twenty-four (24) hours of admission." Review of the providers 11/6/15 Care Plans - Comprehensive policy revealed: **"Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain." **Each resident's comprehensive care plan is designed to: Reflect the resident's expressed wishes regarding care and treatment goals;"	F 279			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281			

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F 281	<p>Continued From page 3</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on record review and interview, the provider failed to ensure appropriate, accurate, and professional documentation had been recorded by two of two sampled registered nurses (RN) (A and the director of nursing [DON]) for one of one sampled resident (1) that had died. Findings include:</p> <ol style="list-style-type: none"> Review of resident 1's complete medical record revealed: <ul style="list-style-type: none"> *He was admitted on 5/13/16. *His physician's orders stated he was a full code. *The nursing note surrounding the resident's death was innacurate per staff interview. *The nursing note had an incorrect time of completion. *There was no nursing note completed by the nurse that was with the resident when he died. <p>Review of resident 1's 5/14/16 at 9:45 p.m. nursing progress notes written by the DON revealed:</p> <ul style="list-style-type: none"> *She was called to the nursing home, because the resident's wound vac was not working properly. *She called the resident's wife. *She paged the ambulance. *"Nurse entered room. Resident started seizure like activity and throwing up brown liquid coming from both his mouth/nose. Not responding verbally at this time but coughing and became unresponsive started turning cyanotic. Nurse was 	F 281	<p>F281</p> <ol style="list-style-type: none"> No correction can be made to Resident 1's documentation entered at the time of his death. All residents are at risk. The Administrator and DON have devised a policy about appropriate, accurate and complete documentation by the licensed professional RN and LPN and have reviewed the cited deficiency. The DON will educate all nurses on the above no later than 6-16-16. Those not in attendance at education session will be educated prior to their first shift worked. The DON or designee will review 4 random samples of documentation to ensure it reflects the resident's care provided. Audits will be weekly for four weeks and then monthly for 3 months. Audits will be discussed by the DON at monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit. 	7/1/16

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F 281	<p>Continued From page 4</p> <p>assessing vitals and directed staff to get suction machine. EMT's [emergency medical technicians] arrived and took over cares. Took pulse and no respirations at this time. 10:45 Eyes fixed and no response. No breath sounds or pulse. Skin cool, clammy and mottled to his knees."</p> <p>Interview on 5/23/16 at 3:15 p.m. with RN B who was also an EMT revealed: *When she arrived in the ambulance to the facility the DON met them at the front door. *The DON informed them the resident had died. *CPR was not performed by emergency services. *She comforted the resident's wife.</p> <p>Interview on 5/23/16 at 3:25 p.m. and at 4:20 p.m. with EMT C regarding what he witnessed when he arrived on the scene revealed: *There was a red substance running from the resident's nose. *The staff were wiping him up. *He had no pulse and no respirations. *It did not seem possible to resuscitate him. *Staff had not initiated CPR. *He did not initiate CPR. *The resident was on his back inclined. *He could not recall if he was informed of the resident's code status. *Large amounts of fluid were running from the resident's nose and airway. *He arrived before the ambulance. *The resident was not seizing or moving. *He made a judgement call not to start CPR. *At 4:20 p.m. EMT C called to make an update to his interview: -Staff had told him the resident was a full code. -He told staff there was nothing they could do.</p> <p>Interview on 5/23/16 at 3:55 p.m. with the DON</p>	F 281			

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F 281	<p>Continued From page 5 regarding what she witnessed regarding resident 1's death revealed:</p> <ul style="list-style-type: none"> *She had been called to the facility by RN A to help with the resident's wound vac. *She went into the resident's room, and he looked a little sweaty. *The resident told her he was fine. *She called the resident's wife and asked her to come to the facility. *She had a CNA get the resident's vitals. *She called the hospital the resident had been admitted from. *She paged an ambulance. *CNA D came down the hall and told her the resident was seizing. *The DON was at the main nurses station. *RN A was assisting the resident. *Two EMTs arrived before the ambulance. *She did not go back to the room until the CNAs had cleaned up the resident. *She had written the nursing note surrounding the resident's death but had not actually been present in the room. *RN A was assisting the resident while the DON was at the main nurses station. *The DON had written the nursing note for RN A. *RN A should have written her own nursing note. <p>Interview on 5/23/16 at 4:34 p.m. with RN A regarding the death of resident 1 revealed:</p> <ul style="list-style-type: none"> *She had been across the hall in another resident's room. *Staff alerted her to come to the resident's room. *The resident was sitting upright with brown liquid coming from his nose and mouth. *She did not witness any seizure like activity. *The resident became cyanotic and unresponsive. 	F 281		

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F 281	<p>Continued From page 6</p> <p>*As the resident became cyanotic and unresponsive EMT C arrived. *She directed a CNA to take the resident's vital signs. *The EMT checked the resident's carotid pulse and said he was gone. *No vitals were taken. *No CPR was initiated.</p> <p>Interview on 5/23/16 at 5:30 p.m. with the administrator revealed they had no policy regarding nursing services, nursing documentation, or professional standards. They would utilize Potter and Perry Fundamentals of Nursing as a resource for that information.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., Elsevier, St. Louis, Mo., 2013, pages 350 and 351 revealed: **"The record is the most current and accurate continuous source of information about a patient's health care status (350)." **"The record must describe exactly what happened to a patient and follow agency standards (350)." **"Legal guidelines for recording: -Guidelines - Chart only for yourself. -Rationale - You are accountable for information you enter into the patient's chart. -Correct Action - Never chart for someone else."</p>	F 281		