

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

ORIGINAL

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2014
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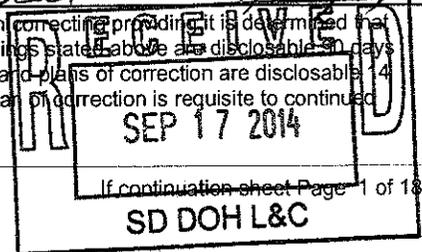
NAME OF PROVIDER OR SUPPLIER SUN DIAL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 410 SECOND STREET POST OFFICE BOX 337 BRISTOL, SD 57219
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F 000	INITIAL COMMENTS Surveyor: 32335 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/19/14 through 8/20/14. Sun Dial Manor was found not in compliance with the following requirement(s): F221, F226, F329, F428, and F441.	F 000	Addendums noted with an asterisk per 10/16/14 telephone to facility DON. KHSDDOCHIME	
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 16385 Based on observation, record review, interview, and policy review, the provider failed to ensure continued quarterly assessments for electric beds with attached quarter and half side panels (bed rails) had been completed for five of five sampled residents (1, 4, 5, 6, and 7) who had electric beds with attached side panels. Findings include: 1. Observation on 8/19/14 at 8:00 a.m. of resident 1's room revealed she had an electric bed with two attached half side panels (bed rails) in the up position. Review of resident 1's 5/30/14 care plan revealed she "has an electric bed with attached side panels - is able to reposition herself independently once into bed. Prefers standard	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Peggy Pearson</i>	TITLE <i>Administrator</i>	(X6) DATE <i>09/15/14</i>
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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 30 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 221	Continued From page 1 mattress." Review of resident 1's medical record revealed a Quarterly Review For Safety Equipment assessment had been completed on 9/5/12. There had been no quarterly assessment done since that date. Interview on 8/20/14 from 10:45 a.m. to 11:20 a.m. with resident 1 revealed she used the half side panels to reposition from side-to-side when in bed. 2. Observation on 8/19/14 at 7:50 a.m. of resident 6's room revealed she had an electric bed with two attached half side panels (bed rails) in the up position. Review of resident 6's 5/30/14 care plan revealed she "has electric bed with attached side panels on bed to aide with self-repositioning once into bed." Review of resident 6's medical record revealed a Quarterly Review For Safety Equipment assessment had been completed on 10/31/12. There had been no quarterly assessment done since that date. Interview on 8/20/14 from 2:00 p.m. to 2:30 p.m. with resident 6 revealed she used the half side panels to reposition herself in bed and to transfer out of bed to her wheelchair. Surveyor: 32332 3. Observation on 8/19/14 at 8:00 a.m. of resident 4's bed revealed two half side panels (bed rails), one on each side of the head of the bed.	F 221	F221 Resident 1's assessment for the use of side rails was completed on 9/4/14. [redacted] care plan updated on 9/5/14 ✓ [redacted] right side panel [redacted] "up during the day & night" and the left side panel [redacted] "up at night". * and assignment sheets were [redacted] * to reflect the following: the [redacted] F221- Resident 6's assessment for the use of side rails was on 9/8/14. [redacted] care plan [redacted] updated on 9/8/14 ✓ [redacted] left side panel "up for transfers & during the night" and the right side panel [redacted] "down at all times"; [redacted] was zip-tied in place on 9/8/14. * and assignment sheets were [redacted] * to reflect the following [redacted] * The right side panel [redacted]	

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F 221	Continued From page 2 Review of his updated 6/19/14 care plan revealed: *He required extensive assistance with bed mobility. *There was no indication the resident had or used bed rails. Review of his medical record revealed: *A 1/29/14 restorative therapy note indicated he used the half rails for independent repositioning. *A Quarterly Review of Safety Equipment assessment for an electric bed with attached side panels had been done quarterly from October 2011 through September 2012. *No assessment after September 2012 had been located for the use of the side panels. *No consent form for the use of the side panels. 4. Observation on 8/19/14 at 11:45 a.m. of resident 5's bed revealed one quarter side panel at the head of the bed facing the center of the room. Review of his updated 8/7/14 care plan revealed: *He required limited assistance with bed mobility. *There was no indication the resident had or used side panels. Review of his medical record revealed: *A 6/26/14 MDS summary by the MDS coordinator indicated he used a quarter side panel to position himself and rise from the bed. *No assessment for the use of the side panel. *No consent form for the use of the side panel. 5. Observation on 8/20/14 at 11:20 a.m. of resident 7's bed revealed one quarter side panel to the head of her bed facing the center of the	F 221	F221-Resident 4's assessment for side rail use was completed on 9/4/14. [redacted] care plan updated on 9/4/14. [redacted] right side rail "up for transferring in & out of bed only". The left side panel [redacted] "down at all times" and has been zip-tied down in place. * and assignment sheets were [redacted] * to reflect the following: his [redacted] F221- Resident 5's assessment for the use of side rails was completed on 9/4/14. [redacted] care plan updated on 9/4/14. Both of his side panels [redacted] "up day & night" (he lays in his bed on & off during the day also). A signed Consent Form was already on his chart. * should be [redacted] * and assignment sheets were [redacted]	

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F 221	<p>Continued From page 3 room.</p> <p>Review of her updated 5/8/14 care plan revealed: *She was able to reposition herself in bed. *She had an electric bed with attached side panels.</p> <p>Review of her medical record revealed: *A Quarterly Review For Safety Equipment assessment for a standard bed with one grab panel had been done quarterly from April 2012 through December 2012. *No assessment after December 2012 had been located. *No consent form for the use of the side rail.</p> <p>6. Interview on 8/19/14 at 3:30 p.m. with the Minimum Data Set (MDS) coordinator revealed: *The restorative therapist (RT) (B) had previously filled out a side rail (panel) assessment (safety equipment assessment) quarterly with each MDS. *When the charting changed over to electronic medical records she had stopped filling out the assessment and just added it to the RT documentation in the chart. *That documentation only indicated the side rails were being used; it had not indicated: -If the side rails were appropriate for the resident to use. -If the rails had been properly documented in the care plan.</p> <p>Interview on 8/20/14 at 3:50 p.m. with the director of nursing revealed: *Side rail panels were not being assessed routinely for appropriateness because they had not considered them to be a restraint. *Her expectation was the side rail panels should have been added to the care plan.</p>	F 221	<p>F221- Resident 7's assessment for the use of side rails was completed on 9/8/14, [redacted] care plan updated on 9/8/14. Her side rails [redacted] "down at all times" & they have been zip-tied down in place. Because they are not to be used, no consent form is needed on the chart.</p> <p>F221- The MDS Coordinator will complete a Restraint Use Assessment on each resident when their quarterly MDS is completed and with all significant change MDS's. At our weekly Interdisciplinary Team Meetings, we will discuss the appropriateness of any side rails in use and discuss possible reductions if they are currently in use. The MDS Coordinator will make the additions/corrections - <i>PLP</i> changes to the care plan as needed. Each week, the DON will randomly select 3 medical records to review for the completion of assessments, coding on the MDS, proper document-</p>	
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** Her K&S/DCH/ME*

** and assessment sheets were K&S/DCH/ME*

** should be K&S/DCH/ME*

** [redacted] K&S/DCH/ME*

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F 221	Continued From page 4 Review of the provider's 7/8/13 Policy and Procedure for Physical Restraints revealed: *The policy had not mentioned the use of side rail panels. *Steps followed to use a restraint would have included: -Proper assessment of the need for a restraint would be done by nursing staff. -A consent form would be signed by the resident or the resident's representative. -The interdisciplinary team would assess the need for the continuation of a restraint, discuss possible reduction, and would ensure proper documentation on the care plan and MDS. -Discussion of the restraint would occur quarterly with the MDS or when there was a significant change in the resident's status.	F 221	F221 cont'd from pg. 4) and whether there is a signed Consent Form in the chart. We will monitor this until we have 2 consecutive months with 100% compliance. The DON will report the results to the QA meeting on 10/8/14 and then continue to QA this for 2 more months. If not 100% compliant, we will continue to QA this until we have 2 consecutive months at 100% compliance.	
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and policy review, the provider failed to thoroughly investigate two of two incidents for abuse and neglect for one of one sampled resident (2) with cognitive (thinking) impairment. Findings include:	F 226	* The concerns with resident 2, could not be followed up on due to the time lapse. KESDDHMF F226-The DON put a binder together that includes the References Relevant to Events Reports, the 24-Hour Report Form, and the 5-Day Report Form. This is available at the Nursing Desk. The Charge Nurse will complete the Accident Report Form for all falls. A Required Nursing Facility Event Report will also be completed for all unobserved falls. The DOH will be notified by fax, email, or phone within 24 hours to inform them that there is an investigation	

* [Redacted] KESDDHMF

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F 226	<p>Continued From page 5</p> <p>1. Review of resident 2's medical record revealed: *An accident report for an unobserved fall dated 2/26/14. *An accident report for an unobserved fall dated 6/10/14. *No investigation documentation for the above falls to determine there was no abuse or neglect.</p> <p>Review of resident 2's 2/24/14 Minimum Data Set (MDS) assessment revealed: *Staff had not completed a resident interview for the Brief Interview for Mental Status section of the assessment. *She had problems with her short term memory. *Her thinking had been severely impaired for making daily decisions. *She had delusions (an unshakeable belief in something untrue).</p> <p>Review of resident 2's 8/9/14 MDS assessment revealed: *All the above areas were assessed the same. *She had hallucinations (a sensory experience of something that does not exist outside of the mind) as well as delusions.</p> <p>Random observations from 8/19/14 through 8/20/14 of resident 2 revealed she had a difficult time communicating with staff. She was unable to answer questions in a clear manner as she would become tearful. She spoke softly making it very hard to understand if she responded.</p> <p>Interview and record review on 8/19/14 at 5:00 p.m. and on 8/20/14 at 11:00 a.m. with the director or nursing regarding neglect and abuse investigations revealed: *Unobserved falls had been considered an</p>	F 226	<p><i>*for potential abuse or neglect in progress. K40000HMF</i></p> <p>F226 cont'd from pg. 5 A 5-Day Investigation Report will be completed. The DON will monitor the falls and incident reports to assure that all unobserved falls are reported and investigated. The DON will QA this and report the results to the QA meeting on 10/8/14 and at the following QA meeting. We will monitor this until we have 2 consecutive months in compliance.</p> <p>F226- There is an extensive note in the Interdisciplinary Notes of Resident 2 written by the SSC on 2/25/14 indicating that she (SSC) had talked with the resident and "due to her distress and confusion, the resident BIMS and mood assessments were not completed, looking at staff information instead." Further notes describe the resident's concerns and feelings.</p>	10/8/14
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F 226	Continued From page 6 incident and should have been investigated for abuse or neglect. *She had not used the Resident Abuse/Neglect Investigation Report Form. *She had not completed investigations for bruises of unknown origin. *There were no investigation reports for this surveyor to review that had been investigated and determined there was no need to report to the state department of health. *She had not completed interviews or followed the abuse and neglect policies for conducting an investigation. Review of the January 2012 Abuse Prevention and Protection of Resident Rights policy revealed: *Key components of the policy included: -"Identification of events and occurrences that may constitute or contribute to abuse, such as suspicious bruising. -Investigation, consisting of procedures for different types of incidents and identifying the staff members responsible for the initial reporting and investigation of an allegation." *Reports of resident abuse or neglect should have been promptly and thoroughly investigated. *The investigation should have consisted of: -"A review of the completed resident abuse report form. -An interview with the person(s) reporting the incident. -Interview with any witnesses to the incident. -An interview with the resident. -A review of the resident's medical record. -An interview of staff members on all shifts having contact with the resident during the period of the alleged incident. -Interview with the resident's roommate, family members, and visitors.	F 226	F226-The DON educated the nursing staff on the importance of reporting any bruises immediately to the Charge Nurse. The DON put together a binder with all the instructions and forms to complete for any bruise from an unknown origin. The binder includes the References Relevant to Event Reports, the 24-Hour Report Form, and the 5-Day Report Form. The Injury of Unknown Source Reporting Flowsheet is in the binder as a guide for reporting. A Nursing Facility Event Reporting form will be completed. The DOH will be notified by fax, email or phone within 24 hours that an investigation is taking place. The 5-Working Day Investigation Report will be completed and sent to DOH by fax, email, or phone. The DON will perform 2 skin assessment/week to assure all bruises are being reported. The DON will monitor the reports to assure proper documentation and investigations were done and will monitor for any patterns. The reports will be placed in the resident's medical record. The DON will report the results of her reviews at the QA meeting on 10/8/14. We will QA this until we are 100% compliant for 2 consecutive months. <i>*for potential abuse or neglect KESDDHMF</i>	

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F 226 F 329 SS=E	<p>Continued From page 7</p> <p>-A review of all circumstances surrounding the incident."</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to: *Have documented justification from the physician for duplicate drug therapy (receiving</p>	F 226 F 329		

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F 329	<p>Continued From page 8</p> <p>more than one medication for the same diagnosis) for one of one sampled resident (2) who was receiving three antidepressant medications.</p> <p>*List individualized targeted behaviors for two of four sampled residents (2 and 5) on psychotropic medications (any medication capable of affecting the mind, emotions, and behavior). Findings include:</p> <p>1. Review of resident 2's August 2014 medication administration record (MAR) revealed: *There had been three antidepressant medications listed. *The first antidepressant medication was Remeron started on 7/21/13. -She was to have taken 30 milligrams (mg) at bedtime. -The diagnosis was depression. *The second antidepressant medication was Trazodone HCL started on 2/11/14. -She was to have taken 50 mg at bedtime. -The diagnosis was dementia (the loss of mental functions such as thinking, memory, and reasoning that is severe enough to interfere with a person's daily functioning). *The third antidepressant medication was sertraline started on 7/24/14. -She was to have taken 75 mg at 8:00 a.m. -The diagnosis was depression.</p> <p>Review of resident 2's medical record revealed: *An admission date of 7/21/13. *An 8/3/13 Minimum Data Set (MDS) assessment that stated she had no significant weight loss. *She had diagnoses of depressive disorder, dementia, and anxiety. *Interdisciplinary notes from 8/2/13 through 8/19/14 had random documentation of her being</p>	F 329	<p><i>* An in-service was completed for nursing staff on 9/18/14 to educate them on the changes. KE/SDD/HMF</i></p> <p>F329- Resident 2 was seen by the physician on 8/22/14. Physician documented "psychotropics are monitored by [redacted] CNP". On 8/28/14, resident 2 was seen by [redacted] CNP who wrote "Documented psychotropic medications reviewed today. No GDR of any of the medications is recommended at this time due to her persistent mood lability. Any change in medications would most likely exacerbate her symptoms to the point that all gains made to this point would be lost. Will address again at time of her next appointment/ medication review." Meds were reviewed by pharmacist consultant on 9/5/14. Noted "Reviewed CNP's note on 8/28/14. No recommendations."</p> <p><i>* the mental health KE/SDD/HMF</i></p> <p><i>* 10/8/14 [redacted] KE/SDD/HMF</i></p>	
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F 329	<p>Continued From page 9</p> <p>"tearful" and/or "weepy." *Medication adjustments had been attempted by the certified nurse practitioner (CNP) from the contracted mental health services. *There had been no explanation from the CNP regarding the need for three antidepressants. *There had been no recommendations by the pharmacist to explain the duplicate drug therapy. *There had been no documentation by the physician of why she had been prescribed three antidepressant medications.</p> <p>Interview and record review on 8/19/14 from 5:15 p.m. through 5:45 p.m. and on 8/20/14 at 7:40 a.m. with the director of nursing (DON) regarding resident 2 revealed: *She was unable to locate any documentation that explained the need for administering three antidepressant medications to the resident. *She believed the Remeron had been started to assist in weight gain but could not find documentation from the primary physician, pharmacist, or CNP to support that. *She had recognized the Remeron had been a medication she had been on since admission.</p> <p>The pharmacist was unavailable for consult on 8/20/14.</p> <p>Review of the provider's 4/23/09 Psychotropic Drug Monitoring policy revealed there was no procedure for identifying or monitoring multiple medications for the same diagnosis.</p> <p>2a. Review of resident 2's August 2014 MAR revealed: *Four psychotropic medications. -Three of the four were antidepressant medications.</p>	F 329	<p>F329- The Social Services Coordinator will review psychotropic medications with each MDS to determine if there is any duplicate therapy. Care Team will review the Psychotropic Medication Quarterly Evaluation for appropriateness of duplicate therapy or reduction of meds on each MDS. This quarterly evaluation will be provided to the attending physician and mental health CNP and pharmacist on their rounds *by the DON.</p> <p><i>*MORTON K/SDDCHIME</i></p> <p><i>K/SDDCHIME</i></p>		

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F 329	<p>Continued From page 10</p> <p>-One of the four was an antianxiety medication.</p> <p>Review of resident 2's medical record revealed: *An admission date of 7/21/13. *She had diagnoses of depressive disorder, dementia, and anxiety. *Interdisciplinary notes from 8/2/13 through 8/19/14 had random documentation of her being "tearful" and/or "weepy." *There had been no other documentation for monitoring resident specific behaviors.</p> <p>Review of resident 2's 8/19/14 care plan revealed: *Nursing staff were to monitor for signs and symptoms of anxiety and depression. *Frequency of monitoring for those symptoms had not been addressed. *No resident specific targeted behaviors were addressed.</p> <p>Interview and record review on 8/19/14 from 5:15 p.m. through 5:45 p.m. with the DON regarding resident 2 revealed: *They had not monitored resident specific behaviors for her. *Nurses documented on a random basis for when she was tearful. *There were no resident specific behaviors listed on the care plan. Surveyor: 32332</p> <p>b. Review of resident 5's medical record revealed: *A 12/10/13 physician's order for Risperdal (medication for abnormal thoughts). *A 1/23/14 physician's order for Sertraline (medication for depression).</p> <p>Review of resident 5's medical record revealed</p>	F 329	<p>F329-Specific targeted behaviors were added to the care plan for Resident 2 on 9/11/14. * [REDACTED] KASDCH/ME</p> <p>F329- A resident monthly behavior flow sheet was completed for Residents 2 & 5. These targeted behaviors will be completed for all residents receiving psychotropic medications.</p> <p>F329-Specific targeted behaviors were added to the care plan for Resident 5 on 9/11/14. * [REDACTED] KASDCH/ME</p>	

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F 329	<p>Continued From page 11</p> <p>his 8/7/14 care plan had the following: *Problems of delirium (sudden severe confusion) and confusion with the staff approach being administration of Risperdal and Zoloft. *No indication of depressive symptoms or of the need to monitor for symptoms. *No indication of what delirium symptoms he had exhibited or what symptoms were to have been monitored. *No indication of who was supposed to monitor the above symptoms.</p> <p>Review of the interdisciplinary notes from 12/10/13 through 8/20/14 revealed: *A 6/24/14 MDS summary by the MDS coordinator revealed he received Zoloft for delirium. *A 6/20/14 note from the social services designee indicating no behavior issues.</p> <p>c. Interview on 8/20/14 at 2:50 p.m. with the social services designee revealed: *She documented on behaviors and moods of residents receiving psychoactive medications quarterly with the MDS assessments. *She was not sure if the nursing department had documented behaviors or moods anywhere. *There had not been daily documentation for the physician or pharmacist to review to see if the medications were helping the resident's symptoms.</p> <p>Review of the provider's 4/23/09 Policy Statement for residents who were receiving psychotropic medications revealed: *Those residents were to have documentation of psychotropic drug monitoring in their medical records. *The residents physicians, physician's assistants,</p>	F 329	<p>F329-Resident 5 was seen by physician on 8/30/14 with no changes in psychotropic medications. Will be seen by [redacted] CNP in Sept. 2014. She will then be able to review the new flowsheets. Resident 5's Resident Monthly Behavior Monitoring Flowsheet was implemented on 9/15/14 to address targeted behaviors and effectiveness of medications. These targeted behaviors will be completed for all residents receiving psychotropic medications.</p> <p>*the mental health KESDDCHIME</p> <p>F 329-Social Services Coordinator will monitor the monthly behavior monitoring flowsheet for targeted behaviors and address on the quarterly evaluation for effectiveness of interventions and coordination of care with the physician, pharmacist, and mental health CNP. SSC will report results at the 10/8/14 QA meeting. [redacted] will continue to monitor the effectiveness of the process of coordinating the psychotropic medications until 2 consecutive months of 100% compliance is met.</p> <p>*the QA committee KESDDCHIME</p>	* [redacted] KESDDCHIME * [redacted] KESDDCHIME

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F 329	Continued From page 12 and pharmacists would be able to review an ongoing flow sheet of psychotropic medication changes, additions, attempted reductions, results, and reason for changes.	F 329		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on record review, interview, and pharmacist contract review, the provider's consultant pharmacist failed to make recommendations for gradual dose reductions and address the need for multiple medications received for the same diagnosis for three of four sampled residents (1, 2, and 5) receiving psychotropic medications (any medication capable of affecting the mind, emotions, and behavior). Findings include: 1. Review of resident 5's medical record revealed the following physician's orders: *A 12/10/13 order for Risperdal (a psychoactive medication for abnormal thoughts). *A 1/23/14 order for Sertraline (a psychoactive	F 428		

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F 428	Continued From page 13 medication for depression). Review of resident 5's monthly pharmacy consultant reports from December 2013 through August 2014 revealed: *The pharmacist wrote "OK" with no further documentation. *No documentation regarding use of the above medications. *No recommendations regarding possible gradual dose reductions for the use of those psychoactive medications. Surveyor: 16385 2. Review of resident 1's medical record revealed the following physician's orders: *A 2/17/12 order for Xanax 0.25 milligrams (mg) BID (two times a day) for anxiety. *A 2/17/12 order for Xanax 0.25 mg PRN (as needed) for anxiety. Review of resident 1's monthly pharmacy consultant reports from December 2013 through August 2014 revealed: *The pharmacist wrote "OK" with no further documentation. *No documentation regarding the use of the above medications. *No recommendations regarding possible gradual dose reductions for the use of the medications for anxiety. Surveyor: 32335 3. Review of resident 2's medical record revealed: *A 7/21/13 order for Remeron (medication for depression) 30 mg at bedtime.	F 428	F428- Medications were reviewed by the Pharmacy Consultant on 9/5/14 for Resident 5. Consultant Pharmacist documented "resident's behaviors are stabilized on current meds." F428- Physician reviewed Resident 1's medications on 8/19/14 and wrote "meds reviewed." Consultant Pharmacist reviewed medication regimen on 9/5/14 stating "Review of I-notes indicates current use is effective." Resident does not see mental health CNP. <i>*the mental health</i> F428- REsident 2 was seen by physician on 8/22/14 and she wrote that psychotropic medications are monitored by _____ CNP. Resident was seen by _____ on 8/28/14 who noted that no GDR was indicated due to persistent mood lability and any change would most likely exacerbate symptoms where gains made to this point would be lost. Consultant Pharmacist reviewed meds on 9/5/14 with a notation acknowledging medication changes made by CNP. <i>*the mental health CNP</i>	* [Redacted] 10/18/14 KLSDDH/MF * [Redacted] KLSDDH/MF * [Redacted] KLSDDH/MF	

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F 428	<p>Continued From page 14</p> <p>*A 2/11/14 order for Trazodone HCL (medication for depression) 50 mg at bedtime.</p> <p>*A 7/15/14 order for Ativan (medication for anxiety) 1 mg three times a day.</p> <p>*A 7/24/14 order for sertraline (medication for depression) 75 mg daily at 8:00 a.m.</p> <p>*There were several changes to the psychotropic medications made by the consulting certified nurse practitioner (CNP).</p> <p>*There had been no documentation of the CNP consulting with the physician or pharmacist regarding the medication changes.</p> <p>Review of resident 2's monthly pharmacy consultant reports from December 2013 through August 2014 revealed:</p> <p>*The pharmacist wrote "OK" with no further documentation.</p> <p>*No documentation regarding the use of the above medications.</p> <p>*No documentation regarding the medication changes made by the CNP.</p> <p>*No recommendations regarding gradual dose reductions for the antidepressant Remeron.</p> <p>*No recommendations to address the use of multiple medications given to the resident for the same indication or diagnosis.</p> <p>4. Interview on 8/20/14 at 11:30 a.m. with the director of nursing (DON) revealed they had no pharmacy policies addressing medication reviews and gradual dose reductions. She had not known the gradual dose reduction process.</p> <p>Review of the provider's 3/31/05 pharmacy contract revealed the pharmacist should have:</p> <p>*Consulted on all aspects of the provision of pharmacy services in the facility.</p> <p>*Reported irregularities found during the drug</p>	F 428	<p>F428- Measures have been put in place to ensure that medications are being reviewed for duplication of therapy and GDR. They are:</p> <ol style="list-style-type: none"> 1. During monthly med reviews the pharmacist will evaluate information on the resident's psychotropic medication, dose, duration, and continued need by reviewing the Psychotropic Monitoring Form and he will forward a request for a GDR to the attending physician and/or mental health CNP. 2. The physician will review the GDR request, the total plan of care, the resident's response to the medication and will continue, modify, or stop the medication. 3. Charge Nurses will complete a monthly behavior monitor flow sheet daily for residents on psychotropic meds. The MDS Review Team will review the completed psychoactive medication quarterly evaluations, which will be provided to the attending physician & mental health CNP & pharmacist on their rounds * by the DON. KJSDOH/ME 4. Prior to any psychotropic meds being prescribed, * [redacted] SSC KJSDOH/ME will complete a pre-psychoactive medication assessment and identify behavioral interventions utilized. SSC will report results at the 10/8/14 QA meeting regarding flowsheet completion & effectiveness. * See page 14. KJSDOH/ME 	

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F 428	Continued From page 15 regimen review to the attending physician and the DON. *Performed services in compliance with all federal, state, and local laws.	F 428	* The QA committee will continue to monitor that GDR's and recommendations have been made until two consecutive months of 100% compliance is met. KESDDH/MF * An in-service was completed on 9/23/14 for all nursing staff to educate them on the changes. KESDDH/MF		
F 441 SS=D	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. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441			

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F 441	<p>Continued From page 16</p> <p>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: 32332 Based on observation, interview, and procedure review, the provider failed to ensure catheter (a tube placed in the bladder to drain urine) care had been done for one of one observed resident (5) with a catheter. Findings include:</p> <p>1. Observation on 8/20/14 at 7:55 a.m. of certified nurse aide (CNA) A during personal care revealed when asked to perform catheter care she:</p> <ul style="list-style-type: none"> *Placed the resident on the toilet. *Washed her hands and applied gloves. *Removed his clothing. *Obtained a bucket from the floor below his sink and filled it with soapy water. *Washed her hands and applied fresh gloves. *Removed his shoes. *Obtained his urinary leg collection bag and squatted in front of the resident. *Placed the urinary leg bag across her legs without a barrier and touched the uncovered tip of the connecting site. *Disconnected the large urinary collection bag (used while the resident slept at night) from his catheter tubing and applied the urinary leg collection bag without cleaning the connection site with alcohol. *Washed the residents buttocks. *Finished dressing him. 	F 441			

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F 441	<p>Continued From page 17</p> <p>The CNA had not washed resident 5's front private parts nor performed catheter care during the observation.</p> <p>Interview on 8/20/14 at 1:10 p.m. with the director of nursing revealed and confirmed CNA A: *Had not performed catheter care. *Should have placed the urinary collection bag on a clean barrier during the bag change. *Should have used alcohol pads to cleanse the catheter bag insertion tip and the catheter tubing prior to connecting them.</p> <p>Review of the provider's undated Urinary Catheter Care procedure revealed: **"Never disconnect the catheter drainage system." **"For the male, use soap and water to cleanse around the meatus [tip of the penis]. Cleanse the glans using circular strokes from the meatus outward. Return the foreskin to normal position." **"Use alcohol pads to cleanse catheter from insertion site to four inches outward."</p>	F 441	<p>F441- On 8/26/14, DON met with CNA A and the policy and procedures were reviewed with her and correct procedure demonstrated. She was given a copy of the Cath Care Policy & Procedure. CNA A did a return demonstration of proper catheter care and switching the tubing to the leg bag. An on-line training course on catheter care was assigned for all CNA's and Nurses. The ADON/MDS Coordinator will observe catheter cares being given once/week. The DON will QA this until we have 2 consecutive months of 100% compliance. The DON will report results at the QA meeting 10/8/14.</p> <p><i>* during AM and/or PM cares. KES/DDH/MF</i></p>	10/8/14

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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 8/20/14. Sun Dial Manor 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 upon correction of deficiency identified at K062 in conjunction with the provider's commitment to continued compliance with the fire safety standards.

K 062 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D

Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5

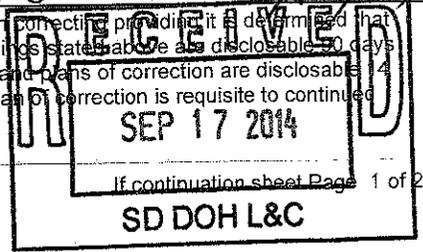
This STANDARD is not met as evidenced by:
Surveyor: 32334
Based on observation, document review, and interview, the provider failed to maintain the automatic sprinkler system in reliable operating condition. The provider must comply with the National Fire Protection Association (NFPA-13) Standard for the Installation of Sprinkler Systems section 18, System Inspection, Testing, and Maintenance. Findings include:

1. Document review at 8:00 a.m. on 8/20/14 revealed a report for a five year internal

K 000 Addendums noted with an asterisk per 9/15/14 email from facility administrator. LFK/DDH/ME

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Peggy L. Pearson* TITLE *Administrator* (X6) DATE *09/15/14*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 30 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 062	<p>Continued From page 1</p> <p>obstruction investigation that was performed by Western States Fire Protection on 10/16/13. Further review of that report revealed a comment by Western States indicating no access was available to a check valve installed on the fire department connection line. That check valve should be inspected and tested as part of the five year internal obstruction investigation. Interview with the maintenance supervisor at the time of the document review revealed he was unaware of that requirement. He indicated he did not know if that valve could be provided with access to be tested. Further interview with maintenance supervisor and Western States revealed that check valve could be relocated to a more accessible location to provide access for inspection, testing, and maintenance.</p> <p>2. Observation at 10:45 a.m. on 8/20/14 revealed a laundry room in the service wing. The sprinkler heads in that room had lint loading of significant amount to potentially interfere with proper operation of that sprinkler head. Interview with the maintenance supervisor at the time of the observation revealed he was unaware the sprinkler heads should be free of loading. He did not indicate that preventative maintenance procedures were in place to ensure loading on sprinkler heads was minimized.</p>	K 062	<p>K062- Maintenance Supervisor contacted Western States Fire Protection. They came to facility and determined a better location for the check valve to improve access for inspection, testing, and maintenance. Parts have been ordered and a work order set up. Work is to be done to correct the access during the week of September 15-19, 2014.</p> <p>K062-Sprinkler head was cleaned on 8/21/14.</p> <p>K062- To ensure that there is no loading of lint buildup on the sprinkler head in the laundry room, cleaning of the head has been added to the daily cleaning duties of the laundress at the end of each day. The Maintenance Supervisor will check all sprinkler heads to ensure there are no obstructions to their functioning on a quarterly basis and report the results at the 10/8/14 QA meeting. 2 consecutive quarters of 100% compliance will be the goal for us to meet. When met, the heads will be inspected with the usual Preventive Maintenance schedule.</p>	<p>*10/16/14 LF/S/D/H/MF</p> <p>*10/16/14 LF/S/D/H/MF</p>

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10598	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2014
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NAME OF PROVIDER OR SUPPLIER SUN DIAL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 410 2ND STREET BRISTOL, SD 57219
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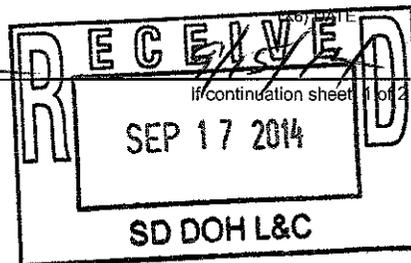
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S 000	Initial Comments Surveyor: 32335 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 8/19/14 through 8/20/14. Sun Dial Manor was found not in compliance with the following requirement: S156.	S 000	Addendums noted with an asterisk per 10/20/14 telephone to facility administrator. LF(SDDH)MF	
S 156	44:04:02:12 VENTILATION Electrically powered exhaust ventilation must be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32334 Based on observation, testing, and interview, the provider failed to maintain exhaust fan ventilation in two randomly observed locations (soiled linen room in the laundry and janitor's closet in central wing). Findings include: 1. Observation and testing at 9:50 a.m. on 8/20/14 revealed a janitor's closet in the central wing. Further observation revealed that room had a strong chemical smell from the cleaning solutions kept in that room. The exhaust for that room was tested by holding a tissue up to the exhaust grille. That test revealed air was not being exhausted through that grille. Interview with the maintenance supervisor at the time of the observation and testing revealed some work had been done in the attic space above that room.	S 156	S156- On 8/21/14, inspection of the exhaust duct in the janitor closet revealed that it had, in fact, come apart. Maintenance Supervisor reconnected the duct securing it with duct tape. Exhaust is now working correctly at this location.	 LF(SDDH)MF

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

TITLE

Peggy L. Pearson Administrator



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10598	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2014
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S 156	Continued From page 1 During that work the exhaust duct to that exhaust grille might have been broken. 2. Observation and testing at 10:15 a.m. on 8/20/14 revealed a soiled linen room by the laundry room. Further observation when entering that room revealed it was abnormally warm in that room. That room was provided with exhaust ventilation, however testing of that exhaust with a tissue revealed that exhaust was not working. Interview with the maintenance supervisor revealed he was unaware of that condition. He did not indicate whether that exhaust was checked on a regular basis to ensure it was working properly.	S 156	S156- Maintenance Supervisor investigated the problem with the exhaust vent in the soiled linen room. It revealed that the belt was loose. He tightened it for the present, but has ordered a new one to replace this one as it was showing signs of wear. New one will be put on when it arrives this week. *Exhaust fan monitoring KES/DDCH/MT S156- [REDACTED] [REDACTED] will be done monthly and documented as part of the Maintenance Supervisor's Preventive Maintenance schedule. Maintenance Supervisor will review the monthly PM schedule results & report findings at the quarterly QA meeting on 10/8/14. This QA study will be reviewed each quarter until we have achieved 100% compliance for 2 consecutive quarters. * [REDACTED] KES/DDCH/MT