

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

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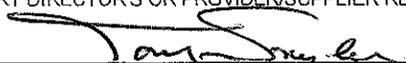
PRINTED: 11/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/30/2014
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NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH JAY STREET ABERDEEN, SD 57401
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F 000	INITIAL COMMENTS Surveyor: 32331 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 10/27/14 through 10/30/14. Avera Mother Joseph Manor Retirement Community was found not in compliance with the following requirements: F176, F250, F279, F281, F311, F315, F323, and F441.	F 000	Addendums noted with an asterisk per 12/14/14 telephone to facility DON. JT/0000H/MF	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, record review, and policy review, the provider failed to follow a resident request to not engage in self-administration of medication for one of two randomly observed residents (17) receiving nebulizer treatments. Findings include: 1. Observation on 10/28/14 at 3:10 p.m. of resident 17 on Abbey Lane wing revealed registered nurse (RN) B: *Set-up and started a nebulizer (machine that turns liquid medication into a mist to be inhaled) treatment for the resident. *He asked what to do when the medication was finished. *RN B responded she would return to check on	F 176	Policy MII-B, "Self Administration of Medication After Set-up" was reviewed. Resident #17 was reassessed for self administration of medications on 11/03/14. It was determined that resident is able to self administer nebulizer only. Physician order was obtained 11/04/14 for self administration of nebulizer only. Each resident with a nebulizer treatment was reassessed for self administration. If resident was appropriate for self administration of nebulizer, a physician order was obtained. Education on policy MII-B, "Self	12/19/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 11/24/14
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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.

NOV 25 2014
If continuation sheet Page 1 of 38
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F 176	Continued From page 1 him and to turn the nebulizer off when the medication was finished. *RN B left the resident's room with the nebulizer running. Interview and record review on 10-29-14 at 2:00 p.m. with RN C regarding resident 17 revealed: *The resident had identified in the 9/10/14 Self Administration Assessment that he had not wanted to self-administer any medications at his bedside or after set-up by a nurse. *The physician's orders dated 9/28/14 had not included an order for the resident to self-administer medications. *RN C had not considered a nebulizer treatment to be self-administration of a medication. *RN C confirmed nebulizer treatments were set up for residents and left to run until completion without a nurse being in the room. *RN C agreed resident could have removed the breathing mask or turned off the machine and interrupted the medication delivery. Review of the provider's February 2014 Self-Administration of Medication after set-up policy revealed: *Residents interested in participating would be assessed by the interdisciplinary team for their ability to self-administer medication. *A physician's order was necessary for each resident to self-administer medications.	F 176	Administration of Medication After Set-up" will be provided to the nurses and medication aides by 11/25/14. Monthly audits of all residents self administering nebulizers will be completed by ADON or designee. The audits will include completion of self-administration of medication assessment and if appropriate to self administer nebulizer; a correct physician order is in place. Audits will be reported quarterly to the QA Committee by ADON until advised to discontinue by the committee.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250	Policy N-250 "Care Planning" was reviewed. Resident #1's care plan was reviewed and revised by the Licensed Social	12/19/14

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F 250	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and job description review, the provider failed to ensure medically necessary social services had been completed for one of one sampled resident (1) who had dementia. Findings include:</p> <p>1. Review of resident 1's 8/4/14 Care Area Assessment (CAA) revealed psychosocial well-being and communication had been identified as areas of concern.</p> <p>Review of resident 1's current care plan revealed: *A problem area for "altered mood and state evidenced by episodes of restlessness causing increased confusion - habit of picking at face and head and difficult to re-direct." *Interventions included one-to-one visits with all departments and a psychological consult.</p> <p>Review of resident 1's medical record revealed: *She had a diagnosis of dementia (the loss of mental functions such as thinking, memory, and reasoning that is severe enough to interfere with a person's daily functioning) and had declined. *She had been identified to be at risk for falling. *She had unwitnessed falls on 4/11/14 and 4/26/14. *She had a witnessed fall on 4/29/14. *She had used a walker prior to the 4/11/14 fall but was currently using a wheelchair. *There had been no documented interventions provided by the licensed social worker regarding the above mentioned areas of concern.</p>	F 250	<p>Worker to include social service interventions.</p> <p>To identify other residents at risk: The Licensed Social Worker will be notified of any resident condition change by resident care supervisors.</p> <p>The Licensed Social Worker will attend monthly Fall Committee meetings.</p> <p>The Licensed Social Worker will attend daily line up nursing staff meetings.</p> <p>When psychosocial well being and/or communication triggers on a resident's CAA it will be care planned by the Licensed Social Worker. Licensed Social Worker will document interventions in the medical record.</p> <p><i>*all JTSDDH/MF</i></p> <p>Monthly audits of care plans for residents identified at risk will be completed by the [redacted] to assure psychosocial and/or communication needs are met.</p> <p>Audits will be reported quarterly to <i>* ADON or designee JTSDDH/MF</i></p>	

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F 250	Continued From page 3 Interview on 10/28/14 at 2:10 p.m. with the licensed social worker revealed: *She was involved in resident care conferences and documented those interactions. *She had not been involved with the concerns listed above for resident 1. *She had been doing admissions since approximately January 2014 due to a coworker resigning and not having the position filled. *She could not locate any documentation regarding resident 1 other than the care conference notes. Review of the provider's July 2014 social worker job description revealed: **The main focus of the social worker is to assist in meeting the psychosocial continuum of care (gradual change from one condition to another) needs of the resident to ensure optimum functioning. *He/She is to arrange for the meeting of these needs through Social Service programming and appropriate referrals to outside Social Service agencies, community resources and professional services. *Review and revise, as necessary, the plan for Social Services intervention. *Timely documentation of assessments, Social Service interventions, etc. in the resident's record. *Promotes, adheres to and supports residents' rights."	F 250	the QA Committee by the Facility's [REDACTED] or designee until advised to discontinue by the committee. * ADDN JT/SDDH/MF	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279	Policy N-250 "Care Planning" was reviewed. Residents 1, 2, 6, and 7 care plans	12/19/14

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F 279	<p>Continued From page 4</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: 33265 Based on observation, record review, interview, and policy review, the provider failed to revise and update care plans for 4 of 13 sampled residents (1, 2, 6, and 7). Findings include:</p> <p>1. Random observations from 10/27/14 through 10/29/14 of resident 2 revealed she: *Moved herself throughout the facility using a wheelchair. *Spent the majority of her time outside of her room at the dining room table. *Preferred to keep her room door closed when she was in the room. *Was unable to answer questions from this surveyor.</p> <p>Review of resident 2's complete medical record</p>	F 279	<p>were reviewed and updated to address identified physical, mental and psychosocial needs.</p> <p>Each resident's care plan will be reviewed and updated as necessary to ensure physical, mental and psychosocial needs are met. A discontinued notation will be put next to all discontinued interventions. Interventions requiring documentation will be placed on resident status board, in the electronic medical record (EMR).</p> <p>Education on policy N-250, "Care Planning," will be provided to Care Plan Team members, nurses, and certified nurse assistants by 11/25/14. Education will include documenting interventions to prevent falls.</p> <p><i>ADON</i> Monthly audits of Care Plans will be completed by ADON or designee to assure current interventions are in place and documented in the EMR.</p> <p>Audits will be reported quarterly by the ADON or designee until advised to discontinue reporting by the QA committee.</p>

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F 279	<p>Continued From page 5</p> <p>revealed there had been six falls since April 2014. Fall records from April 2014 through September 2014 included the following information:</p> <p>*4/8/14 at 1:45 a.m.:</p> <ul style="list-style-type: none"> -Slipped on way to bathroom, landed on left arm, and hit head. -Pain and swelling noted. -Neuros (assessment of nerve functioning) good. -Vitals (heart beat, breathing, temperature) stable. -Recommended non-slip stockings. -Resident sent to emergency room for left shoulder pain where she was found to have a fractured left humerus (upper arm bone). <p>*5/25/14 at 8:00 p.m.:</p> <ul style="list-style-type: none"> -Found on the floor on her left side. -No new injuries. -Encourage resident to use call light and increase monitoring of resident were recommended changes. <p>*6/6/14 time not documented:</p> <ul style="list-style-type: none"> -Found flat on back on floor and was not sure what happened. -Complained of back pain. -Recommended and placed sensor pads in bed. <p>*7/6/14 at 8:00 p.m.:</p> <ul style="list-style-type: none"> -Found on floor. Stated she was trying to put her shoes on. -Bed sensor alarm had not alarmed. Battery not working. <p>*7/12/14 at 5:00 p.m.:</p> <ul style="list-style-type: none"> -No description of fall events documented. -Resident was confused. -Recommended call light within resident reach and reminding resident to use call light. -No documentation as to sensor alarm working or not working. <p>*9/8/14 at 4:02 a.m.:</p> <ul style="list-style-type: none"> -Resident found on floor. She slipped out of bed. 	F 279		

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F 279	<p>Continued From page 6</p> <ul style="list-style-type: none"> -Recommended increased monitoring. -No documentation as to sensor alarm working or not working. <p>Resident 2's 10/20/14 interdisciplinary care plan revealed:</p> <ul style="list-style-type: none"> *High risk for falls. *Fall on 4/8/14 lists recommendation as to "encourage to leave door open to room when she is in the room." No mention of non-slip stocking use. *Fall on 5/25/14 stated "interventions reviewed - continue same." Nothing about the call light location was included. *Fall on 6/6/14 listed a sensor alarm to be used in wheelchair, chair, and bed. *Fall on 7/6/14 stated to change battery in sensor alarm. Noted to ensure alarm on and working every day. No further documentation that showed the alarm battery was checked daily was found or provided. *Fall on 7/12/14 stated "interventions reviewed-continue same." Nothing about the call light location was included. *Fall on 9/8/14 stated "interventions reviewed-continue same." There was nothing about increasing monitoring of the resident. <p>Review of resident 2's 4/25/14 Care Area Assessment (CAA) revealed the following areas were identified as concerns:</p> <ul style="list-style-type: none"> *Cognitive loss (ability to think and reason). *Activities of daily living. *Urinary incontinence (unintentional loss of urine). *Falls. *Nutritional status. *Dehydration/fluid maintenance. *Pressure ulcers (inflammation, sore, open wound that forms whenever prolonged pressure 	F 279		

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F 279	<p>Continued From page 7</p> <p>is applied to skin covering a bony area of the body). *Pain.</p> <p>Interview on 10/29/14 at 3:30 p.m. with RN D revealed resident 2: *Had frequent falls. *Tried to remain as independent as possible. *Wanted the door to her room closed. *Had declined when thickened liquids were started and had improved since liquids were no longer thickened. -She thought the decline had contributed to frequent falls.</p> <p>Surveyor: 32331 2. Review of resident 7's medical record revealed: *He was admitted on 1/10/14. *He had a diagnosis that had included senile dementia (a mental change in the thinking process).</p> <p>Review of resident 7's revised 10/13/14 interdisciplinary care plan revealed he: *Had an impaired activities of daily living (ADL) function. *Needed extensive assistance with his ADLs. *Had a goal to maintain his ADL function. *Was to have had "Restorative therapy Refer to Tx [treatment] plan."</p> <p>Interview on 10/29/14 at 9:35 a.m. with certified nurse assistant/medication aide (CNA/MA) I regarding resident 7's restorative therapy program revealed he was not on therapy. He had been refusing it.</p> <p>Review on 10/29/14 of the provider's undated</p>	F 279		

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F 279	<p>Continued From page 8</p> <p>Boardwalk Restorative Therapy calendar revealed resident 7 was not scheduled for restorative therapy.</p> <p>Confidential interview on 10/29/14 at 11:25 a.m. regarding resident 7 revealed he:</p> <ul style="list-style-type: none"> *Had been refusing restorative therapy. *Had liked to do the NuStep (a type of exercise machine), but he had difficulty getting up on the seat on the machine. *Was no longer doing restorative therapy. <p>Interview on 10/29/14 at 1:45 p.m. with registered nurse (RN) E regarding resident 7 revealed:</p> <ul style="list-style-type: none"> *He was not on a restorative therapy program. *She was unaware of any treatment plan for him to have been on restorative therapy. <p>Interview on 10/29/14 at 2:00 p.m. with RN resident care coordinator D regarding resident 7 revealed:</p> <ul style="list-style-type: none"> *He was not on a restorative therapy program. *She agreed his care plan needed to have been updated as changes occurred for each resident. *It was the responsibility of the care plan team for updating the care plan as needed. <p>Surveyor: 32335</p> <p>3. Review of resident 1's medical record revealed:</p> <ul style="list-style-type: none"> *She had a diagnosis of dementia (the loss of mental functions such as thinking, memory, and reasoning that is severe enough to interfere with a person's daily functioning) and had declined. *She had been identified to be at risk for falling. *She had unwitnessed falls on 4/11/14 and 4/26/14. *She had a witnessed fall on 4/29/14. *She had used a walker prior to the 4/11/14 fall 	F 279		

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F 279	<p>Continued From page 9 but was currently using a wheelchair.</p> <p>Random observations from 10/27/14 through 10/29/14 of resident 1 revealed: *She had used a wheelchair to move around the building with staff assistance. *Staff had to feed her at meals. *She was unable to answer questions from this surveyor. *She had been in her room in front of the television when not at meals.</p> <p>Review of resident 1's 8/4/14 Care Area Assessment (CAA) revealed: *The following areas had been identified as concerns: -Cognitive loss/dementia. -Communication. -Urinary incontinence. -Psychosocial well-being. -Activities. -Falls. -Nutritional status. -Pressure Ulcer.</p> <p>Review of resident 1's current care plan revealed: *Communication had not been addressed. *The risk for pressure ulcers had not been addressed. *Interventions for activities included the following: -Having newspapers to read. -Listen to music. -Be around animals such as pets. -Group activities. -Going outside. -Doing her favorite activities. -Participate in religious activities. *Those activity preferences had not matched the 8/4/14 CAA information.</p>	F,279			

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F 279	<p>Continued From page 10</p> <p>*There had not been a separate problem area for falls.</p> <p>*They had incorporated falls under the problem area of impaired activities of daily living function/potential for injury.</p> <p>*Twelve out of thirteen fall interventions had been put into place after the resident had fallen.</p> <p>- "4/30/14 - to have close supervision when in activities, when in room transfer from w/c [wheelchair] to chair, use sensor pad in w/c and chair, and when in easy chair in room place walker in front of her."</p> <p>- "4/29/14 - fall follow up - anti roll back brakes on w/c."</p> <p>- "4/26/14 - fall follow up - interventions reviewed - continue same - mobility alarm when in w/c and in chair in room."</p> <p>- "4/11/14 - fall follow up - continue same interventions."</p> <p>- "12/23/13 - fall follow up, continue same interventions."</p> <p>- "11/01/13 - fall follow up - continue to check on frequently when she is in room."</p> <p>- "1/21/13 - fall follow up - assure things she needs are in easy reach, falling leaf (dc'd [discontinued] 3/14/13."</p> <p>- "1/10/13 - fall follow up - when resident is noted ambulating, assure walker brakes are off and may need SBA with ambulation."</p> <p>- "9/19/12 - staff to assist her when sitting in DR [dining room] chair."</p> <p>- "9/19/12 - post fall review, continue same."</p> <p>- "1/7/12 - fall follow up - assure pathway is free of clutter - monitor gait."</p> <p>- "1/3/12 - fall follow up - have walker within reach and remind to use."</p> <p>- "9/13/11 - fall follow up - have her sit on bed when being assisted with dressing. 1) keep pathway free of clutter and well lit. 2) needs</p>	F 279		
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F 279	<p>Continued From page 11</p> <p>reminders to use walker with ambulation. 3) if noted to be restless provide distraction activity - enjoys reading in room, listen to music. 4) assist to activity and inform staff of whereabouts."</p> <p>*There had been no added interventions from 12/23/13 to 4/11/14 when she had fallen.</p> <p>*No interventions had been put into place regarding her dementia affecting her mobility.</p> <p>4. Review of resident 6's medical record revealed:</p> <p>*She had been at risk for falls.</p> <p>*She had an unwitnessed fall on 6/19/14 and was sent to the emergency room.</p> <p>- "Monitor elder safe in bed at hs [bedtime] and assist as needed" had been added to the initial fall report.</p> <p>- That had not been added to the care plan.</p> <p>*She had an unwitnessed fall on 8/18/14.</p> <p>- "Elder reminded to use call light and ask for assistance" had been added to the initial fall report.</p> <p>- That had not been added to the care plan.</p> <p>*She had five urinary tract infections (UTI) since 4/26/14.</p> <p>*She had been receiving an anti-depressant medication.</p> <p>Review of resident 6's 10/23/14 CAA revealed the following areas had been identified as areas of concerns:</p> <p>*Delirium.</p> <p>*Cognitive loss/dementia.</p> <p>*Activities of daily living functional/rehabilitation potential.</p> <p>*Urinary incontinence.</p> <p>*Falls.</p> <p>*Nutritional status.</p> <p>*Pressure Ulcer.</p>	F 279			

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F 279	<p>Continued From page 12</p> <p>*Psychotropic drug (any medication capable of affecting the mind, emotions, and behavior) use.</p> <p>Review of resident 6's current care plan revealed:</p> <p>*The only intervention for urinary incontinence had been "provide incontinence care with all episodes of incontinence. Provide with incontinent products to protect her skin."</p> <p>*The five UTIs had not been addressed on the care plan.</p> <p>*A goal to prevent falls with the following interventions:</p> <p>- "7/29/13 post fall review, continue same." - "6/27/12 post fall review, continue same. 1) w/c for locomotion for long distance or when she doesn't want to walk with staff. 2) uses walker with assist to walk to and from meals and activities as she wishes." - "Assure that glasses are clean and worn by resident. Resident has right sided neglect when ambulating." *There had been no fall interventions listed in 2014. *Psychotropic drug use (the anti-depressant) had not been addressed.</p> <p>5. Interview and record review on 10/29/14 at 10:25 a.m. with resident care coordinator D for the Boardwalk and Cedar halls revealed:</p> <p>*She had not discontinued items on care plans, because they wanted to have a list of interventions attempted.</p> <p>*The care plans were hard to read with the interventions listed since some were not applicable even though they had not been discontinued.</p> <p>*The above issues for resident 1 should have been care planned.</p>	F 279		

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F 279	Continued From page 13 Interview and record review on 10/29/14 at 4:00 p.m. with resident care coordinator C for the Abby and Dakota halls revealed the care plans had not been updated to reflect the above areas addressed for resident 6. Review of the provider's June 2012 Care Planning policy revealed: *The interdisciplinary team should have completed the comprehensive assessments and evaluated the identified areas of concern. *The care plan should have consisted of long and short term problems/needs. *A Kardex contained the care plan problems/needs on the front of the care plan. *The information should have been written in pencil and erased as appropriate. 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 A. Based on record review, interview, and policy review, the provider failed to clarify physician's orders and to obtain a stop date for 1 of 13 sampled residents (1) receiving a narcotic medication (drugs that dull the sense of pain and cause drowsiness or sleep). Findings include: 1. Review of resident 1's medical record revealed: *She had a diagnosis of dementia (the loss of mental functions such as thinking, memory, and	F 279	Policy 1901 "Pharmaceutical Services" was reviewed and revised to include revision of stop orders for medications. Resident #1's medication record was reviewed. Tylenol #3 was discontinued by primary care provider on 05/07/14. Education on policy 1901 "Pharmaceutical Services" and policy N 252 "Pain Management Protocol" will be provided to nurses by 11/25/14. Monthly audits of 15 residents on narcotics will be completed by	12/19/14
F 281 SS=D		F 281		

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F 281	<p>Continued From page 14 reasoning that is severe enough to interfere with a person's daily functioning). *She had unwitnessed falls on 4/11/14 and 4/26/14. *She had a witnessed fall on 4/29/14. *On 4/15/14 she had been sent to the emergency room due to pain. *After that visit on 4/15/14 a physician's order had been obtained for the following: -Acetaminophen/Codeine (Tylenol #3) 300 milligrams (mg)/30 mg tablet. -Twelve tablets had been dispensed. -One tablet orally four times per day as needed (PRN). -Zero refills were allowed. -There was no order when to stop the medication.</p> <p>Review of resident 1's 4/1/14 through 4/30/14 medication administration record revealed: *The Acetaminophen/Codeine had been given as follows: -One time on 4/15/14 and one time on 4/16/14. -Zero time on 4/17/14. -Two times on 4/18/14, 4/19/14, and 4/20/14. -Zero time on 4/21/14. -One time on 4/22/14, 4/23/14, and 4/24/14.</p> <p>Review of resident 1's medical record revealed a refill for the Acetaminophen/Codeine had been obtained on 4/23/14 and again on 5/5/14.</p> <p>Interview and policy review on 10/29/14 at 4:50 p.m. with the director of nursing revealed they had not followed their policy. They had not obtained a stop order after three days of administering the medication.</p> <p>Surveyor: 33265 Review of the provider's April 2013</p>	F 281	<p>ADON or designee to assure pain management assessments are completed and physicians are notified if drug regimen appears ineffective.</p> <p>Audits will be reported quarterly to the QA Committee by ADON or designee until advised to discontinue by the committee.</p> <p>Policy N 303 "Charge Nurse Responsibilities when a Resident Dies" was reviewed and revised to include nurse notification of physician at time of vital signs ceasing and obtaining an order to release the body to a mortuary.</p> <p>Education will be provided to nurses on policy N 303 "Charge Nurse Responsibilities when a Resident Dies" by 11/25/14.</p> <p>Death records for each month will be audited by the ADON or designee for compliance with policy N 303.</p> <p>Audits will be reported quarterly to the QA Committee by ADON or designee until advised to discontinue by the committee.</p>	

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F 281	<p>Continued From page 15</p> <p>Pharmaceutical Services policy revealed: *When narcotics (Tylenol #3) were ordered the charge nurse was to have asked the physician to identify the length of time the drug was to be used. *A stop order for three days of use would have gone into effect for narcotics if the physician had not identified the length of time the drug was to be used. *The attending physician was to have been notified of the stop orders by the charge nurse for possible renewals to provide uninterrupted therapeutic treatment.</p> <p>Surveyor: 32335 B. Based on closed record review, interview, and policy review, the provider failed to obtain a physician's order for three of three sampled residents (14, 15, and 16) with a change in condition. Findings include:</p> <p>1. Review of resident 16's medical record revealed: *On 8/30/14 at 12:00 noon it had been documented that "all signs of life ceased, no respirations, no heart rate." *At 1345 (1:45 p.m.) they had notified the funeral home. *At 1400 (2:00 p.m.) they had sent a fax to the physician that stated "_____ [resident name] passed to heaven today at 12 noon." *There had been no physician's order to release the body to the mortician.</p> <p>Surveyor: 32331 2. Closed record review on 10/30/14 of resident 15's complete medical record revealed on 8/16/14: *He had been discharged.</p>	F 281		

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F 281	<p>Continued From page 16</p> <p>*At 7:00 a.m. licensed practical nurse (LPN) L had documented she notified his physician. *His physician had been "informed of residents passing at 0640 [6:40 a.m.] via a fax." *At 7:00 a.m. the funeral home had been notified. *There had been no physician's order to release the body to the mortician.</p> <p>Interview on 10/30/14 at 4:15 p.m. with registered nurse (RN) resident care coordinator C regarding resident 15 revealed: *The charge nurse that had documented the death of the resident had done so without proper diagnosis from the resident's physician. *Making a diagnosis was not within the scope of practice for a nurse. *The provider had not received a physician's order for the body to be released to the mortician.</p> <p>Per letter response dated 8/4/14 from the South Dakota Board of Nursing, a determination of death shall be made in accordance with accepted medical standards.</p> <p>Surveyor: 33265 3. Review of the resident 14's complete closed medical record revealed: *She had been found on 8/9/14 at 3:58 a.m. to be without a heart beat, breathing, or blood pressure (BP). *A fax was sent to the physician on 8/9/14 at 4:15 a.m. that stated: -"Elders resp (breathing) ceased, no audible BP no pulses." -"Elder expired." *The legal next of kin was notified at 4:15 a.m. *The funeral home was notified at 4:40 a.m. *The body was released to the funeral home at 5:15 a.m.</p>	F 281	

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F 281	Continued From page 17 *There had been no physician's order to release the body to the mortician. *There was no documentation of a telephone call to the physician after 6:00 a.m. on the day of the death. 4. Interview on 10/29/14 at 1:45 p.m. with the DON and RN C concerning care following the death of a resident revealed: *Routinely they did not call physicians to tell them a resident had died if the death was expected and had occurred during the night. *Expected was defined as on hospice, comfort care, or declining condition. *The physician was faxed, and the body was released to the funeral home. *Had not been aware pronouncing death was not under the scope of practice for nurses. Review of the provider's July 2013 Charge Nurse responsibilities When a Resident Dies policy revealed the charge nurse was to have: *Notified the physician that vital signs (heart beat, breathing, and temperature) had ceased. *If death had been expected and occurred during the night the notification could have been written and faxed to the physician at the time of death. *The physician was to have been called in the morning (after 6:00 a.m.) to confirm notification of death. *When the death was unexpected the physician must be called at the time of death regardless of the time.	F 281			
F 311 SS=E	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	F 311	Policy 1702 "Restorative Nursing" was reviewed. Resident 2, 3, 4, 5 and 13's Care	12/19/14	

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F 311	<p>Continued From page 18 specified in paragraph (a)(1) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on interview, record review, and policy review, the provider failed to ensure recommendations from the therapy department had been followed for 5 of 13 sampled residents (2, 3, 4, 5, and 13) who were to have received a restorative therapy program. Findings include:</p> <p>1. Interview on 10/28/14 at 8:30 a.m. and at 9:10 a.m. with resident 4 in her room revealed she: *Had not had restorative therapy that day. *Had not been receiving restorative therapy on a consistent basis. *Liked restorative therapy, because it made her feel better. *Had especially liked the moist heat pack that she had been receiving at restorative therapy. *Had not understood why she had not been receiving restorative therapy.</p> <p>Review of resident 4's interdisciplinary revised 10/21/14 care plan revealed she was to have received a restorative therapy program for: *Impaired activities of daily living (ADL) function related to weakness. *Goals for the resident had included the following: -To maintain endurance and strength for ADLs and for mobility. -To maintain mobility and independence. *A restorative range of motion (ROM) program three to five times per week which had included the following interventions: -NuStep (a type of exercise machine). -Pulleys.</p>	F 311	<p>Plans and Functional Maintenance/ Range of Motion (ROM) program sheets were reviewed and revised to ensure accuracy.</p> <p>DON or designee will review all resident care plans and functional maintenance/ROM program sheets to ensure accuracy. <i>by 11/25/14 JT/SDDH/MF</i></p> <p>DON/ADON will ensure that one restorative aide is available in restorative therapy 5 days per week to complete the Restorative Nursing program recommended by the therapy department.</p> <p>Education will be provided to Nursing and Restorative staff on policy 1702 "Restorative Nursing" by 11/25/14.</p> <p>20 Random audits will be done monthly by ADON or designee to assure resident restorative therapy is completed as recommended by therapy.</p> <p>Audits will be reported quarterly to the QA Committee by ADON or designee until advised to discontinue <i>* of the Functional Maintenance/ Range of Motion (ROM) program sheets JT/SDDH/MF</i></p>	

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F 311	<p>Continued From page 19</p> <p>-Rickshaw (a type of exercise for strengthening and developing muscles).</p> <p>-Standing exercises.</p> <p>-A moist heat pack to her right hip and thigh for twenty minutes as needed for pain management.</p> <p>Review of resident 4's 4/14/14 rehabilitation screen by physical therapist (PT) J and certified occupational therapist assistant (COTA) K revealed she was to have continued on current restorative therapy program.</p> <p>Review on 10/29/14 of the provider's undated Abbey Lane Restorative Therapy calendar revealed resident 4 was scheduled for restorative therapy five times per week.</p> <p>2. Interview on 10/28/14 at 10:10 a.m. with resident 13 in her room revealed she:</p> <p>*Had not had restorative therapy that day.</p> <p>*Was unsure of her restorative therapy schedule.</p> <p>*Would have liked to walk more with her walker as she felt weaker.</p> <p>Review of resident 4's interdisciplinary revised 9/8/14 care plan revealed she was to have received a restorative therapy program for:</p> <p>*Impaired ADL function.</p> <p>*Goals for the resident had included the following:</p> <p>-To improve ADL function.</p> <p>-To increase independence with ADLs and to tolerate more activity.</p> <p>-To maintain endurance for mobility with staff assistance and a walker.</p> <p>*A restorative program that had included NuStep (a type of exercise machine).</p> <p>Review of resident 4's 12/2/13 rehabilitation screen by COTA K revealed she was to have</p>	F 311	by the committee.		

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F 311	<p>Continued From page 20 continued on the restorative therapy program.</p> <p>Interview on 10/28/14 at 2:30 p.m. with registered nurse (RN) resident care coordinator D regarding the restorative therapy program revealed: *The provider had been advertising for a restorative therapy coordinator since August 2014. *There were currently two working restorative therapy aides on the schedule. *Those aides were pulled from restorative therapy if needed on the floor. *There had been no restorative therapy on 10/27/14 and 10/28/14. *There was no restorative therapy scheduled for 10/29/14.</p> <p>Interview on 10/29/14 at 9:35 a.m. with certified nursing assistant/medication aide (CNA/MA) revealed: *Restorative therapy was scheduled from 7:00 a.m. to 3:30 p.m. during the weekdays. *Often restorative therapy aides were pulled to work on the floor instead of providing restorative therapy. *He had been scheduled for restorative therapy on 10/29/14. *He had been pulled to work the floor instead of providing restorative therapy. *He agreed restorative therapy was important for the residents.</p> <p>Interview on 10/29/14 at 1:45 p.m. with RN E regarding resident 13's restorative therapy program revealed the resident was to have received restorative therapy three times per week according to the schedule.</p> <p>Review on 10/29/14 of the provider's undated</p>	F 311		

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F 311	<p>Continued From page 21</p> <p>Boardwalk Restorative Therapy calendar revealed resident 13 was scheduled for restorative therapy three times per week.</p> <p>Interview on 10/29/14 at 9:50 a.m. with the director of nursing (DON) regarding the restorative therapy program revealed: *The provider was currently advertising for the restorative therapy coordinator position. *She confirmed the restorative therapy aides were often pulled if needed on the floor. *She agreed restorative therapy was important for the residents scheduled for the program.</p> <p>Surveyor: 33265 3. Review of resident 2's 10/20/14 interdisciplinary care plan revealed she was to have received a restorative therapy program for: *Impaired ADLs. *Goals for the resident had included the following: -Increased independence with ADLs with a tolerable pain level. -Maintain or increase strength in left upper extremity along with maintaining right upper extremity strength. *The restorative program was to have included working three to five times a week with the following machines: -Pulleys. -Richshaw. -Handgripper. -Peg board and or stacking cones with left arm.</p> <p>Review of all restorative program documentation from May 2014 through 10/29/14 revealed: *May 2014: 5/20/14 she received passive range of motion (put muscles through normal motions) for fifteen minutes. *No restorative program documentation was</p>	F 311		
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F 311	<p>Continued From page 22 found for the month of June 2014. *July 2014: 7/28/14 she received no active range of motion, should have had three to five times a week. *August 2014: 8/26/14 she received thirty minutes of active range of motion therapy. *September 2014: -9/3/14 she received twenty-nine minutes of active range of motion therapy. -9/8/14 she received twenty minutes of active range of motion therapy. -9/12/14 she received no active range of motion due to the resident's refusal. -9/17/14 she received fifteen minutes of active range of motion therapy. *October 2014: -10/8/14 she refused active range of motion therapy. -10/13/14 she completed ten minutes of active range of motion therapy. Resident had fallen asleep. -10/17/14 she received twenty minutes of active range of motion therapy. -10/20/14 she received sixteen minutes of active range of motion therapy and refused to finish all her exercises. -No restorative program documentation was found for the time period of 10/21/14 through 10/29/14.</p> <p>Surveyor: 34030 4. Review of resident 3's medical record revealed: *An admission date of 9/28/10. *Diagnoses that include chronic kidney disease and rheumatoid arthritis (a condition that causes inflammation and pain in the joints making them difficult to use).</p>	F 311		

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F 311	<p>Continued From page 23</p> <p>Review of resident 3's Minimum Data Set (MDS) assessment from 8/5/14 and the care plan from the same date revealed:</p> <ul style="list-style-type: none"> *Impaired upper extremity strength and activities of daily living (ADL) function, which decreased the ability to maintain movement. *A care plan goal to maintain upper extremity strength and improve ADL function. *A need for restorative therapy (exercises to maintain or improve body function). *A care plan listing the type of restorative activities being done. <p>Interview on 10/28/14 at 10:00 a.m. with resident 3 revealed she was not receiving restorative therapy and had not for some time. She revealed she would like to receive restorative therapy.</p> <p>5. Review of resident 5's medical record revealed:</p> <ul style="list-style-type: none"> *An admission date of 1/24/13. *Diagnoses that include Parkinson's disease (a degenerative disease of the central nervous system that causes a decline in movement), and contractures (a chronic loss of joint movement due to tightening of muscles, ligaments, and/or tendons) of the upper extremities. <p>Review of resident 5's MDS from 7/29/14 and the care plan dated 10/27/14 revealed:</p> <ul style="list-style-type: none"> *Impaired upper and lower extremity strength and ADL function that decreased the ability to maintain movement. *A care plan goal to maintain ADL function and range of motion (ROM) to decrease risk of contractures. *Care plan interventions for restorative therapy and ROM. 	F 311		

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F 311	Continued From page 24 Review of resident 5's ROM charting from January 2014 to October 2014 revealed ROM had been done one to three times a month. The rest of the charting under ROM talked about the resident's activities. 6. Review of a resident restorative list dated 10/28/14 that included residents 2, 3, 4, and 5 as receiving restorative therapy. It also stated what they were to have done. Interview on 10/29/14 at 4:00 p.m. with the administrator revealed: *There had not been a lead restorative staff person since August 2014. *They had been advertising for staff. **"I don't know why you have to have trained staff to do restorative therapy." *When shown by this writer that resident 5 had not been receiving restorative therapy on a consistent basis since January 2014, he expressed disbelief. Review of the provider's September 2013 restorative nursing policy revealed: **"Restorative nursing will be provided to residents of MJM." (facility) **"Residents will be assessed by licensed nursing or therapy staff. A restorative nursing plan will be developed for the residents based on the assessment." **"Restorative nursing is a function of the MJM nursing department. Physical Therapist or Occupational Therapist will be consulted as needed to evaluate and enhance the restorative nursing program."	F 311			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315	Resident #6's care plan was revised to include problem area and interventions to address urinary incontinence and UTI's.	12/19/14	

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F 315	Continued From page 25 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review and interview, the provider failed to assess and provide interventions for one of one sampled resident (6) with incontinence (unintentional loss of urine) concerns who developed recurrent urinary tract infections (UTI). Findings include: 1. Review of resident 6's 10/14/14 Minimum Data Set (MDS) assessment revealed urinary incontinence had been identified as a concern. Review of resident 6's 7/15/14 and 10/14/14 MDS assessments revealed she had gone from frequently incontinent to always incontinent. Review of resident 6's current care plan revealed there was no problem area for urinary incontinence. Instead there had been a problem area for impaired skin integrity. The only intervention related to incontinence stated "provide incontinence care with all episodes of incontinence. Provide with incontinent products to protect her skin."	F 315	Care plans for all residents identified with incontinence and/or UTI's, will be reviewed and revised for appropriate intervention. Education will be provided to nursing staff on policy N-250 "Care Planning" and assessments for UTI's and incontinence by 11/25/14. Monthly care plan & EMR audits of 10 residents with UTI's and/or urinary incontinence will be completed by ADON or designee. The audits will assure that appropriate problem/needs are identified and applicable assessments are completed. Audits will be reported quarterly to the QA Committee by ADON or designee until advised to discontinue by the committee.	QUARTERLY JT/SDOH/MF	

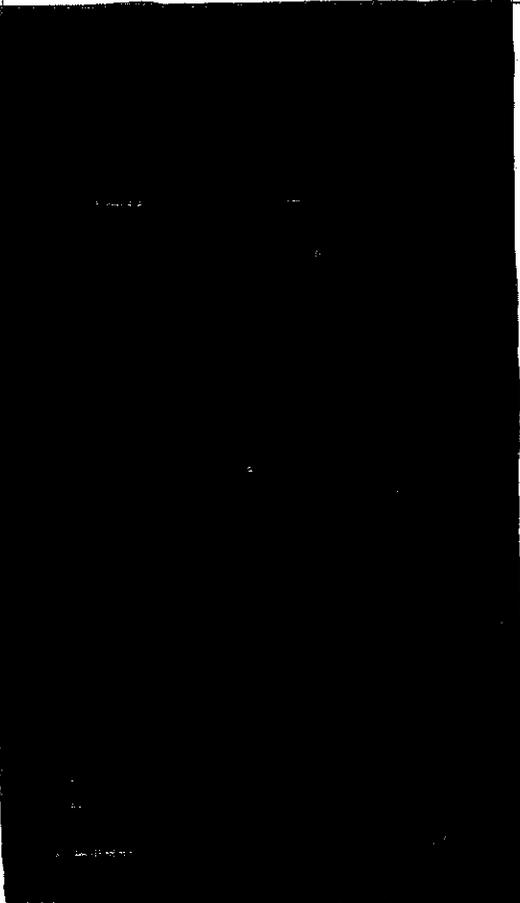
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F 315	<p>Continued From page 26</p> <p>Review of resident 6's medical record revealed she had five UTIs from 4/26/14 through 10/29/14. Those UTIs had not been addressed on the care plan.</p> <p>Interview on 10/29/14 at 4:00 p.m. with resident care coordinator C revealed:</p> <ul style="list-style-type: none"> *Incontinence had not been identified on resident 6's care plan. *The UTIs had been treated, but no additional interventions had been attempted. *The fifth UTI had just been confirmed on 10/29/14. *There was no individualized toileting program for resident 6. *They had no policy on urinary incontinence. <p>Review of the provider's June 2012 Care Planning policy revealed:</p> <ul style="list-style-type: none"> *The interdisciplinary team should have completed the comprehensive assessments and evaluated the identified areas of concern. *The care plan should have consisted of long and short term problems/needs. *A Kardex contained the care plan problems/needs on the front of the care plan. *The information should have been written in pencil and erased as appropriate. 	F 315	 <p style="text-align: right;">JF/SDDH/MF</p>	
F 323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p>	F 323	<p>Policy N-559 "Accident, Falls and Safety" was revised.</p>	12/19/14

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F 323	Continued From page 27 This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and policy review, the provider failed to: *Ensure appropriate interventions were put in place to prevent falls for three of eight sampled residents (1, 2, and 6) with multiple falls. *Complete pain and neurological (monitors vital signs, pupil reaction, consciousness, and responsiveness) assessments as needed after unwitnessed falls for two of eight sampled residents (1 and 6). Findings include: 1. Random observations from 10/27/14 through 10/29/14 of resident 1 revealed: *She had used a wheelchair with staff assistance to move around the building. *Staff had to feed her at meals. *She was unable to answer questions from this surveyor. Review of resident 1's medical record revealed: *She had a diagnosis of dementia (the loss of mental functions such as thinking, memory, and reasoning that is severe enough to interfere with a person's daily functioning). *She had been identified as being at risk for falling. *She had unwitnessed falls on 4/11/14 and 4/26/14. -Pain assessments and neurological assessments had not been done after those two falls. *She had a witnessed fall on 4/29/14.	F 323	Residents 1, 2, 6's care plans were reviewed and revised to include interventions currently in use to prevent falls. Each resident identified at risk for fall at admit, with a change of condition, at quarterly assessment, or with history of previous falls will have care plan reviewed/ revised to include interventions currently in use to prevent falls. Review of care plans and interventions will be completed at monthly fall committee meetings to ensure appropriate fall prevention interventions are in place. Education will be provided to nursing staff on the following by 11/25/14. 1.) Policy N-559, "Accident, Falls and Safety" 2.) Fall follow up process to include pain assessments and neurological assessments. 3.) Documentation that appropriate fall prevention interventions are completed.	

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F 323	<p>Continued From page 28</p> <p>*She had used a walker prior to the 4/11/14 fall. *She had x-rays done on 5/16/14 that showed "age-indeterminate mild compression fractures."</p> <p>Review of resident 1's 1/24/14 Minimum Data Set (MDS) assessment revealed: *Her thinking ability had been severely impaired. *She needed limited assistance from one staff person to walk in the corridor. *She needed extensive assistance from one staff person to: -Move in bed. -Transfer. -Walk in her room. -Dress. -Eat. -Bath.</p> <p>Review of resident 1's 4/29/14 MDS assessment revealed: *There had been two changes from the above MDS assessment areas as follows: -She needed extensive assistance from one staff person to walk in the corridor. -She needed total assistance from one staff person to bath.</p> <p>Review of resident 1's 7/25/14 MDS assessment revealed: *There had been one change from the above MDS assessment areas: -She had only walked in her room and in the corridor one or two times with the assistance of one staff person. *Falls had been identified as an area of concern.</p> <p>Review of resident 1's current care plan revealed: *There had not been a separate problem area for falls.</p>	<p>F 323</p> <p><i>* all JTS/DOH/inf</i></p>	<p>Monthly audits will be completed by ADON or designee for fall follow ups to identify that pain and/or neurological assessments were completed, if appropriate. Audits will also include the review of care plans to ensure appropriate problem areas and interventions are in place.</p> <p>Audits will be reported quarterly to the QA Committee by ADON or designee until advised to discontinue by the committee.</p>	

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F 323	Continued From page 29 *They had incorporated falls under the problem area of impaired activities of daily living function/potential for injury. *Twelve out of thirteen fall interventions had been put into place after the resident had fallen. - "4/30/14 - to have close supervision when in activities, when in room transfer from w/c [wheelchair] to chair, use sensor pad in w/c and chair, and when in easy chair in room place walker in front of her." - "4/29/14 - fall follow up - anti roll back brakes on w/c." - "4/26/14 - fall follow up - interventions reviewed - continue same - mobility alarm when in w/c and in chair in room." - "4/11/14 - fall follow up - continue same interventions." - "12/23/13 - fall follow up, continue same interventions." - "11/01/13 - fall follow up - continue to check on frequently when she is in room." - "1/21/13 - fall follow up - assure things she needs are in easy reach, falling leaf (dc'd [discontinued] 3/14/13." - "1/10/13 - fall follow up - when resident is noted ambulating, assure walker brakes are off and may need SBA with ambulation." - "9/19/12 - staff to assist her when sitting in DR [dining room] chair." - "9/19/12 - post fall review, continue same." - "1/7/12 - fall follow up - assure pathway is free of clutter - monitor gait." - "1/3/12 - fall follow up - have walker within reach and remind to use." - "9/13/11 - fall follow up - have her sit on bed when being assisted with dressing. 1) keep pathway free of clutter and well lit. 2) needs reminders to use walker with ambulation. 3) if noted to be restless provide distraction activity -	F. 323		

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F 323	<p>Continued From page 30.</p> <p>enjoys reading in room, listen to music. 4) assist to activity and inform staff of whereabouts." *There had been no added interventions from 12/23/13 to 4/11/14 when she had fallen. *No interventions had been put into place regarding her dementia affecting her mobility.</p> <p>Review of resident 1's 4/11/14 fall follow-up computerized form revealed: *The fall had been unwitnessed. *They had answered yes for new onset of pain and stated "difficult to assess."</p> <p>Interview on 10/29/14 at 8:45 a.m. with the director of nursing regarding resident 1 revealed: *She was uncomfortable answering questions regarding the specific falls and directed this surveyor to speak with resident care coordinator D. *Neurological assessments should have been completed for the two unwitnessed. *Pain assessments should have been completed for resident 1 as she was unable to explain what had happened after the fall on 4/11/14.</p> <p>Interview on 10/29/14 at 10:25 a.m. with resident care coordinator D regarding resident 1 revealed: *All the fall interventions had been implemented after the falls had occurred. *Keeping the pathway free from clutter was an intervention they used on a daily basis for all residents. *Her dementia had declined, but they had not addressed that on the care plan. *They had attempted therapy after the falls had occurred, but she was unable to complete the tasks due to her dementia. *The neurological assessments should have been completed after the unwitnessed falls.</p>	F 323		

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F 323	<p>Continued From page 31.</p> <p>*When staff had answered yes to new onset of pain on the fall follow-up form a pain assessment should have been completed but was not.</p> <p>2. Review of resident 6's medical record revealed: *She had been at risk for falls. *She had an unwitnessed fall on 6/19/14 and was sent to the emergency room. -The 6/19/14 initial fall report had the following intervention added "Monitor elder safe in bed at hs [bedtime] and assist as needed." -That had not been added to the care plan. *She had an unwitnessed fall on 8/18/14. -The 8/18/14 initial fall report had the following intervention added "Elder reminded to use call light and ask for assistance." -That had not been added to the care plan.</p> <p>Review of resident 6's current care plan revealed: *A goal to prevent falls. *Interventions included: -"7/29/13 post fall review, continue same." -"6/27/12 post fall review, continue same. 1) w/c for locomotion for long distance or when she doesn't want to walk with staff. 2) uses walker with assist to walk to and from meals and activities as she wishes." -"Assure that glasses are clean and worn by resident. Resident has right sided neglect when ambulating." *There had been no fall interventions listed in 2014.</p> <p>Interview on 10/29/14 at 2:45 p.m. with resident care coordinator C revealed: *They had a falls committee that met and reviewed falls that had occurred. *She agreed the interventions in place for</p>	F 323		

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F 323	<p>Continued From page 32.</p> <p>resident 6 had not been preventative.</p> <p>3. Further review of resident 1 and resident 6's above falls revealed there was no evidence they had evaluated/investigated: *When was the last time the residents had been toileted. *When was the last time the residents had been repositioned. *What medications could have contributed to the falls. *Was the call light within reach since each time the residents had fallen. *Who the staff person was that was responsible for the residents when they had fallen.</p> <p>Surveyor: 33265</p> <p>4. Random observations from 10/27/14 through 10/29/14 of resident 2 revealed she: *Moved herself throughout the facility using a wheelchair. *Spent the majority of her time outside of her room at the dining room table. *Preferred to keep her room door closed when she was in the room. *Was unable to answer questions from this surveyor.</p> <p>Review of resident 2's complete medical record revealed there had been six falls since April 2014. Fall records from April 2014 through September 2014 included the following information: *4/8/14 at 1:45 a.m.: -Slipped on way to bathroom, landed on left arm, and hit head. -Pain and swelling noted. -Neuros (assessment of nerve functioning) good. -Vitals (Heart beat, breathing, temperature) stable.</p>	F 323		

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NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH JAY STREET ABERDEEN, SD 57401
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F.323	<p>Continued From page 33</p> <ul style="list-style-type: none"> -Recommended non-slip stockings. -Resident sent to emergency room for left shoulder pain where she was found to have a fractured left humerus (upper arm bone). *5/25/14 at 8:00 p.m.: -Found on the floor on her left side. -No new injuries. -Encourage resident to use call light and increase monitoring of resident were recommended changes. *6/6/14 time not documented: -Found flat on back on floor and was not sure what happened. -Complained of back pain. -Recommended and placed sensor pads in bed. *7/6/14 at 8:00 p.m.: -Found on floor. Stated she was trying to put her shoes on. -Bed sensor alarm had not alarmed. Battery not working. *7/12/14 at 5:00 p.m.: -No description of fall events documented. -Resident was confused. -Recommended call light within resident reach, and reminding resident to use call light. -No documentation as to sensor alarm working or not working. *9/8/14 at 4:02 a.m.: -Resident found on floor. She slipped out of bed. -Recommended increased monitoring. -No documentation as to sensor alarm working or not working. <p>Resident 2's 10/20/14 interdisciplinary care plan revealed:</p> <ul style="list-style-type: none"> *High risk for falls. *Fall on 4/8/14 lists recommendation as to "encourage to leave door open to room when she is in the room." No mention of non-slip stocking 	F 323		

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F 323	<p>Continued From page 34 use.</p> <p>*Fall on 5/25/14 stated "interventions reviewed - continue same." Nothing about the call light location was included.</p> <p>*Fall on 6/6/14 listed a sensor alarm to be used in wheelchair, chair, and bed.</p> <p>*Fall on 7/6/14 stated to change battery in sensor alarm. Noted to ensure alarm on and working every day. No further documentation that showed alarm battery was checked daily was found or provided.</p> <p>*Fall on 7/12/14 stated "interventions reviewed-continue same." Nothing about the call light location was included.</p> <p>*Fall on 9/8/14 stated "interventions reviewed-continue same." There was nothing about increasing monitoring of the resident.</p> <p>Review of resident 2's 4/25/14 Care Area Assessment (CAA) revealed the following areas were identified as concerns:</p> <ul style="list-style-type: none"> *Cognitive loss (ability to think and reason). *Activities of daily living. *Urinary incontinence (unintentional loss of urine). *Falls. *Nutritional status. *Dehydration/fluid maintenance. *Pressure ulcers (inflammation, sore, open wound that forms whenever prolonged pressure is applied to skin covering a bony area of the body). *Pain. <p>Interview on 10/29/14 at 3:30 p.m. with RN D revealed resident 2:</p> <ul style="list-style-type: none"> *Had frequent falls. *Tried to remain as independent as possible. *Wanted the door to her room closed. *Had declined when thickened liquids were 	F 323		

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F 323	Continued From page 35 started and had improved since liquids were no longer thickened. -She thought the decline had contributed to the frequent falls. Surveyor: 32335 5. Review of the provider's February 2014 Accidents, Falls, and Safety policy revealed: *An individualized plan of care would be developed and implemented for residents at risk for falling. *Staff should have documented the fall and any intervention changes on the care plan. *If the resident had struck their head during the fall or staff had suspected the resident had struck their head a neurological assessment should have been completed for twenty-four hours. *The policy had not addressed unwitnessed falls or completing pain assessments.	F 323			
F 441 SS=E	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, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	The policy on cleaning MJM bathrooms (E100) was reviewed and revised. Education on bathroom policy (E100) will be provided to all Environmental Services staff by the Environmental Services Director (ESD), on 11/19/14. Education will include manufacturer's product directions and contact time. Follow-up training will be done monthly at department meetings and a yearly competency will be completed by each Environmental Services employee.	12/19/14	

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F 441	<p>Continued From page 36</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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: 34030 Based on interview, policy review, and manufacturer's data review, the provider failed to ensure manufacturer's instructions were followed for the use of Quat disinfectant cleaner in all of the residents' bathrooms for three of four hallways: Dakota, Cedar, and Abbey. Findings include:</p> <p>1. Interview on 10/28/14 at 9:00 a.m. with housekeeper G on Dakota hall revealed she: *Sprayed Quat disinfectant cleaner onto the residents' bathroom surfaces. *Left it on those surfaces for forty-five seconds, then wiped it off with a clean dry cloth.</p>	F 441	<p>Monthly audits of Environmental Services staff will be completed by ESD or designee to assure appropriate disinfectant contact time is followed [REDACTED]</p> <p>Audits will be reported quarterly to the QA Committee by ESD or designee until advised to discontinue reporting by the QA Committee.</p>	

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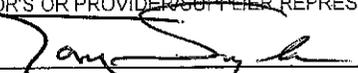
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F 441	<p>Continued From page 37</p> <p>Interview on 10/28/14 at 9:20 a.m. with housekeeper I on Abbey hall revealed she: *Sprayed Quat disinfectant cleaner onto the residents' bathroom surfaces. *Left it on those surfaces for twenty seconds, then wiped it off with a clean dry cloth.</p> <p>Interview on 10/28/14 at 10:05 a.m. with housekeeper H on Cedar hall revealed she: *Sprayed Quat disinfectant cleaner onto the residents' bathroom surfaces. *Left it on those surfaces for twenty minutes, then wiped it off with a clean dry cloth.</p> <p>Review of the provider's October 2013 policy on cleaning, disinfection, and trash disposal under transmission based precautions revealed "For all cleaning,.....healthcare approved disinfectants must be used. If disinfectant cloths are used, the area must remain wet for at least 1-2 minutes or as noted on the disinfectant."</p> <p>Interview on 10/29/14 at 1:30 p.m. with the head of housekeeping about the disinfection of the residents' bathrooms revealed she: *Had given me the above policy and highlighted the areas quoted. *Agreed housekeeping had not used disinfectant cloths as mentioned in the policy. *Agreed the contact time (time the Quat disinfectant was left on a surface to ensure all bacteria, viruses, and fungi were destroyed) should have been ten minutes.</p> <p>Review of the manufacturer's January 2012 technical data sheet revealed contact time to kill bacteria, viruses, and fungi was ten minutes.</p>	F 441		

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K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 10/28/14. Avera Mother Joseph Manor Retirement Community (building 01) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 10/29/14 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiency identified at K050 and K056 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 028 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers provide a minimum clear width of 32 inches (81cm) for swinging or horizontal doors. Vision panels are of fire-rated glazing or wired glass panels and steel frames. 19.3.7.5, 19.3.7.7 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation, measurement, and record review, the provider failed to maintain at least 32	K 028		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 11/24/14
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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.

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K 028	Continued From page 1 inches of clear width for one set of randomly observed smoke barrier doors (between the 1961 original building and the 1980 addition) opening. Findings include: 1. Observation at 9:00 a.m. on 10/28/14 revealed the cross-corridor doors from the 1961 original building and the 1980 addition measured 30 inches in clear width. Review of the previous survey report revealed those doors were part of the original construction. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K 028		F
K 032 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and record review, the provider failed to maintain at least two exits from the second level. Findings include: 1. Observation at 10:30 a.m. on 10/28/14 revealed the second level was not equipped with a conforming exit. The east and west stair enclosures discharged into the main level corridor system. Review of previous life safety code	K 032		F

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K 032	Continued From page 2 surveys confirmed those findings.	K 032		
K 033 SS=C	<p>The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and record review, the provider failed to maintain a one-hour fire-resistive path of egress from the second level to the exterior of the building. Two randomly observed stair enclosures discharged into the main level corridor system. Findings include:</p> <p>1. Observation at 11:00 a.m. on 10/28/14 revealed the east and west second level stair enclosures discharged into the main level corridor system. A one-hour fire-resistive path of egress was not provided to the exterior of the building. Review of the previous life safety code survey confirmed that finding.</p> <p>The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.</p>	K 033		F

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K 050 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure staff were familiar with fire drill procedures. Findings include:</p> <p>1. Observation at 1:15 p.m. on 10/28/14 during a fire drill revealed the nurse responding to the fire drill did not follow the R.A.C.E (Rescue, Alarm, Contain, Extinguish) procedure adopted by the provider. Upon finding the simulated fire in the resident's room the nurse exited the room and went to the nurse station to call 911. He did not rescue the residents from the room and did not close the door to the room to contain smoke and fire. The nurse then pulled the manual fire alarm pull station but failed to announce where the fire was located. The fire alarm summoned other nurses to respond to the appropriate building wing, but they were unsure where the fire was located. Staff began closing all the corridor doors to aid in containing the smoke and fire. The responding nurse then went to the resident's room where simulated fire was located and removed the residents to an adjacent smoke</p>	K 050	<p>Policy 2702, "Code Red Plan and Drills" was reviewed.</p> <p>Education on Policy 2702 will be provided for all staff by 12/19/14. All staff are considered part of the fire brigade and will receive education on R.A.C.E., P.A.S.S. and code red procedure during orientation and yearly.</p> <p>Monthly audits of code red drills will be completed by ADON to assure code red plan is followed as directed. There will be a staff critique after each fire drill.</p> <p>Audits will be reported quarterly to the QA committee by ADON or designee until advised by the committee to discontinue.</p>	12/19/14

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K 050	Continued From page 4 compartment. A second nurse then responded with a fire extinguisher and pretended to extinguish of the simulated fire. The nurse confirmed the fire was extinguished, and a code red all clear was called over the paging system. Interview with the assistant director of nursing revealed rescuing of residents was not a usual problem during fire drills. She was unsure why the R.A.C.E procedure was not followed.	K 050		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure the facility was protected throughout by automatic sprinklers in two randomly observed locations (walk-in cooler and freezer). Findings include: 1. Observation at 11:10 a.m. on 10/28/14 revealed a kitchen in the central service area.	K 056	Western States Fire Protection will install a sprinkler system in the walk-in cooler and freezer by 12/12/14. Western States will add these sprinklers to its preventive maintenance check list. Verification of the completion of the sprinkler system installation and the check list will be presented to the next QA committee meeting by director of plant operations.	12/19/14

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K 056	Continued From page 5 Further observation of the walk-in cooler and freezer within that kitchen revealed those areas were not provided with sprinkler protection. All rooms in a complete automatic fully sprinkled NFPA 13 facility shall be provided with sprinkler protection. Interview with the maintenance supervisor at the time of the observation revealed he was unaware of that requirement.	K 056			

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number 435042	Provider/Supplier Name AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY
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Type of Survey (select all that apply)

I	H			
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- A Complaint Investigation
- B Dumping Investigation
- C Federal Monitoring
- D Follow-up Visit
- M Other
- E Initial Certification
- F Inspection of Care
- G Validation
- H Life Safety Code
- I Recertification
- J Sanctions/Hearing
- K State License
- L CHOW

Extent of Survey (select all that apply)

A				
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- A Routine/Standard Survey (all providers/suppliers)
- B Extended Survey (HHA or Long Term Care Facility)
- C Partial Extended Survey (HHA)
- D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 32334	10/28/2014	10/28/2014	2.00	0.00	6.50	0.00	5.00	6.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours.....	0.00	Total RO Supervisory Review Hours.....	0.00
Total SA Clerical/Data Entry Hours....	0.00	Total RO Clerical/Data Entry Hours.....	0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

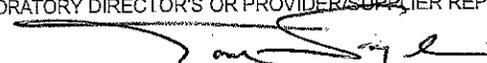
ORIGINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10590	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/30/2014
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NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR RETIREMEI	STREET ADDRESS, CITY, STATE, ZIP CODE 1002 N JAY STREET ABERDEEN, SD 57401
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 000	Initial Comments Surveyor: 32331 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 10/27/14 through 10/30/14. Avera Mother Joseph Manor Retirement Community was found not in compliance with the following requirement: S236.	S 000	2-Step TB policy action plan for New Employees	12/19/14
S 236	44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of Mantoux skin test to establish a baseline within 14 days of employment or admission to a facility. Any two documented Mantoux skin tests completed within a 12 month period prior to the date of admission or employment shall be considered a two-step. Skin testing is not necessary if documentation is provided of a previous positive reaction of ten mm induration or greater. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32335 Based on employee file review, interview, and policy review, the provider failed to ensure one of four sampled new employees (A) received the	S 236	Employee Health reviewed and revised the policy for Tuberculosis Control Program for Employees. New employee files were reviewed by Employee Health to ensure requirements for Mantoux completion were met. 1. A NCR form will be developed that will be located at the point of TB plant (Employee Health or Business Health). When the nurse plants the TB they will document the date and record the follow up date. Employee will be given the NCR copy and asked to follow up in 48-72 hours with Employee Health to have it read. The original form will be sent to Employee Health. 2. When the employee has the TB	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 11/24/14
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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10590	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/30/2014
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NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR RETIREMEI	STREET ADDRESS, CITY, STATE, ZIP CODE 1002 N JAY STREET ABERDEEN, SD 57401
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 236	<p>Continued From page 1</p> <p>two-step tuberculin (TB) screening within fourteen days of being hired. Findings include:</p> <p>1. Review of employee A's file revealed her date of having been hired was 9/30/14. The two-step TB screening had not been completed until 10/28/14. That was four weeks after her date of having been hired.</p> <p>Interview on 10/29/14 at 9:30 a.m. with employee health nurse M revealed: *The two-step TB screenings had not been completed within the required fourteen days of having been hired for employee A. *She thought they had thirty days to complete the TB screening.</p> <p>Review of the provider's January 2014 Pre-Employment Physical policy revealed: **"A two step is required within fourteen days of hire." *The first step must be read forty-eight to seventy-two hours after it was given. *Those who had a negative reaction should have been given the second step with the intent to be completed within fourteen days of being hired.</p>	S 236	<p>read, they will be given a date to come back for the second step, this will be recorded on the form. When the employee comes to have the 2nd step planted they will then be given a follow up date, this will be recorded on the form and copy to the employee.</p> <p>3. As a checks and balance, all new employees hired will have a system generated alert that will be sent to the Employee Health nurse and HR Officer if a TB is not completed within 10 days of hire (start) date. Employee Health will notify the employee that they need to complete all steps within 14 days. If all steps are not completed within 14 calendar days of Employee Hire Date, the HR Officer will suspend employee and notify manager until all steps are completed.</p> <p>Monthly audits will be completed by the Employee Health Nurse on new employees for completion of 2-step Mantoux by Employee Health.</p> <p>Audits will be reported to the QA committee by ADON or designee until advised to discontinue.</p>	
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