

ORIGINAL

PRINTED: 06/23/2014  
FORM APPROVED

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10591</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER <b>MORNINGSIDE MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 CHURCH STREET, PO BOX 500 ALCESTER, SD 57001</b>
--	--

(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
--------------------	--	---------------	---	--------------------

S 000 Initial Comments

Surveyor: 32335  
A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 6/10/14 through 6/12/14. Morningside Manor was found not in compliance with the following requirements: S253 and S437.

S 000

Addendums noted with an asterisk per 6/11/14 telephone to facility administrator. KE/SDDOH/MF

S 253 44:04:04:11.01 SECURED UNITS

Each facility with secured units must comply with the following provisions:  
 (1) A physician's orders for confinement that includes medical symptoms that warrant seclusion or placement must be documented in the...resident's chart and must be reviewed periodically by the physician;  
 (2) Therapeutic programming must be provided and must be documented in the overall plan of care;  
 (3) Confinement may not be used as a punishment or for the convenience of the staff;  
 (4) Confinement and its necessity must be based on a comprehensive assessment of the...resident's physical and cognitive and psychosocial needs, and the risks and benefits of this confinement must be communicated to the...resident's family;  
 (5) Locked doors must conform to Sections 18.2.2.2.4 and 19.2.2.2.4 of NFPA 101 Life Safety Code, 2000 edition; and  
 (6) Staff assigned to the secured unit must have specific training regarding the unique needs of...residents in that unit. At least one caregiver must be on duty on the secured nursing unit at all times.

S 253

(1) Nurse Aide D, along with all staff will attend an All Staff In-service on 07/16/14. The in-service will be "Understanding the World of Dementia/The Person and Disease." This is Module I in the Hand-in-Hand Series.  
 (2) All new hires will watch Module I of the Hand-in-Hand Series as part of their orientation.  
 (3) The secretary will review the orientation check list for all new employees to make sure they watch Module I of the Hand-in-Hand Series. The secretary will complete an audit monthly for 12 months. She will give the audit report to the Administrator who will report monthly to the QA Committee. After 12 months, the QA Committee will determine if audits need to continue.

08/01/14

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

*Dorenda Marten*

RECEIVED

HGEF11  
JUL 31 2014

SD DOH L&C

RECEIVED

07/02/14

JUL 10 2014

SD DOH L&C

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10591</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/12/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>MORNINGSIDE MANOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 CHURCH STREET, PO BOX 500 ALCESTER, SD 57001</b>	
(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
S 253	<p>Continued From Page 1</p> <p>This Rule is not met as evidenced by: Surveyor: 33265 A. Based on record review, interview, and policy review, the provider failed to ensure there were physician's orders for admission and continued stay in the memory support unit for one of twelve residents (6). Findings include:</p> <p>1. Review of resident 6's complete medical record revealed: *The resident was admitted into the memory support unit on 11/8/13 and remained in the memory support unit. *Written orders signed by the physician on 11/8/13 at admission had not included an order for admission to the memory support unit. *Physician's orders signed on 11/27/13 included a handwritten order for being in the memory support unit. *Physician's orders signed on 11/29/13 had not included an order for being in the memory support unit. *Physician's orders signed on 12/12/13 included a handwritten order for being in the memory support unit.</p> <p>Interview with the director of nursing on 6/11/14 at 1:00 p.m. revealed she agreed: *There had been no admission order for the memory support unit. *There had not been consistent physician's orders for resident 6 to remain in the memory support unit.</p> <p>Review of the provider's 8/22/12 special care/secured unit admission criteria policy revealed: *A physician's order should have been obtained that stated the individual required care in the memory support unit. *The physician should have provided</p>	S 253	<p>(1)Resident 6 now has an order for admission to the Special Care Unit (SCU) (memory care unit)) on 01/24/14. The original order did include a hand written order for admission to the SCU. This was not transcribed to Omnicare. The order was included on Omnicare physician order, medication and treatment sheet on 12/12/13. The order is now on the physician order, medication and treatment sheet.</p> <p>(2)There was an in-service on 07/02/14 to review transcription orders, admit orders, signing of doctor's orders and clarification of doctor orders for admission to the Special Care Unit (SCU) (memory care unit) along with medical reasons documented why placement in the SCU is necessary. There will be 72 hour checks for admission orders.</p> <p>(3) The DON will audit the 72 hour checks for admission. This will be done weekly for four weeks and then monthly for 11 months. The DON will bring the audit results to the QA Committee monthly. After 11, months, the QA Committee will determine if the audits need to continue.</p> <p style="text-align: right;"><i>08/10/14 D.M. 07/23/14</i></p>

\*   
KLEDDH/MF

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10591</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/12/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>MORNINGSIDE MANOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 CHURCH STREET, PO BOX 500 ALCESTER, SD 57001</b>		
(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
S 253	Continued From Page 2  documentation upon visits to the resident of continued need for residing in the memory support unit.  B. Based on record review, interview, and policy review, the provider failed to train each staff member before being assigned to work in the memory support unit on the special needs of the twelve residents residing in the memory support unit. Findings include:  1. Review of nursing aid D's orientation file revealed she had: *Been hired on 4/4/14. *Not had training on the special needs of the residents in the memory support unit. *Worked on the memory support unit.  Interview with the administrator on 6/11/14 at 2:30 p.m. revealed they had not been providing education on the special needs of the residents in the memory support unit to new employees during orientation or before being assigned to work in the memory support unit.  Review of the provider's 8/22/12 special care/secured unit admission criteria policy revealed nine specific characteristics and needs identified as belonging to residents in the memory support unit.	S 253		
S 437	44:04:17:06 Right To Manage Financial Affairs  A resident may manage personal financial affairs. A facility may not require residents to deposit their personal funds with the facility. If the resident chooses to deposit funds with the facility and gives written authorization, the facility must hold the funds in accordance with SDCL	S 437	(1)There is no specific resident identified on the CMS2567.	

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10591</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/12/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>MORNINGSIDE MANOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 CHURCH STREET, PO BOX 500 ALCESTER, SD 57001</b>		
(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
S 437	Continued From Page 3  34-12-15.1 to 34-12-15.10, inclusive.  This Rule is not met as evidenced by: Surveyor: 32335 Based on record review and interview, the provider failed to have proper insurance coverage for the resident trust account. Findings include:  1. Review of the current resident trust fund surety bond dated 7/10/03 revealed coverage in the sum of \$10,000.  Review of the resident trust fund bank reconciliation records revealed from 8/31/14 through 4/30/14 the resident trust fund amount had ranged from \$10,830.84 to \$13,804.14.  Interview on 6/12/14 at 9:00 a.m. with the administrator confirmed they had more money in the resident trust fund than they had coverage for. They would have to increase the surety bond.	S 437	(2)Administrator contacted HCIS/Vaaler Insurance, Inc. on 06/12/14. They contacted Nationwide who insures Morningside Care Center's Surety Bond. Effective 06/12/14 the Surety Bond was increased to \$20,000.00. (3)The Secretary in charge of the Resident Trust Accounts will print off the bank reconciliation at the end of every month. She will use this to complete an audit monthly for 12 months. She will give the audit report to the administrator monthly who will bring the audit to the QA Committee monthly meeting, After 12 months, the QA Committee will decide if the audits need to continue.	08/01/14

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

ORIGINAL

PRINTED: 06/23/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435062</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/12/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>MORNINGSIDE MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 CHURCH STREET POST OFFICE BOX 500 ALCESTER, SD 57001</b>
--	--

(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) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 32335 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/10/14 through 6/12/14. Morningside Manor was found not in compliance with the following requirement(s): F252, F271, F281, and F371.</p> <p><b>F 252 SS=E</b> 483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 A. Based on observation and interview, the provider failed to maintain a homelike environment by not controlling a strong urine odor in the memory support unit. Findings include:</p> <p>1. Observation on 6/10/14 at 8:50 a.m. in the memory support unit revealed: *A very offensive urine odor when the main unit entrance door was opened. *The odor continued in the hallway to the sitting area before the kitchen.</p> <p>Observation on 6/10/14 at 11:15 a.m. in the memory support unit revealed the offensive urine odor was still present.</p> <p>Observation and interview on 6/11/14 at 3:15 p.m.</p>	F 000	<p>Addendums noted with an asterisk per 6/14/14 telephone to facility administrator. KG/ODDH/ME</p> <p>(1) Residents in room 139 have the following plan of correction. The cloth chair has been removed. Staff now supervise when the resident is using the bathroom. A bathroom door alarm will be installed so that staff are alerted each time one of the resident's enter the bathroom. Staff will encourage the resident to sit down to urinate to keep the floor free of urine. A bleach tablet will be placed in the back of the toilet to help eliminate odors each time the toilet is flushed. Staff will cue the residents about the need to go to the bathroom every two hours. If needed, staff can use the new spray product for use on urine areas. The staff started using a hospital grade disinfectant to mop the floors in room 139 on 06/20/14. On 06/20/14, staff started using a hospital grade disinfectant to mop all the floors in the nursing home, including room numbers 127, 129, 130, 134, 139, 145 and 146.</p> <p>(2) If a room becomes the source of an offensive urine odor, the resident's toileting needs will be evaluated to see if a bathroom door</p>	K8/10/14 KG/ODDH/ME
-------	--	-------	---	------------------------

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Dorinda Hatten</i>	TITLE <i>Administrator</i>	(X6) DATE <i>07/02/14</i>
--	-------------------------------	------------------------------

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.

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

PRINTED: 06/23/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435062</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/12/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>MORNINGSIDE MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 CHURCH STREET POST OFFICE BOX 500 ALCESTER, SD 57001</b>
--	--

(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) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 252	<p>Continued From page 1</p> <p>with certified nursing assistant A revealed:</p> <ul style="list-style-type: none"> <li>*The offensive urine odor was present.</li> <li>*She had smelled the odor at 2:00 p.m. when she entered the memory support unit to begin her shift.</li> <li>*In room 139 there had been urine in the toilet and on the floor around the toilet bowl.</li> <li>*She had not attempted to mop the floor and had not flushed the toilet.</li> </ul> <p>Interview on 6/11/14 at 3:40 p.m. with the administrator, director of nursing, and maintenance supervisor regarding the urine odor in the memory support unit revealed:</p> <ul style="list-style-type: none"> <li>*The hallway smelled like urine.</li> <li>*Room 139 still had urine in the toilet bowl and on the floor.</li> <li>*All agreed the smell had been offensive.</li> <li>*Housekeeping was responsible for mopping the floors one time per day.</li> <li>*The nursing staff should have mopped up any urine on the floors and flushed toilets as needed.</li> </ul> <p>B. Based on product review and interview, the provider failed to use a cleaning disinfectant on the floors in seven of seven shared residents' rooms (127, 129, 130, 134, 139, 145, and 146). Findings include:</p> <p>1. Interview and product review on 6/12/14 at 8:20 a.m. with the housekeeping and laundry supervisor revealed she used 3M Neutral Cleaner Concentrate on all the floors including rooms that had two residents in them (127, 129, 130, 134, 139, 145, and 146). She did not know if the product was a disinfectant.</p> <p>Phone interview on 6/12/14 at 9:00 a.m. with the account manager at the product distributor's</p>	F 252	<p>alarm would be appropriate. Staff will cue residents about the need to go to the bathroom every two hours. Staff will encourage the resident to sit down to urinate to keep the floor free of urine. If needed, the nursing/housekeeping staff will use the new spray product for use on urine areas. The staff now use a hospital grade disinfectant to mop in the Special Care Unit (SCU). Nursing staff know they are to mop the floors as needed throughout the day to keep the unit free Staff know they are to flush stools and mop up urine around the stools immediately. All the above items in number 1 and 2 above were presented at a nurse aide in-service in 06/26/14. A demonstration was given by the Special Care Unit Coordinator about the proper way to use the new mop system and the new 3M disinfectant that is a hospital grade disinfectant. (Facility has been using the new disinfectant since 06/20/14). Nursing Staff are to mop as needed. Housekeepers will continue to mop the Special Care Unit one time a day. More mop handles are being ordered to make sure there are enough for the nurse aides to use in all areas of the</p>	
-------	--	-------	---	--

20

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

PRINTED: 08/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435062</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/12/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MORNINGSIDE MANOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 CHURCH STREET POST OFFICE BOX 500 ALCESTER, SD 57001</b>		
(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) COMPLETION DATE
F 252	<p>Continued From page 1</p> <p>with certified nursing assistant A revealed: *The offensive urine odor was present. *She had smelled the odor at 2:00 p.m. when she entered the memory support unit to begin her shift. *In room 139 there had been urine in the toilet and on the floor around the toilet bowl. *She had not attempted to mop the floor and had not flushed the toilet.</p> <p>Interview on 6/11/14 at 3:40 p.m. with the administrator, director of nursing, and maintenance supervisor regarding the urine odor in the memory support unit revealed: *The hallway smelled like urine. *Room 139 still had urine in the toilet bowl and on the floor. *All agreed the smell had been offensive. *Housekeeping was responsible for mopping the floors one time per day. *The nursing staff should have mopped up any urine on the floors and flushed toilets as needed.</p> <p>B. Based on product review and interview, the provider failed to use a cleaning disinfectant on the floors in seven of seven shared residents' rooms (127, 129, 130, 134, 139, 145, and 146). Findings include:</p> <p>1. Interview and product review on 6/12/14 at 8:20 a.m. with the housekeeping and laundry supervisor revealed she used 3M Neutral Cleaner Concentrate on all the floors including rooms that had two residents in them (127, 129, 130, 134, 139, 145, and 146). She did not know if the product was a disinfectant.</p> <p>Phone interview on 6/12/14 at 9:00 a.m. with the account manager at the product distributor's</p>	F 252	<p>X (3) An audit specific to the presence or absence of odor will be completed by the Special Care Unit Coordinator and brought to the QA Committee monthly. The audits will be done weekly times four weeks and then monthly times eleven months. The Special Care Unit Coordinator will give the audits to the Director of Nurses, who will report to the QA Committee monthly. At that time the QA Committee will determine if the audits need to continue.</p> <p style="text-align: right;"><i>KEISDORH/MF</i></p>	

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

PRINTED: 08/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435062</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/12/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MORNINGSIDE MANOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 CHURCH STREET POST OFFICE BOX 500 ALCESTER, SD 57001</b>		
(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) COMPLETION DATE
F 252	<p>Continued From page 1</p> <p>with certified nursing assistant A revealed:</p> <ul style="list-style-type: none"> <li>*The offensive urine odor was present.</li> <li>*She had smelled the odor at 2:00 p.m. when she entered the memory support unit to begin her shift.</li> <li>*In room 139 there had been urine in the toilet and on the floor around the toilet bowl.</li> <li>*She had not attempted to mop the floor and had not flushed the toilet.</li> </ul> <p>Interview on 6/11/14 at 3:40 p.m. with the administrator, director of nursing, and maintenance supervisor regarding the urine odor in the memory support unit revealed:</p> <ul style="list-style-type: none"> <li>*The hallway smelled like urine.</li> <li>*Room 139 still had urine in the toilet bowl and on the floor.</li> <li>*All agreed the smell had been offensive.</li> <li>*Housekeeping was responsible for mopping the floors one time per day.</li> <li>*The nursing staff should have mopped up any urine on the floors and flushed toilets as needed.</li> </ul> <p>B. Based on product review and interview, the provider failed to use a cleaning disinfectant on the floors in seven of seven shared residents' rooms (127, 129, 130, 134, 139, 145, and 146). Findings include:</p> <p>1. Interview and product review on 6/12/14 at 8:20 a.m. with the housekeeping and laundry supervisor revealed she used 3M Neutral Cleaner Concentrate on all the floors including rooms that had two residents in them (127, 129, 130, 134, 139, 145, and 146). She did not know if the product was a disinfectant.</p> <p>Phone interview on 6/12/14 at 9:00 a.m. with the account manager at the product distributor's</p>	F 252	<p>The new mop system uses a handle with a flat base that sticks to a pad on the flat base and handle. The flat mop system was purchased from Heartland Paper Company on 01/22/14. When the Center began using the new flat mop system, The Account Manager for Heartland Paper Company came to the center and trained/demonstrated the use of the new flat mop system to the Housekeeping/Laundry Supervisor. The Housekeeping/Laundry Supervisor trained all the department director's whose staff needed to use the new system. The department director's trained their staff. The Housekeeping/Laundry Supervisor trained the Special Care Unit Coordinator how to use the new mop system and the new 3M disinfectant that is hospital grade. According to 3M, product manufacturer, the directions for cleaning, disinfecting and deodorizing is as follows:</p> <p>Remove heavy soil deposits from surface. Then thoroughly wet surface with a use-solution of ½ ounce of concentrate per gallon of water or equivalent. Let solution remain on surface for a minimum of 10 minutes. Staff uses a premixed dispenser that mixes the appropriate amount of</p> <p style="text-align: right;"><i>KL/SDDCH/MF</i></p>	

*nc*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435062</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/12/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MORNINGSIDE MANOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 CHURCH STREET POST OFFICE BOX 500 ALCESTER, SD 57001</b>		
(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) COMPLETION DATE
F 252	<p>Continued From page 1</p> <p>with certified nursing assistant A revealed: *The offensive urine odor was present. *She had smelled the odor at 2:00 p.m. when she entered the memory support unit to begin her shift. *In room 139 there had been urine in the toilet and on the floor around the toilet bowl. *She had not attempted to mop the floor and had not flushed the toilet.</p> <p>Interview on 6/11/14 at 3:40 p.m. with the administrator, director of nursing, and maintenance supervisor regarding the urine odor in the memory support unit revealed: *The hallway smelled like urine. *Room 139 still had urine in the toilet bowl and on the floor. *All agreed the smell had been offensive. *Housekeeping was responsible for mopping the floors one time per day. *The nursing staff should have mopped up any urine on the floors and flushed toilets as needed.</p> <p>B. Based on product review and interview, the provider failed to use a cleaning disinfectant on the floors in seven of seven shared residents' rooms (127, 129, 130, 134, 139, 145, and 146). Findings include:</p> <p>1. Interview and product review on 6/12/14 at 8:20 a.m. with the housekeeping and laundry supervisor revealed she used 3M Neutral Cleaner Concentrate on all the floors including rooms that had two residents in them (127, 129, 130, 134, 139, 145, and 146). She did not know if the product was a disinfectant.</p> <p>Phone interview on 6/12/14 at 9:00 a.m. with the account manager at the product distributor's</p>	F 252	<p>concentrate per gallon of water. Staff has been trained on the use of the premixed dispenser.*</p> <p>Housekeeping/Laundry Supervisor learned the proper procedure from the directions on the container of the new 3M disinfectant directions on the container. On 06/26/14, at a nurse aide in-service, a demonstration was provided how to use the new mop system and the new 3M disinfectant. The same demonstration and education was provided at the All-Staff In-service on 07/16/14. The Housekeeping/Laundry Supervisor will continue to make sure that the premixed dispenser is working appropriately*<i>TIMES 1 MONTH</i></p> <p><i>KEISDDOH/MF</i></p> <p><i>and instructions for mixing. All new staff will be trained on this procedure. KEISDDOH/MF</i></p>	

*nd*

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

PRINTED: 06/23/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435062</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/12/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MORNINGSIDE MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 CHURCH STREET POST OFFICE BOX 500 ALCESTER, SD 57001</b>	
(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) COMPLETION DATE
F 252	Continued From page 2 company with the administrator present revealed the 3M Neutral Cleaner Concentrate was not a disinfectant or sanitizer.	F 252		
F 271 SS=D	483.20(a) ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE  At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.  This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on record review, interview, and policy review, the provider failed to obtain a signed physicians' orders for two of two residents (6 and 10) upon admission. Findings include:  1. Review of resident 6's complete medical record revealed: *He had been admitted on 11/8/13. *He had admission orders to the facility that were not signed by a physician on or since admission. *The unsigned orders located in the medical record included the: -Standing orders sheet. -Provider general admission orders sheet.  2. Review of resident 10's complete medical record revealed: *Resident 10 had been admitted on 5/6/14. *He had admission orders to the facility that were not signed by a physician on or since admission. *The unsigned orders located in the medical record included the: -Hand written admission orders sheet. -Do not resuscitate (DNR) order form.	F 271	(1)Resident 6 had the standing orders signed by the physician on 06/11/14. Resident 6's physician signed the admit to SCU on 01/24/14. In future, will have orders faxed to physician for signature on day of admission.. The center will check in 72 hours to make sure that physician signed the orders. Provider general admission order sheet will be faxed to Omnicare on the date of admission. Resident 10s physician signed his admission orders on 06/11/14. The physician signed the Do Not Resuscitate (DNR) order on 06/13/14. The standing orders were signed by physician on 07/01/14. In future, will have orders faxed to physician for signature on day of admission. The center will check in 72 hours to make sure that physician signed the orders. Provider general admission order sheet will be faxed to Omnicare on the date of admission. (2)DON reviewed and revised as necessary the policy and procedure about receipt of orders. An in-service on 07/02/14 for all RNs and LPNs reviewed all policies and procedures for admission orders, standing orders,	x 06/01/14 KJ/KDD/HME

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

PRINTED: 08/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435062</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/12/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MORNINGSIDE MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 CHURCH STREET POST OFFICE BOX 500 ALCESTER, SD 57001</b>	
(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) COMPLETION DATE
F 252	Continued From page 2	F 252		
F 271 SS=D	<p>company with the administrator present revealed the 3M Neutral Cleaner Concentrate was not a disinfectant or sanitizer.</p> <p>483.20(a) ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE</p> <p>At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on record review, interview, and policy review, the provider failed to obtain a signed physicians' orders for two of two residents (6 and 10) upon admission. Findings include:</p> <p>1. Review of resident 6's complete medical record revealed: *He had been admitted on 11/8/13. *He had admission orders to the facility that were not signed by a physician on or since admission. *The unsigned orders located in the medical record included the: -Standing orders sheet. -Provider general admission orders sheet.</p> <p>2. Review of resident 10's complete medical record revealed: *Resident 10 had been admitted on 5/6/14. *He had admission orders to the facility that were not signed by a physician on or since admission. *The unsigned orders located in the medical record included the: -Hand written admission orders sheet. -Do not resuscitate (DNR) order form.</p>	F 271	<p>orders and provider general admission order sheet. Also, signing of doctor order sheets. A new system will be implemented 07/02/14 for 72 hour physician order checks by two nurses to double check everything for orders. (3)The DON will complete a weekly audit times four weeks and then a monthly audit for 11 months. The audit will include admit orders, signing of doctor's orders timely, hand written admission order sheet, DNR order form, standing admission order sheet, standing order sheet and provider general admit sheet. The DON will bring the results of the audits to the QA Committee monthly. At that time the QA Committee will determine if the audits need to continue.</p> <p><i>The DON will bring the audits to the QA Committee monthly, for 11 months.</i> <i>DM 07/31/14</i> <i>KG/SDDH/ME</i></p>	

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

PRINTED: 06/23/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435062</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/12/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>MORNINGSIDE MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 CHURCH STREET POST OFFICE BOX 500 ALCESTER, SD 57001</b>
--	--

(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) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 271	Continued From page 3 -Standing admission order sheet. -Standing orders sheet. -Provider general admission orders sheet.  3. Interview on 6/11/14 at 1:00 p.m. with the director of nursing revealed she agreed there were unsigned physicians' admission orders in both resident 6 and 10's medical record.  Review of the provider's 12/27/10 Physician Orders policy revealed admission orders were required at the time of admission to the facility.  Review of the provider's 12/29/10 Physician Services policy revealed physicians were to have signed and dated all orders.	F 271		
F 281 SS=E	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: 33265 Based on record review, interview, and policy review, the provider failed to clarify physicians' orders for one of ten sampled residents (6). Findings include:  1. Review of resident 6's complete medical record revealed: *A do not resuscitate (DNR) order form was signed by the physician on admission on 11/8/13. -The resident's choice was to not be resuscitated. -There had been no order for DNR included on any order summary sheet following admission to	F 281	(1) Resident 6 had a signed Do Not Resucitate (DNR) order but it was not transcribed correctly to the Omnicare physician orders, medication and treatment sheet. The (DNR) is now on the Omnicare's physician orders, medications and treatment sheet. Order for mole skin to Resident 6's ear was on the treatment sheet. On 06/06/14 a physician ordered a non- stick dressing PRN to right ear. Even during the survey, this order replaced the order for mole skin. This order is on the treatment sheet. (2) Discontinuation of orders and clarification of orders were reviewed at an RN/LPN in-service on 07/02/14. Also clarified protocol if the resident	*06/10/14 KG/SDD/HMF

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

PRINTED: 06/23/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435062</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/12/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>MORNINGSIDE MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 CHURCH STREET POST OFFICE BOX 500 ALCESTER, SD 57001</b>
--	--

(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) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 281	<p>Continued From page 4 time of survey.</p> <p>Interview regarding resident 6 on 6/11/14 at 1:00 p.m. with the director of nursing (DON) revealed she agreed the DNR order had not been carried through and was not on the present order sheet dated 5/13/14.</p> <p>Review of resident 6's complete medical record also revealed: *An open area on both ears was identified on 4/8/14. A physicians' order for mole skin (protective fabric) to be applied to the ears every evening at bed time had been written on 4/9/14 and added to the treatment record. -The application of mole skin to the ears had not been done. -The treatment record for the mole skin application had not been signed during the month of April 2014.</p> <p>Interview regarding resident 6 on 6/12/14 at 9:12 a.m. with the DON revealed: *The resident would not allow anyone to touch his ears. *They had never attempted to place the mole skin on his ears. *They should have notified the physician of the inability to use the mole skin and gotten the order discontinued.</p> <p>Review of the providers' 12/27/10 Physician's Orders policy revealed: *Physician's orders should have been reviewed for completeness and accuracy, and clarified if necessary. *All orders were to have been reviewed for accuracy. *The physician was to have reviewed the medical</p>	F 281	<p>is non-compliant with physician orders. Reviewed policy for taking doctor orders, review for completeness of orders, clarified orders if necessary and review for accuracy, and treatment records. Continue with the 24 hour checks.</p> <p>(3)The DON will pull four medical records and review them weekly for four weeks and then monthly for 11 months. Records will be reviewed for completeness, clarification and accuracy. The DON will report to the QA Committee monthly. After 11 months, the QA Committee will determine if the audits need to continue.</p> <p><del>(1) Resident 6 now has an order for admission to the Special Care Unit (SCU) (memory care unit) on 01/24/14. The original order did include a hand written order for admission to the SCU. This was not transcribed to Omnicare. The order was included on Omnicare physician order, medication and treatment sheet on 12/12/13. The order is now on the physician order, medication and treatment sheet.</del></p> <p>(2) There was an in-service on 07/02/14 to review transcription orders, admit orders, signing of</p> <p><i>AM</i> <i>07/12/14</i></p>	
-------	---	-------	--	--

5a

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

PRINTED: 06/23/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435062</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/12/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>MORNINGSIDE MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 CHURCH STREET POST OFFICE BOX 500 ALCESTER, SD 57001</b>
--	--

(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) COMPLETION DATE
F 281	<p>Continued From page 4 time of survey.</p> <p>Interview regarding resident 6 on 6/11/14 at 1:00 p.m. with the director of nursing (DON) revealed she agreed the DNR order had not been carried through and was not on the present order sheet dated 5/13/14.</p> <p>Review of resident 6's complete medical record also revealed: *An open area on both ears was identified on 4/8/14. A physicians' order for mole skin (protective fabric) to be applied to the ears every evening at bed time had been written on 4/9/14 and added to the treatment record. -The application of mole skin to the ears had not been done. -The treatment record for the mole skin application had not been signed during the month of April 2014.</p> <p>Interview regarding resident 6 on 6/12/14 at 9:12 a.m. with the DON revealed: *The resident would not allow anyone to touch his ears. *They had never attempted to place the mole skin on his ears. *They should have notified the physician of the inability to use the mole skin and gotten the order discontinued.</p> <p>Review of the providers' 12/27/10 Physician's Orders policy revealed: *Physician's orders should have been reviewed for completeness and accuracy, and clarified if necessary. *All orders were to have been reviewed for accuracy. *The physician was to have reviewed the medical</p>	F 281	<p>Morningside Care Center's Policy and Procedure for 24 Hour Chart Checks. Purpose: (1) To ensure that Physician's orders are transcribed correctly. (2) To ensure resident's charts, MAR's or TAR's reflect the correct physician order in a timely fashion. Procedure: (1) After receiving a physician's order, transcribe to tri-sheets located in resident's chart. Flag top copy for the physician to sign. (2) Put yellow copy in bin for Resource Nurse, as well as a copy of the original order (if faxed or written by physician). (3) Finish transcribing and implementing orders per transcribing policy. (4) Resource nurse will follow up on these orders left in their bin within 24 hours, Monday-Friday. (5) If it is the weekend, Charge Nurse is responsible for doing their own 24 hour chart check. This policy and procedure will be on-going.</p>	

x   
5b of 8  
KANDOR/MF

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

PRINTED: 06/23/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435062</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/12/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>MORNINGSIDE MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 CHURCH STREET POST OFFICE BOX 500 ALCESTER, SD 57001</b>
--	--

(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) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 281  F 371 SS=D	<p>Continued From page 5 record and plan of care.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, interview, and policy review, the provider failed to: *Maintain serving temperatures at 140 degrees Fahrenheit (F) for ground meat during one of two meal services for residents. *Maintain sanitary conditions for multiple storage, prep, and sink surfaces in the kitchen. Findings include:</p> <p>1. Observation and interview on 6/10/14 from 5:05 p.m. through 5:55 p.m. of cook C revealed: *Temperatures for the following: -Ham 160 degrees F. -Ground meat 140 degrees F. -Pancakes 150 degrees F. -Strawberries 43 degrees F. *She had not taken the temperatures of the sandwiches. *At 5:30 p.m. this surveyor asked her to temp the last ground meat being served.</p>	F 281  F 371	<p>(1)There is no specific resident identified on the CMS2567.</p> <p>(2)The food temperatures will be monitored and recorded prior to service of all meals. If food temperatures are not 140 degrees or above prior to meal service the food item will be reheated to bring up to this temperature range. The temperature ranges were reviewed at a dietary in-service on 06/17/14 and this information will be reinforced on the temperature record.</p> <p>(3)The temperature records will be reviewed weekly by the Dietary Manager to ensure dietary staff is completing the food temperature record. A monthly audit will be done by the Dietary Manager to check the maintenance of food temperatures throughout meal service. The review of temperature records and monthly audit will be reported to the QA Committee monthly by the Dietary Manager for 11 months. At that time the QA Committee will determine if the audits need to continue.</p> <p><i>Education was provided to Cook C regarding temperatures and reheating food items.</i></p>	<p><i>08/01/14</i></p> <p><i>Products of In-service was 06/17/14. DMG 07/24/14.</i></p>
----------------------------	--	--------------------	---	---

*DMG 07/30/14*

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

PRINTED: 06/23/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435062</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/12/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>MORNINGSIDE MANOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 CHURCH STREET POST OFFICE BOX 500 ALCESTER, SD 57001</b>		
(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) COMPLETION DATE
F 371	<p>Continued From page 6</p> <p>*That temperature had been 95.7 degrees F. *She served that meat without reheating it. *That had been her normal process. *She would not have reheated the item in the microwave.</p> <p>Interview on 6/11/14 at 10:15 a.m. with the registered dietician revealed cook C should have reheated the ground meat.</p> <p>Review of the provider's 2000 Food Temperature policy revealed: **All hot food items must be served to the resident at the temperature of at least 140 degrees F at the time the resident received the food. *Normally hot foods will be 165 degrees F to 180 degrees F or higher when removed from the cooking heat source. If held at 160 degrees F to 180 degrees F this will ensure serving to the residents at 140 degrees F or above."</p> <p>2. Random observations from 6/10/14 through 6/12/14 revealed: *The hand sink in the kitchen had dirt on the edges and inside the sink. *The walk-in cooler and walk-in freezer doors were sticky to the touch. *Two of two white three drawer organizers had visible dirt and crumbs on the outside of them. *The cook's table had crumbs and debris on the bottom shelf scattered all over. *In the dining room the cabinet doors under the juice and water machines were sticky to the touch. *All of the above areas were used during the random observations.</p> <p>Interview and review of the cleaning schedule on</p>	F 371	<p><i>Cook C was present at the Dietary In-service on 06/17/14. Dm 07/23/14</i></p> <p>(1) There is no specific resident identified on the CMS2567. (2) The maintenance of sanitary conditions in the dietary department was addressed through a dietary in-service on 06/17/14. The cleaning schedules were reviewed at in-service and up dated to include areas cited by surveyor. Cleaning duties and expectation of all positions are on cleaning job duty log. Dietary staff is to sign when jobs are completed. (3) The Dietary Manager will review signed cleaning schedules weekly for completion. Monthly, each staff member's cleaning will be reviewed by dietary manager to ensure it meets standards. A sanitation audit will be completed monthly by the consultant dietitian for 6 months and as needed thereafter. The sanitation audit and cleaning schedule reviews will be reported to the QA Committee by the Dietary Manager. These audits will be completed for 11 months. At that time, the QA Committee will determine if the audits need to continue.</p>	<p><i>*K... [redacted]</i></p> <p><i>Dm 07/23/14</i></p> <p><i>*K... [redacted]</i></p>

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

PRINTED: 06/23/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435062</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/12/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MORNINGSIDE MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 CHURCH STREET POST OFFICE BOX 500 ALCESTER, SD 57001</b>		
(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) COMPLETION DATE	
F 371	Continued From page 7 6/11/14 at 10:15 a.m. with the registered dietician and cook B revealed the hand sink, walk-in cooler, walk-in freezer, and the cabinets in the dining room were not on the cleaning schedule. Cook B stated she cleaned the cook's table shelf on the weekends, but she had not worked the past weekend. The cleaning schedule had indicated it was to have been cleaned on Fridays.	F 371			

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

ORIGINAL

PRINTED: 06/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435062</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/11/2014</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>MORNINGSIDE MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 CHURCH STREET POST OFFICE BOX 500 ALCESTER, SD 57001</b>
--	--

(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) COMPLETION DATE
K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 6/11/14. Morning Side Manor was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Nanda Maite* TITLE *Administrative* (X6) DATE *07/02/14*

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.

JUL 10 2014  
If continuation sheet Page 1 of 1  
SD DOH L&C