

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

ORIGINAL

PRINTED: 06/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2014
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NAME OF PROVIDER OR SUPPLIER avera rosebud country care center	STREET ADDRESS, CITY, STATE, ZIP CODE 300 PARK STREET POST OFFICE BOX 408 GREGORY, SD 57533
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F 000	INITIAL COMMENTS Surveyor: 32332 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/19/14 through 5/21/14. Avera Rosebud Country Care Center was found not in compliance with the following requirements: F156, F221, F226, F280, F281, F311, F332, F441, and F520.	F 000	<i>Addendums noted with an asterisk per 6/18/14 telephone to facility administrator. SJS/BOOH/MF</i>	
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Administrator</i>	(X6) DATE <i>6-17-14</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 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER AVERA ROSEBUD COUNTRY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 PARK STREET POST OFFICE BOX 408 GREGORY, SD 57533		
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F 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156			

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F 156	<p>Continued From page 2</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on interview, record review, and the provider's admission agreement, the provider failed to ensure: *One of one sampled resident (10) had documentation of the demand bill (request for review of discharge or denial of payment) in the medical record. *Four of four sampled residents (1, 2, 4, and 9) had received Medicare denial notices (written notices given to resident identifying the date Medicare benefits would end) upon admission. *Two of two residents (13 and 14) received denial notices after being readmitted following a hospitalization. Findings include:</p> <p>1. Review of resident 10's complete medical record revealed no documentation regarding the demand bill.</p> <p>Interview on 5/20/14 at 10:15 a.m. with the chief financial officer (CFO) regarding resident 10 revealed:</p>	F 156	<p>The Medicare Explanation of benefits will be placed in Resident #10's medical record when it is received. Admission policy has been changed to include Medicare non-coverage form and demand bill to</p>		

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F 156	<p>Continued From page 3</p> <p>*The resident had requested a demand bill in November 2013 that had been sent in at that time.</p> <p>*There was no documentation of that demand bill in the resident's medical record.</p> <p>*That was the only demand bill that had been requested.</p> <p>Further interview on 5/21/14 at 7:35 a.m. with the CFO revealed:</p> <p>*An error had been found in the demand bill sent in for resident 10, and the error was corrected and the demand bill was resubmitted.</p> <p>-She was unable to provide the specific date the demand bill had been resubmitted.</p> <p>-There was no documentation of the resubmitted demand bill in resident 10's medical record.</p> <p>-They stated they had watched monthly to see the progress on the demand bill.</p> <p>2. Review of residents 1, 2, 4, and 9's medical record revealed:</p> <p>*Those residents had been admitted to the skilled nursing facility within the last year.</p> <p>*There were no denial notices in their medical records.</p> <p>Interview on 5/20/14 at 9:30 a.m. with the social services designee revealed they had not provided any denial notices to the above residents.</p> <p>Interview on 5/20/14 at 10:15 a.m. with the CFO revealed:</p> <p>*No denial notices would have been found in the long term care residents' medical records, because they had not provided any.</p> <p>*The residents had signed a form when discharged from the hospital swing beds (unused hospital beds that can be used for skilled nursing</p>	F 156	<p>Continued from page 3 be included in the admission packet.</p> <p>Swing bed denial notices will be placed in the charts of residents 1, 2, 4 and 9. For residents 10, 13, 14 and all other future admissions/readmissions, the Admission Policy and Admission Packet will be updated to include the Notice of Non-coverage and Demand bill forms to be signed by the resident or responsible party.</p> <p>*An SDSDDH/MF audit will be completed by the Director of Nursing or designee regarding completion of the correct forms. Results will be reported by the Director of Nursing to SDSDDH/MF and quarterly to the Performance Improvement Committee at the next scheduled meeting on July 17, 2014 for six (6) months or until the Performance Improvement Committee advises to discontinue.</p> <p>*The director of nursing will monitor each resident that should have received a denial notice. This will occur weekly times 1 month, then monthly thereafter. SDSDDH/MF</p> <p>*the administrator monthly beginning July 2014. SDSDDH/MF</p>	6-30-14

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F 156	<p>Continued From page 4</p> <p>care) acknowledging their Medicare benefits were ending when they left the swing bed.</p> <p>*All residents in the skilled nursing facility had been in swing beds before they were transferred to the skilled nursing care facility.</p> <p>Further interview on 5/21/14 at 7:35 a.m. with the CFO revealed:</p> <p>*The residents typically went from the hospital to a hospital swing bed, then to the provider's nursing facility bed.</p> <p>*The residents received denial notices before they left the swing bed.</p> <p>*A resident from another medical facility would have entered into the hospital and a swing bed before being transferred to the skilled nursing facility.</p> <p>*The long term care facility residents' monthly room and board were paid by private pay or Medicaid if eligible for Medicaid.</p> <p>Interview with registered nurse (RN) case manager for the hospital on 5/21/14 at 10:25 a.m. revealed that eligible residents had received denial notices before they left their swing beds and were transferred and admitted to the skilled nursing facility.</p> <p>3. Review of the provider's 5/1/14 resident activity report for April 2014 listed two residents (13 and 14) who had been sent to the hospital emergency room :</p> <p>*Were later readmitted to the skilled nursing facility.</p> <p>*There had been no denial notices in those two residents' medical records at the time of the survey.</p> <p>Review of provider's 1/8/09 nursing care facility</p>	F 156		

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F 156	Continued From page 5 admission agreement revealed "Medicare - May cover services up to 100 days based on if the Resident meets skilled care criteria. The full use of these 100 days is not guaranteed. The Facility Representative will review specifics of this program if you qualify. Whether you qualify can change day-to-day so they will do their best to know changes promptly and inform you. The resident is responsible for any co-pay not covered by supplemental insurance."	F 156		
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: 26180 Based on observation, record review, interview, and policy review, the provider failed to ensure side rail assessments had been completed for six of nine sampled residents (4, 5, 6, 7, 8, and 9) with side rails. Findings include: 1. Random observations of resident 9 from 5/19/14 through 5/21/14 revealed a one-quarter length side rail on the top quarter of his bed. The side rail was consistently pulled up on the bed. Review of resident 9's entire medical record revealed there had not been a a side rail assessment completed that verified the side rail was not used as a restraint.	F 221		

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F 221	<p>Continued From page 6</p> <p>Review of resident 9's Minimum Data Sets completed 1/6/14 and 3/26/14 revealed he had not used a physical restraint which included side rails.</p> <p>Review of resident 9's interdisciplinary care plan with documented reviews and updates on 2/20/14 revealed the use of side rails had not been addressed.</p> <p>Surveyor: 32332 2. Random observations on 5/20/14 through 5/21/14 revealed resident 8's bed had two raised quarter-length side rails to each side of the head of his bed.</p> <p>Review of resident 8's medical record revealed no side rail assessments had been completed that verified the side rails were not used as a restraint.</p> <p>Review of resident 8's 1/8/14 and 4/21/14 MDSs revealed he had not used restraints or side rails.</p> <p>Review of his revised 4/2/14 interdisciplinary care plan had revealed the use of side rails had not been addressed.</p> <p>Surveyor: 33265 3. Observation on 5/20/14 at 7:30 a.m. and review of resident 4's complete medical record revealed: *There was a positioning bar attached to the side of her bed. *The use of the positioning bar was documented in the care plan dated 12/5/13.</p>	F 221		

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F 221	<p>Continued From page 7</p> <p>*There had been no self-assessment completed on the use of the positioning bar.</p> <p>Surveyor: 33488</p> <p>4. Random observations from 5/19/14 to 5/21/14 between the hours of 7:00 a.m. and 6:30 p.m. of resident 5's bed revealed:</p> <p>*An assist bar located on the left side of the resident's bed.</p> <p>*The right side of the bed had been up against the wall.</p> <p>Review of resident 5's medical record revealed no assessment had been performed to ensure the assist bar was used only for repositioning and not a potential restraint.</p> <p>Surveyor: 32331</p> <p>5. Observation on 5/19/14 at 5:05 p.m. of resident 7 revealed he was laying on his bed with two quarter side rails up on the top half of his bed.</p> <p>Review of resident 7's medical record revealed:</p> <p>*No assessment had been completed for the use of the side rails.</p> <p>*There were no physician's orders for the side rails.</p> <p>*There had been a Communication to Residents/Families About Side Rails and Restraints acknowledgement form signed on 12/21/07.</p> <p>Review of resident 7's revised 5/8/14 care plan revealed the side rails had been documented on the care plan for restorative bed mobility.</p> <p>Review of resident 7's 4/30/14 MDS assessment, section P revealed there were no side rails used as a restraint on his bed.</p>	F 221			

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F 221	<p>Continued From page 8</p> <p>6. Observation on 5/19/14 at 6:40 p.m. of resident 6 revealed his bed had a quarter side rail up on the top half of his bed.</p> <p>Review of resident 6's medical record revealed: *Resident had a history of falls. *No assessment had been completed for the use of the side rail. *There were no physician's orders for the side rail.</p> <p>Review of resident 6's revised 4/3/14 care plan revealed the side rail had been documented on the care plan for restorative bed mobility.</p> <p>Review of resident 6's 3/26/14 MDS assessment, section P revealed there was no side rail used as a restraint on his bed.</p> <p>7. Interview on 5/20/14 at 6:10 p.m. with the MDS coordinator regarding side rails on resident beds revealed: *Side rails were not being assessed, because the provider had no half or full side rails on resident beds. *She stated "we have no restraints." *No assessments were being done on quarter side rails or any side rails. *She was not aware all side rails needed to have been assessed.</p> <p>Interview on 5/21/14 at 9:30 a.m. with the director of nursing regarding side rails on residents' beds revealed: *There were no assessments being done on side rails. *She agreed side rails needed to have been assessed.</p>	F 221	<p>*Residents with side rails or grab bars will be assessed for appropriate use routinely. SD/DOCH/ME</p> <p>*and as a change in condition occurs SD/DOCH/ME</p> <p>*7, SD/DOCH/ME</p> <p>All residents, including residents 4, 5, 6, 8 and 9 will have the use of grab bars or quarter rails attached to the beds assessed as possible restraints. This will be done by the Director of Nursing or designee.</p> <p>*The restraint policy has been updated. SD/DOCH/ME</p> <p>All future admissions who have the use of a grab bar or side rail attached to the bed assessed as a possible restraint on the day of admission by the charge nurse on duty.</p> <p>* .</p> <p>Family and or the resident will be provided with the restraint policy on the day of admission by the Social Services Designee or designee. *If the side rails are assessed as appropriate, the resident or family will be contacted for consent. SD/DOCH/ME</p> <p>Physician's order will be obtained for all current residents who have a grab bar or side rail attached to the bed. This will be completed by the Director of Nursing or designee.</p> <p>All current comprehensive care plans will be updated to include the use of all positioning and transfer devices to include grab bars and side rails. Director of Nursing or designee will complete.</p>	

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F 221	Continued From page 9 Review of the provider's 4/24/14 Restraints policy revealed: *Physical restraints were defined as: -Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body. -Resident could not remove easily. -Restricted freedom of movement or normal access on one's body. **"Side rails sometimes restrain residents. The use of side rails as restraints is prohibited unless they are necessary to treat a resident's medical symptoms."	F 221	Continued from page 9 *Weekly x 1 month, then monthly thereafter. @/SD04/MF In-service will be held on June 20, 2014 regarding the restraint policy. An audit of all admissions for orders and documents will be completed by the Director of Nursing or designee. Results will be reported by the Director of Nursing to *the administrator monthly beginning JUN 2014. @/SD04/MF [REDACTED] and quarterly to the Performance Improvement Committee at the next scheduled meeting on July 17, 2014 for six (6) months or until the Performance Improvement Committee advises to discontinue.	
F 226 SS=D	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: 33265 Based on observation, interview, record review, and policy review, the provider failed to investigate and report bruising of unknown cause for one of three sampled residents (4) with bruises. Findings include: 1. Observation and record review on 5/21/14 at 7:45 a.m. of resident 4 revealed: *Visible bruising on the right lower lateral arm. *Bruising of right lower lateral (side) arm and left lower lateral leg were first documented on	F 226		7-10-14

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F 226	<p>Continued From page 10</p> <p>4/25/14 on the basic skin assessment at 10:33 p.m. by registered nurse (RN) I.</p> <p>Interview on 5/21/14 at 8:45 a.m. with the director of nursing (DON) included a request for information on the bruising of resident 4's right arm and left leg.</p> <p>Further interview on 5/21/14 at 10:30 a.m. with the DON revealed she:</p> <ul style="list-style-type: none"> *Had not been aware of the bruising. *Had called RN I about the skin assessment documentation, and RN I informed her: <ul style="list-style-type: none"> -It had been a busy Friday night. -She had not notified the resident's physician, family, or her supervisor. -She had not documented on the short term care plan as she should have done. -She had not completed an investigation at the time the bruising had been found. *Agreed notification to the physician, family, supervisor, and possibly the state Department of Health, should have been completed. *Agreed an investigation into the cause of the bruising should have been completed. <p>Interview with resident 4 on 5/21/14 at 10:30 a.m. revealed she could not remember how she had acquired the bruises.</p> <p>Review of the provider's January 2014 abuse prohibition policy and procedure revealed:</p> <ul style="list-style-type: none"> *Employees received training on abuse during orientation and annual training which included: <ul style="list-style-type: none"> -A review of possible forms of abuse and neglect and corresponding signs and symptoms including but not limited to bruises, unexplained injuries, weight loss, pressure sores, dehydration, depression, sadness, and loss of personal 	F 226			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2014
NAME OF PROVIDER OR SUPPLIER AVERA ROSEBUD COUNTRY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 PARK STREET POST OFFICE BOX 408 GREGORY, SD 57533	
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F 226	Continued From page 11 property. -Procedure to report suspected abuse. *Procedure for reporting suspected abuse included: -The person who had found signs or symptoms of possible abuse was to have reported the findings immediately to the charge nurse, who would have then reported to the DON or the administrator. -An investigation should have begun immediately. -Documentation should have included a thorough explanation and description of the findings from the resident, involved staff, and other potential witnesses.	F 226	Weekly skin assessments will be done by the Charge Nurse on Resident #3 as well as all other residents, per the Abuse and Neglect policy. In-service education will be done for licensed personnel regarding the Abuse and Neglect policy, to be held on June 20,2014. Skin assessments will be monitored weekly by the Director of Nursing or designee. Results will be reported by the Director of Nursing to [REDACTED] and quarterly to the Performance Improvement Committee at the next scheduled meeting on July 17, 2014 for six (6) months or until the Performance Improvement Committee advises to discontinue.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	* the administrator monthly beginning July 2014. [REDACTED]	7-10-14

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

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FORM APPROVED
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F 280	<p>Continued From page 13</p> <p>Interview on 5/21/14 at 2:00 p.m. with CNA E regarding resident 3 revealed: *She required the assistance of one to two CNAs for most of her activities of daily living. -This included walking, transfers, toileting, dressing, and other personal care. *Sometimes she was more cooperative and some care could have been done with one person. -Usually for safety they would have used two people.</p> <p>Review of resident 3's medical record revealed: *Laboratory results had tested positive for a urinary tract infection (UTI) on 2/5/14, 3/5/14, 3/30/14, 4/15/14 and 5/7/14 . *She had been treated with antibiotics each time. *She was started on a dysphagia (difficulty with swallowing/risk for choking) diet with thickened liquids.</p> <p>Review of resident 3's 3/10/14 interdisciplinary care plan revealed: *It had not addressed her recurring UTIs. *It had not been updated when her diet was changed to the dysphagia diet with thickened liquids. *It had not been updated when her care needs changed from one to two person assist, with walking, dressing, toileting, and bathing. *She was to have participated in the walk-to-dine program as tolerated. *It had not addressed her refusal to cooperate with care or the restorative program. *It had not addressed having her come to exercise before she was placed in the recliner.</p> <p>Review of the provider's September 2010 Comprehensive assessment/care plan poicy</p>	F 280	<p><i>x weekly times 1 month, then monthly thereafter SBJSDOH/ME</i></p> <p>Resident #3 care plan has been updated by the Director of Nursing. All resident care plans will be updated with changes as they occur. In-service education will be done for all pertinent personnel regarding care plans on June 20, 2014. [REDACTED] *An SBJSDOH/ME audit will be completed by the MDS Coordinator or designee. Results will be reported by the Director of Nursing to *the administrator monthly beginning July 2014. SBJSDOH/ME and quarterly to the Performance Improvement Committee at the next scheduled meeting on July 17, 2014 for six(6) month or until the Performance Improvement Committee advises to discontinue.</p>	7-10-14

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

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F 280	Continued From page 14 revealed "The comprehensive care plan and the short term care plan will be kept current by licensed nurses, social services, nutrition, activities, and PT/OT [physical therapy/occupational therapy]".	F 280		
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: 32331 Based on observation, interview, record review, and policy review, the provider failed to follow physicians' orders for: *A night-time respiratory aid of a continuous positive airway pressure (CPAP) a treatment that used mild air pressure to keep the airways open for residents with breathing problems for one of one sampled resident (6). *A physical therapy consultation for one of one sampled resident (4). *Three medications for two of nine sampled residents (4 and 8). Findings include: 1. Review of resident 6's medical record revealed: *He had been admitted on 1/4/13. *He had a diagnosis of sleep apnea (a condition when breathing stops during sleep, because the brain temporarily stops sending signals to the muscles that control breathing). *He had a diagnosis of Chronic Obstructive Pulmonary Disease (COPD), a lung disease that	F 281		

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

PRINTED: 06/03/2014
FORM APPROVED
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F 281	<p>Continued From page 15 makes it hard to breathe. *He had a 11/22/13 physician's order for "CPAP/BIPAP [Bilevel (two levels) Positive Airway Pressure] Night with 2l [two liters] O2 [oxygen] Leaked Into CPAP/BIPAP."</p> <p>Review of resident 6's treatment administration records for April 2014 and May 2014 through 5/18/14 revealed: -On 4/15/14, 4/17/14, 4/19/14, and 4/21/14 it was "not working." -On 4/26/14 and 5/1/14 it was "not in room." -On 5/3/14 it was "not working." -On 5/5/14, 5/10/14, and 5/13/14 it was "not in room."</p> <p>Review of resident 6's 5/9/14 physician's progress note revealed "He continues to decline with burden of his multisystem failures."</p> <p>Observation and interview on 5/20/14 at 10:10 a.m. with certified nursing assistant (CNA) G and CNA H in resident 6's room revealed: *No CPAP machine. *Both CNAs had not seen the machine in the resident's room recently.</p> <p>Interview on 5/20/14 at 10:35 a.m. with the director of nursing (DON) regarding resident 6's CPAP machine revealed: *It had been broken, and the family had removed it as they were going to have it repaired. *The family had declined a rented CPAP machine. *The provider did not own a CPAP machine for the resident to have used. *She confirmed the resident's physician had not been informed regarding the above breathing treatment that was no longer being provided as</p>	F 281		

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

PRINTED: 06/03/2014
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OMB NO. 0938-0391

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F 281	<p>Continued From page 16 ordered: *She agreed the resident's physician should have been informed of that.</p> <p>Review of the nurse's fax on 5/20/14 to resident 6's physician revealed: *The resident's CPAP machine had been in for repairs since 4/16/14. *His O2 saturation levels (the concentration of oxygen the blood) had been in the 90 percent (%) level daily (normal blood oxygen levels are considered 95-100%).</p> <p>Interview on 5/21/14 at 1:40 p.m. with the DON revealed the provider had no policy on physician notification for broken equipment such as a CPAP machine.</p> <p>Surveyor: 32332 2. Review of resident 8's medical record revealed: *A 5/5/14 physician's order for Ativan (for shortness of breath and anxiety) 0.25 milligrams (mg) every six hours, as needed. *A 5/10/14 physician's order from an emergency room visit to "Continue taking these medications: Ativan 0.5 mg every six hours as needed."</p> <p>Review of resident 8's May 2014 medication administration record (MAR) revealed an order for Ativan 0.25 mg every six hours as needed.</p> <p>Interview on 5/21/14 at 11:15 a.m. with registered nurseRN C revealed: *She had received and noted the 5/10/14 orders from the emergency room visit, but she had not noticed the change in dose of the Ativan. *The Ativan dose should have been changed at</p>	F 281		

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

PRINTED: 06/03/2014
FORM APPROVED
OMB NO. 0938-0391

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F 281	<p>Continued From page 17</p> <p>the time the order had been received. *If she believed the order had been written in error the physician should have been contacted to clarify whether the dose was to have remained the same.</p> <p>Review of the provider's March 2014 Medication Policy revealed: *When transcribing orders the nurse was to have entered the orders on the MAR. *To discontinue medications the nurse was to: -Write discontinue and the date, then write their initials beside the date. -Shade through the order with a highlight marker. -Remove the discontinued medication from the medication area. *Incorrect procedures for taking off physician's order was to have been considered a medication error. *In the event of a medication error the nurse was to have notified the attending physician and designated family members.</p> <p>Review of Patrician A Potter et al., Fundamentals of Nursing, 8th Ed., Elsevier, St. Louis, Mo., 2013, p. 306, revealed: **Nurses are responsible for performing all procedures correctly and exercising professional judgement as they carry out health care providers' orders." **Nurses follow health care provider's orders unless they believe the orders to be in error or harmful to patients."</p> <p>Surveyor: 33265 3. Observation on 5/20/14 at 8:30 a.m. of resident 4 revealed an ace bandage was wrapped around her left lower leg and ankle.</p>	F 281		

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

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F 281	<p>Continued From page 18</p> <p>Review of resident 4's complete medical record revealed:</p> <p>*There had been a fax sent from RN C to the physician on 4/2/14 at 3:00 p.m. requesting a physical therapy (PT) consult to address the foot drop (medical condition where the foot was not able to maintain its normal positioning) brace the resident was unable to wear.</p> <p>*There had been a faxed response by the physician on 4/2/14 at 3:15 p.m. ordering a PT consult regarding the left foot and leg.</p> <p>*The order had been noted by RN C on 4/2/14.</p> <p>*There had been no documentation of a PT consult following this order in the medical record.</p> <p>Interview on 5/21/14 at 8:45 a.m. with the director of nursing (DON) regarding resident 4 revealed:</p> <p>*There was no documentation in the resident's medical record of the PT consult ordered on 4/2/14.</p> <p>*There were a series of email messages on 4/3/14 between the DON and physical therapist K concerning the PT consult orders that were printed out from the computer by the DON.</p> <p>*There was an entry on the resident's short term care plan dated 4/3/14 which stated to put ace bandage to left lower leg in a figure eight pattern until the resident had been able to wear shoes with the foot drop brace per PT.</p> <p>Interview with PT K and the DON on 5/21/14 at 11:35 a.m. revealed PT K:</p> <p>*Had not seen resident 4 to complete the consult the physician had ordered on 4/2/14.</p> <p>*Had seen resident 4 "in the past" and did not believe she needed to see the resident again to complete a consult.</p> <p>*She agreed she had not personally assessed the resident's condition when she received the PT</p>	F 281	<p>Resident #6, physician gave the order to hold CPAP and continue monitoring oxygen saturation with administration of nebulizers on May 20, 2014 to the Charge Nurse. Medication treatment policy was updated by the Director of Nursing to include resident equipment procedure, including the necessity of physician's orders to discontinue care.</p> <p>Resident #8 had order clarified by Charge Nurse and family was notified on May 21, 2014. Resident #4 chart had the PRN corn pads removed from the order sheet. Physician order also discontinued ace wrap and resumed use of foot drop brace. All consults will be recorded in the order accountability log.</p>	

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

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F 281	<p>Continued From page 19</p> <p>consult and the condition of the resident's leg and foot could have changed.</p> <p>*She agreed she had not documented in the resident's medical record any steps she had taken to acknowledge or complete the PT consult after the consult was received.</p> <p>4. Record review of resident 4's complete medical record revealed:</p> <p>*The corn pads were discontinued by the physician on 4/11/14 at 10:30 a.m.</p> <p>*The DON noted the order on 4/11/14 at 11:00 a.m.</p> <p>*The MAR had an entry dated 3/4/14 for corn pads topically prn (as needed) to toes.</p> <p>Interview on 5/21/14 at 8:45 a.m. with the DON revealed she had discontinued the scheduled corn pads but had missed the prn corn pads.</p> <p>F 311 SS=E 483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS</p> <p>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, record review, interview, and policy review, the provider failed to ensure recommendations from the therapy department had been followed for three of eight sampled residents (3, 8 and 9) who were to have been in a walk-to-dine program. Findings include:</p> <p>1. Review of resident 3's interdisciplinary care</p>	F 281	<p>Continued from page 19</p> <p>A daily order accountability log requiring all new orders to be checked by two separate staff members on a daily basis will be implemented. The Medication Treatment policy was updated by the Director of Nursing to include the order accountability procedure.</p> <p>*An audit will be completed by the Director of Nursing or designee to confirm accuracy of physician orders. In-service education will be held on June 20, 2014. Results will be reported by the Director of Nursing to _____ and quarterly to the Performance Improvement Committee at the next scheduled meeting on July 17, 2014 for six (6) months or until the Performance Improvement Committee advises to discontinue.</p> <p>* weekly times 1 month, then monthly thereafter. SB/SD/CH/MF</p> <p>* for all nursing home employees SB/SD/CH/MF</p> <p>* the administrator monthly beginning July 2014. SB/SD/CH/MF</p>	7-10-14

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 311	<p>Continued From page 20 plan revealed: *She was to participate in the walk-to-dine program as part of her restorative program. -That had been recommended on 4/2/13 at the time she had been admitted.</p> <p>Observations of resident 3 starting with the supper meal on 5/19/14 through the noon meal on 5/21/14 revealed: *She was brought to the dining room for each meal in her wheelchair. *When she was walked it required two people to assist her in walking. *She was assisted by two staff when she was taken to the bathroom.</p> <p>Interview on 5/21/14 at 8:30 a.m. with certified nursing assistant (CNA)/restorative aide F regarding resident 3 revealed: *She sometimes was uncooperative with the restorative program. *She came to the group exercise program after breakfast at times. *If she had already been sat in her recliner she was more likely to refuse the exercises. *The registered nurse/Minimum Data Set (MDS) coordinator oversaw the restorative program. *There were days when there was only one CNA working in restorative therapy. -Then they had to rely on one of the CNAs on the floor to assist when a resident required two people assist. -Resident 3 required two people to assist with her walking. -Sometimes they could not find that second person to assist if the other CNAs were too busy or if there was not enough staff that day. -The CNA assigned to a resident was responsible for doing the walk-to-dine with that</p>	F 311		

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

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F 311	<p>Continued From page 21 resident.</p> <p>Interview on 5/21/14 at 9:00 a.m. with CNA E revealed resident 3 had not participated in the walk-to-dine program. She was not aware she was on that program. She was familiar with her routines because she was consistently assigned to work on the wing that resident 3 was on.</p> <p>Review of resident 3's 4/2/13 interdisciplinary care plan revealed she was to participate in the walk-to-dine program as tolerated.</p> <p>Interview on 5/21/14 at 8:30 a.m. of resident 3 confirmed she had not been walked to any of her meals. She always came in her wheelchair.</p> <p>2. Observations of resident 8 starting with the supper meal on 5/19/14 through the noon meal on 5/21/14 revealed he was brought to the dining room for each meal in his wheelchair.</p> <p>Review of resident 8's 12/30/13 interdisciplinary care plan revealed he was to have participated in the walk-to-dine program.</p> <p>Review of resident 8's entire medical record and restorative documentation revealed there was no record of that occurring.</p> <p>Interview on 5/21/14 at 10:00 a.m. with the MDS coordinator revealed: *She was not responsible for the restorative program. -She only completed the quarterly restorative progress notes. *She was unable to say whether resident 3 participated in the walk-to-dine program. *The physical therapist (PT) K was responsible</p>	F 311		

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

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F 311	<p>Continued From page 22 for the restorative program.</p> <p>-The PT was occasionally in the skilled nursing facility.</p> <p>-She concurred it would have been difficult to evaluate the appropriateness of the restorative program if you were only there occasionally.</p> <p>*Either the restorative aide or the CNA assigned to a resident could have done the walk-to-dine with the resident.</p> <p>-She could not say who was responsible for it, stating "They both could help with it."</p> <p>Interview on 5/21/14 at 11:00 a.m. with PT K revealed:</p> <p>*She was responsible for doing a PT evaluation if there was a new admission or a decline prior to starting a resident on a restorative program.</p> <p>*The PT assistant was in the skilled nursing facility about once a month.</p> <p>*She communicated to PT K if there were changes or if a resident needed a PT evaluation.</p> <p>Interview on 5/21/14 at 11:00 a.m. with the director of nursing revealed she:</p> <p>*Could not say who was ultimately responsible for oversight of the restorative program.</p> <p>*Knew that all CNAs were trained on the walk-to-dine program and should have known which residents were included in that program.</p> <p>Surveyor: 32332 Review of resident 8's interdisciplinary care plan revealed:</p> <p>*He was able to walk independently or with assist of one staff member.</p> <p>*He was to have participated in the walk-to-dine program as part of his restorative program.</p>	F 311			

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

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NAME OF PROVIDER OR SUPPLIER avera rosebud country care center	STREET ADDRESS, CITY, STATE, ZIP CODE 300 PARK STREET POST OFFICE BOX 408 GREGORY, SD 57533
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	<p>Continued From page 23</p> <p>Observations of resident 8 during breakfast and lunch meals on 5/21 revealed: *He wheeled himself to the dining room for the breakfast meal. *He required two staff members to assist him with walking.</p> <p>Interview on 5/21/14 at 10:10 a.m. with resident 8 revealed he was only able to tolerate walking once daily.</p> <p>Interview on 5/21/14 at 10:15 a.m. with CNA/restorative aide F revealed: *Resident 8 had some physical declines in April 2014. *Since then he had required one or two staff assistance with walking. *Staff walked him in the hallway. *He was not participating in the walk-to-dine program.</p> <p>Interview on 5/21/14 at 9:15 a.m. with the MDS coordinator revealed: *She documented resident restorative performance as part of the MDS assessments. *She updated the restorative records and care plan to reflect the current programs the PT had recommended. *She was not in charge of overseeing the restorative programs. *Physical therapist K oversaw the restorative programs. *All CNAs and restorative aides were responsible for: -Assisting residents with the walk-to-dine program. -Documentating that restorative exercises had occurred.</p>	F 311		

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

PRINTED: 06/03/2014
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER AVERA ROSEBUD COUNTRY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 PARK STREET POST OFFICE BOX 408 GREGORY, SD 57533		
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F 311	<p>Continued From page 24</p> <p>Interview on 5/21/14 at 11:15 a.m. with PT K revealed: *She was not in charge of the restorative program. *All restorative aides and CNAs were responsible for walking the residents. *The PT aide was expected to notify her if there had been changes in residents' conditions. *She was to have observed residents if there had been significant changes in their status and updated the restorative program to fit their needs.</p> <p>Interview on 5/21/14 at 11:10 a.m. with the DON revealed when questioned who was in charge of the restorative program, she had not commented.</p> <p>Review of the provider's undated unnamed policy revealed: **"Each resident will receive the necessary care and service to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. *Individualized walking programs which may include walk to dine, ambulation with restorative individually in hall or room as resident is able and or as outlined in the restorative program."</p>	F 311	<p>Resident 3, 8 and 9 and all other residents will have their restorative programs assessed and supervised by a licensed nurse. The restorative program policy will be updated and implemented by the Director of Nursing. An in-service will be held on June 20, 2014 to educate the staff on the restorative program. [REDACTED] *An SB/SDDH/ME audit of [REDACTED] walk to dine program will be completed by the MDS Coordinator or designee. *all SB/SDDH/ME</p> <p>Results will be reported by the Director of Nursing to [REDACTED] and quarterly to the Performance Improvement Committee at the next scheduled meeting on July 17, 2014 for six (6) months or until the Performance Improvement Committee advises to discontinue.</p> <p>* weekly times 1 month, then monthly thereafter SB/SDDH/ME</p> <p>* the administrator monthly beginning July 2014. SB/SDDH/ME</p>	7-10-14
F 332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 332		

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

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F 332	<p>Continued From page 25</p> <p>Surveyor: 33488</p> <p>Based on observation, interview, manufacturer's guidelines, and policy review, the provider failed to ensure a less than 5 percent (%) medication error rate for 3 of 25 resident's (11, 8, 12) observed medication administrations. Findings include:</p> <p>1. Observation on 5/20/14 at 7:40 a.m. of licensed practical nurse (LPN) A while she administered two puffs of a Pro Air (albuterol sulfate) inhaler to resident 11 revealed: *She handed the resident the inhaler. *The resident inhaled one puff, held her breath for 5 seconds, waited another 5 seconds, and then inhaled the second puff from the inhaler. *LPN A had not instructed the resident to wait one minute between puffs.</p> <p>Manufacturer's guidelines for the inhaler revealed "Hold your breath as long as you can up to 10 seconds, then breathe normally. If your doctor has told you to use more sprays, wait 1 minute and shake the inhaler again."</p> <p>2. Observation on 5/20/14 at 11:10 a.m. of registered nurse (RN) B while she administered Humalog (a rapid acting insulin) to resident 8 revealed: *She prepared seven units of the insulin for administration. *She wiped the resident's lower right abdomen with an alcohol wipe. *She pinched the resident's skin. *She inserted the needle on the syringe into the resident's skin, released the skin, and administered the insulin dose into the tissue below the skin. *She immediately pulled the insulin needle out of</p>	F 332		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 332	<p>Continued From page 26</p> <p>the resident's skin after administration. *The resident would not eat his next meal until later at 12:00 noon which was fifty minutes after the medication had been administered.</p> <p>3. Observation on 5/20/14 at 11:15 a.m. of registered nurse (RN) B administering Novalog (a rapid acting insulin) to resident 12 revealed: *She prepared eight units of the insulin for administration. *She wiped the resident's lower right abdomen with an alcohol wipe. *She pinched the resident's skin. *She inserted the needle on the syringe into the resident's skin, released the skin, and administered the insulin dose into the tissue below the skin. *She immediately pulled the insulin needle out of the resident's skin after administration. *The resident would not eat his next meal until later at 12:00 noon, forty-five minutes after the medication had been administered.</p> <p>Interview on 5/20/14 at 3:10 p.m. with RN B regarding the above insulin administrations revealed she: *Knew the above medications were rapid-acting insulins. **"Thought they were to be given 30 minutes to 1 hour prior to a meal." *Agreed she should have followed manufacturer's guidelines and given the insulin no more than 15 minutes before or after a meal. *Had been unaware she should not immediately remove the needle to allow for absorption into the tissue.</p> <p>Interview on 5/21/14 at 8:00 a.m. with the director</p>	F 332		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 332	Continued From page 27 of nursing (DON) regarding the above medication observations revealed it had been her expectation: *LPN A should have advised the resident to wait one minute between inhaler puffs. *RN B should have given the insulin according to manufacturer's guidelines and waited five seconds before removing her needle for the insulin to be effectively absorbed into the resident's tissue. Manufacturer's guidelines revealed "Humalog is a rapid-acting insulin. You should take Humalog within fifteen minutes before eating or right after eating a meal." David C. Dugdale, III, MD, "Giving an insulin injection," National Institutes for Health, dated 11/29/12, < http://www.nlm.nih.gov/medlineplus/ency/patientinstructions/000660.htm >, guideline for administering insulin revealed: -"Push the needle all the way into the skin." -"Let go of the pinched skin." -"Inject the insulin slowly and steadily until it is all in." -"Leave the syringe in place for 5 seconds after injecting." Review of the provider's 1/20/09 Medication Policy revealed medications would be given at the right time and the right method of administration and if not it would be considered a medication error.	F 332	Resident #11 had Medication Administration Record/Treatment Administration Record (MARTAR) updated with inhaler instructions on June 11, 2014. Resident 8 and 12 had MAR/TAR updated with insulin instructions on June 11, 2014. Consultant Pharmacist reviewed all current medications for instructions per manufacturer's instructions on June 9, 2014. MAR/TAR will be [redacted] *updated with administration instructions per consultant pharmacist recommendations during his monthly visit. Licensed nurses and medications aide will be re-educated on medication administration and will be given a competency for MAR/TAR administration. *Audi's [redacted] will be conducted on *all updated MAR/TAR's by the Director of Nursing or designee. Results will be reported by the Director of Nursing to [redacted] and quarterly to the Performance Improvement Committee at the next scheduled meeting on July 17, 2014 for six (6) months or until the Performance Improvement Committee advises to discontinue.	7-10-14
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441	*Weekly times 1 month, then monthly thereafter. *the administrator monthly beginning July 2014.	

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

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OMB NO. 0938-0391

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F 441	<p>Continued From page 28</p> <p>Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488</p>	F 441			

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

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F 441	<p>Continued From page 29</p> <p>Based on observation, interview, and policy review, the provider failed to appropriately clean two of two nebulizer cups for two of two residents (8, 6). Findings include:</p> <p>1a. Observation on 5/20/14 at 10:45 a.m. of registered nurse (RN) B administering a nebulizer treatment (breathing treatment) to resident 8 revealed: *She administered the nebulizer treatment to the resident. *Upon completion she set the nebulizer equipment (mask, cup, and tubing) on the resident's nightstand. *She had not disassembled or cleaned the nebulizer cup prior to leaving his room.</p> <p>b. Observation on 5/20/14 at 1:08 p.m. with licensed practical nurse (LPN) A administering a nebulizer treatment to resident 6 revealed: *She administered the nebulizer treatment to the resident. *Upon completion she set the nebulizer equipment (mask, cup, and tubing) on the resident's nightstand. *She had not disassembled or cleaned the nebulizer cup prior to leaving his room.</p> <p>c. Interview on 5/21/14 at 9:50 a.m. with RN C regarding nebulizer treatments revealed it had not been her usual practice to clean the nebulizer after she administered a treatment.</p> <p>Interview on 5/21/14 at 10:00 a.m. with RN D regarding the nebulizer treatments revealed she had also not cleaned the nebulizer after she administered a treatment.</p> <p>Interview on 5/21/14 at 10:10 a.m. with the</p>	F 441		

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

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FORM APPROVED
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F 441	Continued From page 30 infection control coordinator regarding nebulizer cleaning revealed it had been her expectation nursing staff would disassemble and clean the nebulizer after each treatment had been given. Review of the provider's 2014 revised Concentrators and Nebulizers Policy revealed nebulizers were to be disassembled, rinsed, and air dried after each use.	F 441	In-service education will be held with licensed nurses and medication aides on proper cleaning of nebulizers. Monitoring of correct procedure for nebulizer cleaning will be completed by the Director of Nursing or designee.* Results will be reported by the Director of Nursing to [REDACTED] and quarterly to the Performance Improvement Committee at the next scheduled meeting on July 17, 2014 for six (6) months or until the Performance Improvement Committee advises to discontinue.	<i>* on 6/17/14</i> <i>SP/SD/DM/ME</i>
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520	<i>Nebulizer auditing will take place on all residents receiving nebulizer treatments weekly times 1 month, then monthly thereafter.</i> <i>*the administrator</i> <i>weekly times 1 month, then monthly thereafter, beginning July 2014.</i> <i>SP/SD/DM/ME</i>	7-10-14

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

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F 520	<p>Continued From page 31</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331</p> <p>Based on interview, record review, and policy review, the provider failed to maintain quality assessment and assurance (QAA) quarterly meetings with a physician and the director of nursing in attendance at those meetings. Findings include:</p> <p>1. Interview on 5/21/14 at 9:25 a.m. with the director of nursing revealed: *A QAA meeting had been held on 10/16/13, 1/16/14, 2/20/14, 3/20/14, and 5/15/14. *A QAA meeting prior to the October 2013 meeting had been held on 4/18/13. *The QAA meetings were currently being held monthly each year. *The QAA meetings had previously been held quarterly each year. *A physician never attended the QAA meetings. *The director of nursing had attended the QAA meetings on 1/16/14 and 3/20/14.</p> <p>Review of the October 2013, January 2014, February 2014, March 2014, and May 2014 QAA meeting attendance records revealed: *A physician was not in attendance at any of the above listed QAA meetings. *The director of nursing was not in attendance at the October 2013, February 2014, and May 2014 QAA meetings.</p> <p>Interview on 5/21/14 at 9:50 a.m. with the director of nursing confirmed: *Quarterly meetings had not been held. *The meetings did not have a physician in attendance. *The director of nursing was not always in</p>	F 520			

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

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F 520	Continued From page 32 attendance. *She had not been aware a physician and the director of nursing needed to have been in attendance at QAA quarterly meetings. Review of the provider's undated Reporting and Improvement plan policy statement revealed: *The quality committee included groups representing the following: -Acute care. -Ambulatory care. -Long-term care. -Rehabilitation services. -Laboratory. -Radiology. -Health information management. -Environmental services. -Business office. *The quality director was responsible for the coordination of quarterly meetings.	F 520	<i>*the administrator</i> Medical Director and [REDACTED] will attend the Performance Improvement Committee on a quarterly basis. Attendance sheets will be kept with the minutes. A quarterly audit will be conducted by the Director of Nursing or designee. Results will be reported by the [REDACTED] quarterly to the Performance Improvement Committee at the next scheduled meeting on July 17, 2014 for six (6) months or until the Performance Improvement Committee advises to discontinue. <i>*administrator</i>	7-10-14	

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

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PRINTED: 05/28/2014
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435029	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2014
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NAME OF PROVIDER OR SUPPLIER AVERA ROSEBUD COUNTRY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 PARK STREET POST OFFICE BOX 408 GREGORY, SD 57533
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K 000	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 05/21/14. Avera Rosebud Country Care Center was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 05/21/14 upon correction of the deficiency identified below. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiency identified at K034 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 028 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers provide a minimum clear width of 32 inches (81cm) for swinging or horizontal doors. Vision panels are of fire-rated glazing or wired glass panels and steel frames. 19.3.7.5, 19.3.7.7 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and measurement, the provider failed to maintain clear door widths of at least 32 inches in two smoke barriers (central	K 028		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 6-17-14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

JUN 18 2014
If continuation sheet Page 1 of 4
SD DOH L&C

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

PRINTED: 05/28/2014
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER avera rosebud country care center			STREET ADDRESS, CITY, STATE, ZIP CODE 300 PARK STREET POST OFFICE BOX 408 GREGORY, SD 57533		
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K 028	Continued From page 1 core area to the north wing and west wing). Findings include: 1. Observation and measurement at 10:30 a.m. on 05/21/14 revealed each leaf of the two sets of smoke barrier doors for the central core area to the north wing and the west wing were only 30 inches wide. Those door leafs did not provide the required clear opening width of 32 inches. This would affect two of three resident smoke compartments. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K 028			
K 034 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and interview, the provider failed to maintain conforming exit stairs. Items were stored in two of two exit stairs on the lower lever. Emergency medical technician (EMT) supplies were stored in the north stair and combustible Christmas decorations were stored in the central stair enclosure. Findings include: 1. Observation at 11:30 a.m. on 05/21/14 revealed EMT supplies were stored on the lower landing of the north stair enclosure. Further	K 034	EMT supplies were removed from the landing of the north stairwell by the Environmental Services Manager on May 21, 2014. Cardboard boxes and decorations were removed from the lower landing of the central stairwell enclosure also by the Environmental Services Manager on May 21, 2014.	F	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435029	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2014
NAME OF PROVIDER OR SUPPLIER AVERA ROSEBUD COUNTRY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 PARK STREET POST OFFICE BOX 408 GREGORY, SD 57533		
(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 034	Continued From page 2 observation at 11:35 a.m. on 05/21/14 revealed several cardboard boxes and Christmas decorations were stored on the lower landing of the central stair enclosure. Interview with the maintenance supervisor at the time of the observation confirmed those findings. She indicated staff were aware storage in stair enclosures was not permitted. She was unaware those items were in that location.	K 034	Continued from page 2 Monthly monitoring of stairwells will be completed by the Environmental Service Manager or designee. Results will be reported by the Environmental Service Manager or designee to Compliance on a quarterly basis beginning August 7, 2014 and quarterly to Performance Improvement Committee at the next scheduled meeting on July 17, 2014 for six (6) months or until the Performance Improvement Committee advises to discontinue.	5-21-14	
K 038 SS=C	This would not affect any of the three resident smoke compartments. NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on document review and interview, the provider failed to install a paved path of exit discharge to the public way at three exits (the middle of the west wing, the end of the west wing, and the exit out of the connecting link for the hospital). Findings include: 1. Review of the previous survey revealed: *The exit in the middle of the west wing basement had a landing that ended approximately 150 feet from the nearest public way. *The exit at the end of the west wing in the basement had a landing that ended approximately 200 feet from the nearest public	K 038			

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K 038	Continued From page 3 way. Interview with the environmental services director at 9:35 p.m. on 05/21/14 confirmed that condition. She added they had been clearing a path from those exits to a public way when any snow fell. This would not affect any of the resident smoke compartments. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K 038		F	

ORIGINAL

PRINTED: 06/03/2014
FORM APPROVED

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10625	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2014
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NAME OF PROVIDER OR SUPPLIER avera rosebud country care ctr	STREET ADDRESS, CITY, STATE, ZIP CODE 300 PARK STREET, PO BOX 408 GREGORY, SD 57533
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S 000	Initial Comments Surveyor: 32332 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 5/19/14 through 5/21/14. Avera Rosebud Country Care Center was found not in compliance with the following requirements: S281, S300, and S301.	S 000	<i>Addendums noted with an asterisk per 6/20/14 telephone to facility administrator. SD/DOH/ME</i>	
S 281	44:04:06:05 RESIDENT CARE PLANS AND PROGRAMS The nursing service of a health care facility must provide safe and effective care from the day of admission through the ongoing development and implementation of written care plans for each...resident. The care plan must address medical, physical, mental, and emotional needs of the...resident. The health care facility must establish and implement procedures for assessment and management of symptoms including pain. The care plan for nursing facility residents must be based on the resident assessments required in sections 44:04:06:15 and 44:04:06:16 and must be developed and approved by the resident's physician; the resident, the resident's family, or the resident's legal representative; the interdisciplinary team consisting of at least a licensed nurse, the facility's social worker or social service designee, the dietary manager or dietitian, the activities coordinator, and other staff in disciplines determined by the resident's needs. The care plan shall describe the services necessary to meet the resident's medical, physical, mental or cognitive, nursing, and psychosocial needs and shall contain objectives	S 281		

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

[Signature]

TITLE

Administrator

RECEIVED (X6) DATE
6-17-14
JUN 18 2014
SD DOH L&C

If continuation sheet 1 of 7

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10625	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2014	
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S 281	<p>Continued From Page 1</p> <p>and timetables to attain and maintain the highest level of functioning of the resident. The care plan must be completed within seven days after the completion of each resident assessment required in sections 44:04:06:15 and 44:04:06:16.</p> <p>This Rule is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure the dietary department had been participating in two of nine sampled residents (3 and 9) interdisciplinary care plan meetings. Findings include:</p> <p>1. Review of resident 3's entire medical record revealed: *She had been admitted on 4/1/13. *She had nutritional concerns including weight changes and needed a special diet related to being at risk for choking. *Since her admission the dietary department had not been represented at her care conferences.</p> <p>Interview on 5/20/14 at 5:00 p.m. with the certified dietary manager (CDM) revealed: *She had only occasionally been able to attend a care conference. *She had needed to help as a cook in the kitchen for several months, so she had not been as available for care conferences. *She was aware she should have been participating in all the resident care conferences.</p> <p>Review of resident 3's interdisciplinary care plan implemented on 4/1/13 revealed: *There was a key to the staff initials and department represented on the care plan. *The CDM had not been represented.</p> <p>2. Review of resident 9's 1/14/14</p>	S 281	<p><i>*social services designee SB/SDDH/MF</i></p> <p><i>*and #9 SB/SDDH/MF</i></p> <p>Residents #3 care plan was reviewed by Registered Dietitian and Dietary Manager on May 27, 2014. Resident care conferences will be attended by the Dietary Manager or her designee beginning June 10, 2014.</p> <p>Monthly audit of all resident care conferences will be conducted by the [redacted] or designee. Audits will begin June 10, 2014. Results will be reported by the [redacted] to [redacted] <i>*the administrator SB/SDDH/MF</i> and quarterly to the Performance Improvement Committee at the next scheduled meeting on July 17, 2014 for six (6) <i>months</i> or until the Performance Improvement Committee advises to discontinue.</p> <p><i>*social services designee SB/SDDH/MF</i></p> <p><i>*weekly times 1 month, then monthly thereafter SB/SDDH/MF</i></p>	5-27-14

SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 281	Continued From Page 2 interdisciplinary care plan revealed: *There was a key to the staff initials and department represented on the care plan. *The CDM had not been represented. Interview on 5/21/14 at 11:00 a.m. with the Minimum Data Set coordinator revealed: *It had been nearly a year since the CDM had participated in the care conferences. *She always tried to communicate dietary changes or concerns related to a resident through e-mail. -It would have been beneficial to have the CDM at the meeting so they could discuss with her the concerns and have her input. Review of the provider's January 2014 care plan policy revealed "The interdisciplinary team will identify relevant assessment information regarding resident's status after obtaining input from the resident, resident's family, significant other, guardian or legally authorized representative. The interdisciplinary members will make the decision whether or not to develop a care plan based on information gathered during resident assessment process.	S 281			
S 300	44:04:07:14 Nutritional assessments A registered dietitian shall ensure a nutritional assessment is completed on each new resident upon admission; any resident having a significant change in diet, eating ability, or nutritional status; monthly for any resident receiving tube feedings; and on any resident with a disease or condition that puts the resident at significant nutritional risk. A monthly tube feeding assessment must include nutritional adequacy of calories, protein, and fluids. An annual assessment shall be	S 300			

SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 300	<p>Continued From Page 3</p> <p>completed for each resident.</p> <p>This Rule is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure two of nine sampled residents (2 and 3) had nutritional assessments completed as nutritional changes occurred. Findings include:</p> <p>1. Review of resident 2's Minimum Data Set (MDS) revealed: *On 7/24/13 a significant change assessment revealed he weighed 140 pounds (lb). *On 12/17/13 his quarterly assessment revealed he weighed 127 lb. *On 3/25/14 his quarterly assessment revealed he weighed 140 lb.</p> <p>Review of nutritional documentation revealed: *On 12/16/13 the registered dietitian (RD) documented "High nutritional risk related to a history of weight loss. This could also be related to diuretic therapy he was on. Continue on high nutrition risk monitoring intakes and weights." *There had been no further reviews by the RD.</p> <p>Interview with the certified dietary manager (CDM) on 5/20/14 at 5:00 p.m. revealed: *The RD always reviewed residents who were at risk and made a note when the resident had stabilized in their weights. *She was unsure why resident 2 had not been reviewed by the RD after 12/16/13. *The CDM might have overlooked putting him on the nutrition-at-risk list.</p> <p>2. Review of resident 3's physician's orders revealed an order for the resident to receive a nectar thickened liquids-dysphagia (a diet for people at risk for choking) diet.</p>	S 300	<p>Resident #2 and #3 annual nutritional assessments were completed by Registered Dietitian [REDACTED] on May 27, 2014.</p> <p><i>SB/SDO/HMF</i></p> <p>Monthly audit will be completed of resident's requiring nutritional assessment by the Registered Dietitian. Audits began May 27, 2014. Results will be reported by the Dietary Manager to [REDACTED] and quarterly to Performance Improvement Committee at the next scheduled meeting on July 17, 2014 for six (6) months or until the Performance Improvement Committee advises to discontinue.</p> <p><i>* administrator monthly beginning July 2014. SB/SDO/HMF</i></p>	5-27-14

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S 300	<p>Continued From Page 4</p> <p>Review of resident 3's laboratory results revealed she had tested positive for a urinary tract infection (UTI) four times since February 2014.</p> <p>Review of resident 3's 5/7/14 physician's progress notes revealed the physician felt her increased number of UTIs might have been due to the change in diet for thickened liquids. The resident had not liked the thickened liquids and was not drinking them.</p> <p>Review of resident 3's nutritional documentation revealed: *An annual assessment was completed by the RD on 3/14/14. -At that time she was on a regular diet. *There were no further reviews or assessments completed by the RD. *The certified dietary manager (CDM) documentation revealed: -On 5/6/14 "[Name of resident] refused thickened milk at breakfast stating that she wanted regular milk to mix into her cereal. -Still requests a small amount of regular milk to thin/cool it" [her cereal]. -On 5/19/14 "The resident had refused her thickened liquids because they hurt her stomach. She requested her milk not be thickened."</p> <p>Interview on 5/20/14 at 5:00 p.m. with the CDM regarding resident 3 revealed: *Dietary had not had her on nutritional risk because she had gained weight. *She was unaware the resident had recurring UTIs. *She was unaware the resident's physician had commented on her decreased fluid intake playing a role in her UTIs. *She had not attended care conferences regularly and had not had that information</p>	S 300		

SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 300	Continued From Page 5 communicated to her. 3. Review of the provider's February 2013 Nutrition at Risk policy revealed "When a resident is identified to be at nutritional risk, the RD will review the list of residents at nutritional risk monthly, and will document in the medical record as appropriate." Review of the provider's role of consultant dietitian policy revealed "The consultant dietitian will completed nutritional assessments upon admission, readmission, annual assessments, significant change and tube feedings and those at nutritional risk."	S 300		
S 301	44:04:07:16 Required dietary inservice training The dietary manager or the dietitian in ...nursing facilities...shall provide ongoing inservice training for all dietary and food-handling employees...Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. This Rule is not met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to ensure one of nine required annual inservice training sessions (leftover food handling policies) was offered yearly for food-handling staff. Findings include:	S 301		

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S 301	Continued From Page 6 1. Record review of the required inservice training sessions for 2013 and 2014 for all food handling staff revealed those staff had received no training on leftover food handling policies. Interview on 5/20/14 at 2:35 p.m. with the dietary manager revealed: *Food handling staff were identified as dietary, nursing, social services designee, and activities staff. *There was not a policy on required inservice training sessions for dietary staff and all food handlers. Interview on 5/21/14 at 10:15 a.m. with the director of nursing revealed: *Food handling staff were identified as the administrator, nursing, social services designee, activities, and dietary staff. *There had not been an inservice on leftover food handling offered yearly for food-handling staff. Review of the provider's undated Personnel Training policy revealed it had not included required inservice training sessions for dietary staff and all food handlers.	S 301	Policy on required in-service training sessions for dietary has been updated to include all food handlers. In-service for Registered Nurses was completed on June 3, 2014 and all [redacted] will be on June 20, 2014. *nursing home staff [redacted] * by the director of nursing [redacted] Dietary Manager or designee will monitor food handlers weekly during meals beginning June 12, 2014. Results will be reported by the Dietary Manager or designee to [redacted] and quarterly to Performance Improvement committee at the next scheduled meeting on July 17, 2014 for six (6) months or until the Performance Improvement Committee advises to discontinue. * the administrator weekly times 1 month, then monthly thereafter [redacted]	6-20-14