

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  An extended/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 and from 5/27/14 through 5/28/14. Michael J. Fitzmaurice South Dakota Veterans Home was found not in compliance with the following requirements: F157, F176, F241, F252, F280, F281, F309, F314, F323, F329, F332, F364, F368, F371, F441, F490, F493, F514, and F520.	F 000	A Performance Improvement Projects (PIPs) will be developed to examine and improve care or services identified in the deficiency report.	6/28/14
F 157 SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or	F 157	F157 NOTIFY OF CHANGES: Residents #1, 4, 8, 12, 14, 13, 15, and 16's physicians and/or families/responsible parties were notified of: Residents weight loss, Changes in skin integrity Changes of condition, and Pain management  A new policy entitled NOTIFICATION OF PROVIDER AND/OR FAMILY has been developed to ensure notification of provider and family in a timely manner. In the event of an/a: •accident with injury involving the resident, •significant change in the resident's physical, mental, or psychosocial status (deterioration in status in either life threatening conditions or clinical complications), •need to alter treatment significantly (need to discontinue an existing form of treatment because of adverse consequences, or start a new or different form of treatment), or •decision to transfer or discharge the resident from the facility; Notification to the resident, resident's physician, and if known, the resident's legal representative or an interested family member will occur immediately.  Expected Date of Completion: 6/28/14  Nursing staff were made aware 5/21/14 of change in the Notification of Provider and/or Family policy that reflects IMMEDIATE notification.	

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

TITLE

(X6) DATE

*Bradley T. Richardson*

*Director/ Superintendent*

*21 JUL 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 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 157	<p>Continued From page 1</p> <p>regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the provider failed to ensure the physicians and/or families were notified in a timely manner in regards to changes in condition related to: *Pressure ulcers for 5 of 16 sampled residents (1, 4, 12, 13, 15, and 16). *Weight loss for 1 of 16 sampled residents (1). *Other skin issues for 1 of 16 sampled residents (8). *A change/decline in condition for 8 of 16 sampled residents (1, 4, 8, 12, 13, 14, 15, and 16). Findings include: 1. Review of resident 8's nurses notes revealed he had a change in condition: *On 5/18/14 at: -11:32 a.m. He was unable to eat or drink. -11:39 a.m. He had symptoms of dehydration that included a dry mouth, increased temperature, dry skin, and sunken/dull eyes. Had an elevated temperature of 100.3 Fahrenheit (F). -11:41 a.m. Had decreased output from his urinary catheter. *On 5/19/14 at: -6:39 p.m. Noted a reddened, blanchable area on his left outer thigh. *On 5/21/14 at:</p>	F 157	F157 NOTIFY OF CHANGES continued: The DON or designee will perform a minimum of 5 resident record audits weekly X 4weeks, then monthly until the QA committee directs otherwise. The auditor will be reviewing for compliance of physician and family notification for those residents who may have had an accident with injury, significant change, need to alter treatment plan, or there was a decision for transfer or discharge from the facility.		

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 157	<p>Continued From page 2</p> <p>-6:25 a.m. He had an elevated temperature of 100.9 F</p> <p>-6:31 a.m. A Tylenol suppository was given for the elevated temperature. The medication was ineffective to reduce his temperature. A cool wash cloth was placed on his forehead. He was unresponsive when trying to given medications.</p> <p>Observation from 5/20/14 through 5/21/14 revealed resident 8 was lying in bed. He did not respond when spoken to.</p> <p>Interview on 5/21/14 at 10:00 a.m. with licensed practical nurse D revealed: *She was aware that resident 8 had declined. *She was not sure if his physician or family had been notified of his current condition. *She agreed there was no documentation that his physician or family had been notified of his current condition.</p> <p>Interview on 5/28/14 at 1:30 p.m. with the director of nursing (DON) revealed her expectations were that when a resident had a change of condition that the family and physician should have been notified within forty-eight hours. She also expected families and physicians to be notified along with dietary, physical and occupational therapy, and activities if a resident developed a pressure ulcer. They should have been notified within forty-eight hours.</p> <p>2. Review of resident 4's complete medical record revealed: *Multiple nursing notes regarding pressure ulcers noted since admit on 3/6/13. *There had been no documentation the physician had been notified. Refer to tag F314, finding 4.</p>	F 157			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 157	<p>Continued From page 3</p> <p>3. Review of resident 15's complete medical record revealed: *Since December 2013 there were multiple nurses notes regarding pressure ulcers. *There had been no documentation the physician had been notified. Refer to tag F314, finding 5.</p> <p>4. Review of resident 16's complete medical record revealed: *Since March 2014 there were multiple nurses notes regarding pressure ulcers. *There had been no documentation the physician had been notified. Refer to tag F314, finding 6.</p> <p>Interview on 5/28/14 at 3:20 p.m. with the director of nursing confirmed the physician had not been notified of pressure ulcers and other skin conditions until 5/22/14.</p> <p>5. Review of resident 1's April and May 2014 medication administration records (MAR) revealed he had refused his Tramadol (pain medication) that had been scheduled to be given four times a day (QID) twenty times during April. Review of the medical record revealed no documentation that the physician had been notified of any refusal of medications. As of 5/28/14 he had refused that same medication six times and his physician had not been notified. Refer to F309.</p> <p>6. Review of resident 12's nurses notes revealed: *4/6/14 Resident had an open area on his right lower buttock that was described as "Excoriation (superficial traumatic abrasions and scratches which remove some of the skin) from freq</p>	F 157			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747	
(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 157	Continued From page 4 (frequent) bowel incontinence." -The family and physician had not been notified of those findings. *5/12/14 He had a "Stage one (reddened area) or greater ulcer on the right lower buttock with excoriation, left mid back, right mid back, left lower buttock and right lower buttock" described as "Flushed, pale pink with thickened in appearance, and a fold like crack midline." -Physician or family had not been updated of those findings.  7. Review of resident 13's nurses notes revealed: *4/17/14 Resident's "Right mid calf, posterior right lower leg had been weeping slightly and there had been open areas to the left lower leg." *4/21/14 Had noted the measurements of the open areas. Family had not been notified. The physician had not been notified until 4/22/14.  8. Review of resident 14's nurses notes revealed: *4/7/14 Mental health nurse practitioner had ordered a new medication for agitation. -Family had not been notified of the medication change.  Review of the provider's nurses notes indicated no clarification with the physician the change of medications, the resident's condition, and had not notified the family of the change in medications.  9. Interview on 5/28/14 at 1:30 p.m. with the DON confirmed she would have expected the staff to update the physician or family within forty-eight hours. She confirmed the provider did not have have a physician nor family notification or a change of condition policy.	F 157		
F 176	483.10(n) RESIDENT SELF-ADMINISTER	F 176		

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747	
(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 176 SS=E	<p>Continued From page 5</p> <p>DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to follow their policy for resident self-administration of medications for five of eight sampled residents (6, 9, 10, 15, and 16) in the special care unit (SCU) and two of nine sampled residents (3 and 4) in the nursing care unit (NCU). Findings include:</p> <p>1. Observation on 5/20/14 at 2:30 p.m. revealed a small plastic medication cup on the bedside table in resident 6's room. That medication cup contained a pink ointment.</p> <p>Review of resident 6's May 2014 medication administration record (MAR) revealed he was to have Calmoseptine ointment [protective barrier ointment] three times daily to his perineal (peri)-area [bottom] for excoriation [superficial traumatic abrasions and scratches which remove some of the skin]. There was no physician's order that medication should have been left at his bedside.</p> <p>2. Review of resident 9's May 2014 MAR revealed an entry for "Calazime cream (protective barrier) to peri-area BID [twice daily] PRN [as needed] et [and] with brief changes. May keep at bedside." A 5/3/14 physician's order was present for that medication to be at the bedside.</p>	F 176	<p>F176 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>The facility failed to follow our policy for resident self-administration of medications. Residents #6, 9, 10, 15, and 16 are all residents on Special Care Unit (Dementia). Medications were removed from their rooms. Residents #3 and 4 will be assessed for their ability to self-administer medications by 6/28/14. All residents on NCU will be reviewed if they are self-administrating medications by 6/28/14. The policy and procedure on self-administration of medication has been revised to include:</p> <p>a.No resident on the Special Care Unit will be able to administer their own medications based on their need for a secured environment, have poor judgment, and decision making abilities. All medications for the Special Care Unit will be maintained at the nursing station in the secured medication room or cart.</p> <p>b.All residents not residing on the SCU and request to administer their medications will have an assessment done. Based on the assessment tool, a provider's order is required. The resident and family representative will meet in team care conference and criteria discussed.</p> <p>c.Abilities and assessment will be done quarterly correlate with their team care conference.</p> <p>Expected Date of Completion: 6/28/14</p>	6/28/14

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 176	Continued From page 6  3. Review of resident 10's May 2014 MAR revealed and entry for "Calazime skin protectant paste topical as needed. AM, PM, and Noc (night). May have at bedside." A 4/3/14 physician's order was present for that medication to be at the bedside.  Review of resident 9 and 10's medical records revealed there had been no assessments to determine if they were capable to self administer medications.  4. Review of resident 3's complete medical record revealed: *A 5/5/14 physician's order for Calazime ointment three times a day as needed (PRN). May have at bedside. *No assessment had been completed for the resident to self-administer medications. *Self-administration of medications had not been on the resident's care plan.  5. Review of resident 4's complete medical record revealed: *A 5/20/14 physician's order for Calazime skin protectant twice a day. May have at bedside. *No assessment had been completed for the resident to self-administer medications. *Self-administration of medications had not been on the resident's care plan.  6. Review of resident 15's complete medical record revealed: *A 4/3/14 physician's order for Calazime ointment to perineal area PRN. May keep at bedside. *No assessment had been completed for the resident to self-administer medications. *Self-administration of medications had not been	F 176	The SCU nursing supervisor will audit all SCU resident rooms weekly x 4 weeks and then monthly for the presence of medications. She will report these findings to the DON or designee. The ADON will complete audits of all residents on NCU who wish to self-administer medications. ADON will complete these monthly, and then quarterly. ADON will report these findings to the DON or designee. DON or designee will bring to QA on a quarterly basis until advised otherwise.		

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 176	<p>Continued From page 7 on the resident's care plan. *The resident was in the SCU.</p> <p>7. Review of resident 16's complete medical record revealed: *A 4/3/14 physician's order for Calazime ointment to peri-area PRN. May have at bedside. *No assessment had been completed for the resident to self-administer medications. *Self-administration of medications had not been on the resident's care plan. *The resident was in the SCU.</p> <p>Surveyor 26632 Interview on 5/27/14 at 3:00 p.m. with licensed practical nurse D revealed most of the residents that lived in the SCU had Calmoseptine in their rooms. On their bedside table or placed in a drawer beside their bed. She stated it was just more convenient for staff to have it close by.</p> <p>Interview on 5/28/14 at 1:30 p.m. with the director of nursing revealed she was aware calazime and Calmoseptine were stored in residents' rooms in the SCU. She agreed those residents did not have assessments completed to ensure they were capable of self-administration of medication.</p> <p>Review of the provider's reviewed 5/22/14 Self-Administration of Medications policy revealed: *Residents would require a physician's order to self-administer medications. *Residents would be able to demonstrate a proper understanding of self-administration by being able to identify each medication and why and when it was to be taken. *The resident's care plan would be updated to identify the self-administration.</p>	F 176			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 176	Continued From page 8 *Self-administration of medications would be reviewed on a semi-annual basis or as the need arises for an evaluation.	F 176	F241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY: All 52 resident rooms are private rooms. While the facility is undergoing a new structure building project, staff will provide increased privacy and acknowledge dignity with use of the toilet by the privacy curtain and close the room door.	6/28/14	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to ensure dignity had been maintained for all residents using the toilet and handwashing facilities in all fifty-two residents' rooms. Findings include:  1. Random observations from 5/19/14 through 5/21/14 of all fifty-two resident room toilet and handwashing sink areas revealed those areas could only be separated by a privacy curtain from the remainder of the resident room.  Interview on 5/28/14 at 1:00 p.m. with the physical plant manager confirmed resident rooms had been remodeled in 1996. The closet walls had been removed to make room for the addition of a sink and toilet in every resident room. Toilet and sink walls were not rebuilt due to federal resident room area square footage requirements.	F 241	All staff will be educated by 6/28/14, what constitutes dignity especially with personal cares and toileting and the planned use of privacy curtains and closed door. The DON or designee will monitor daily for compliance and re-educate staff in the event of non-compliance. Monitoring results will be shared with QA committee at a minimum of a quarter, then until the QA committee directs otherwise.		
F 252 SS=B	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT  The facility must provide a safe, clean,	F 252			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 252	Continued From page 9 comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain a homelike environment for all residents residing in the facility. Exposed plumbing, exhaust, return air piping, and cable runs were visible in the ceilings and along the walls in corridors, residents' rooms, and resident use areas. Findings include:  1. Random observations from 5/19/14 through 5/21/14 revealed corridors, residents' rooms, and resident use areas had plumbing, exhaust and return air piping, and cable runs visible in the ceilings and along the walls.  Interview on 5/28/14 at 1:00 p.m. with the physical plant manager confirmed he was aware of the visible piping, venting, and cable runs. The building had been in that condition before he had started at the facility. At one time he had looked into putting in a false ceiling, but then the rooms would not have met the room height requirements.	F 252	F252 SAFE, CLEAN, COMFORTABLE, AND HOMELIKE ENVIRONMENT We recognize the need to provide a more homelike environment for residents we serve. While exposed plumbing and ductwork detract from that homelike atmosphere, our residents consider this facility as their home. We are very proud of that fact and do everything we can to address concerns relating to maintaining an older building as quickly as possible. To address this deficiency, the provider proposes to construct a replacement facility which has already begun and is slated for completion in spring, 2017. The architect has addressed the exposed piping and ductwork by concealing these items within walls and above ceilings. The replacement building will meet all construction requirements to participate as a Medicare/Medicaid Certified nursing home. Project completion should be approximately 18-24 months from project start date barring any unforeseen developments.		
F 280 SS=F	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.	F 280			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 280	<p>Continued From page 10</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to update the care plans to reflect the current status for 12 of 16 residents (1, 2, 3, 4, 6, 7, 8, 12, 13, 14, 15, and 16). Findings include:</p> <p>1. Observation on 5/21/14 at 8:30 a.m. of resident 1 during personal care revealed: *He required extensive assistance with activities of daily living (ADL). He had refused the breakfast meal. The items on the breakfast tray were Ensure, milk, juice, and coffee.</p> <p>Review of resident 1's 4/4/14 updated care plan revealed: *Problem area: "Potential for self care deficit (unable to do by himself) related to history of schizophrenia/depression/diabetes with neuropathy (numbness)/secondary to parkinsonism (disease that causes shaking)." -Interventions for the nurses "Per residents</p>	F 280	<p>F280 483.20(D)(3), 483.10(K)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE Residents 1, 2, 3, 4, 6, 7, 8, 12, 13, 14, 15, and 16 care plans have been reviewed and revised as needed. All residents have a right to participate in their own care plan in which it is current and reflects their actual care status. Review of the Comprehensive Care Planning policy has been reviewed and renamed to Team Care Conference and Team Care Creation to resident and family participation in the team care conference. MDS Coordinators have been tasked with doing monthly chart audits to ensure compliance with this deficiency. Staff has received and will continue to receive education of importance of residents/family participating in care planning creation and updating the care plan as cares change on the active document. These audits will be monitored by the DON who will report to QA. Expected Date of Completion: 6/28/14 Responsible Party: DON or designee will bring to QA on a quarterly basis until advised otherwise.</p>	6/28/14	

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	<p>Continued From page 11</p> <p>preference he likes to be in his room naked, door will be kept shut to allow for privacy." -Interventions for the CNAs "Change clothes when they are soiled and assist with ADLs as needed." -Goal: "I will have no further decline in ability to perform ADLs. Clean/fed/well groomed."</p> <p>There was conflicting information in his care plan as to if the resident was to be dressed or not.</p> <p>*Problem area: "Potential for hyperglycemia/hypoglycemia related to adult onset diabetes." -Interventions for dietary: "Provide ordered diet. Monitor nutrition/hydration. Offer substitute foods." -Interventions for activity "Provide low-calorie foods and fluids." -Goal: "No symptoms of hypo (low) or hyperglycemia (high)."</p> <p>The resident had been losing weight and had not been eating well. They had been providing him foods that he wanted to encourage intake as noted in the meal provided at breakfast on 5/21/14.</p> <p>*Problem area: "Unintended weight loss related to constipation, skips meals, prefers to smoke vs (versus). eat." -Interventions for nurses "Encourage (resident's name) to wait to smoke after meals have ended. Monitor and record meal intakes per facility protocol." -Goal: "Weight within ideal body weight range."</p> <p>Currently the resident's weight was below ideal weight at 114 pounds on 3/11/14 as documented</p>	F 280			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 280	<p>Continued From page 12 by the registered dietician.</p> <p>*Problem area: "Potential for impaired skin integrity related to use of psychotropic medications, diabetes, history of cellulitis, and dehydration." -Interventions for the nurses "Skin assessment per policy. Administer supplements as ordered. Use pressure relieving devices: pressure relieving mattress. Note nutrition and hydration status and address sources of deficiency." -Goals: "No skin breakdown. No sign or symptom of infection."</p> <p>Observation on 5/21/14 at 8:30 a.m. of personal care provided to resident 1 by certified nursing assistants (CNA) A and B revealed: The status of resident 1's skin had been ten open areas around his rectal opening. CNA A then applied calazime cream. Review of his care plan revealed that had not been indicated as an intervention in the care plan. There were actual skin issues not potential skin issues as the care plan stated.</p> <p>2. Review of resident 2's updated 4/24/14 care plan revealed: *Problem area: "Potential for impaired skin integrity related to limited mobility, urinary incontinence, pruritis (itchiness)." -Interventions for the nurses were "Skin assessments per policy." For the CNAs: "Keep skin clean and dry. Use of incontinent products. Barrier cream to peri area as needed. (Resident name) wears diabetic shoes for prevention of skin breakdown." -Goal: "No skin breakdown. No sign or symptom of infection."</p> <p>On 5/5/14 staff obtained a physician's order for</p>	F 280			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 280	<p>Continued From page 13</p> <p>calazime ointment to peri-area three times a day as needed for the excoriation. The excoriated area had not been listed as a problem area and was an actual skin issue not a potential as the care plan stated.</p> <p>3. Review of resident 7's updated 5/9/14 care plan revealed: *Problem area: Initiated on 1/30/14 of "Pressure ulcer bi-lateral heels and left buttock with admit from (specific hospital)." -Interventions for nurses: "Measure and document size of ulcer as ordered. Keep skin dry and linens clean and dry and wrinkle free every shift. Provide extra protein. Assist with repositioning. Apply dressings/ointments as ordered. Pressure relieving mattress." -Goal of "Resident's ulcer will not increase in size daily."</p> <p>Interview on 5/28/14 at 1:30 p.m. with the director of nursing confirmed there had been no formal skin assessment protocol when there had been an open area. She would have expected the wound to be assessed daily by the nurse, and the measurements documented weekly.</p> <p>4. Review of resident 12's updated 5/27/14 care plan revealed: *Problem area: "Impaired skin integrity, moderate risk for skin breakdown (Braden [assessment to reveal risk for skin breakdown] 14). Widespread pruritis. Pale/pink area to left lower buttock, right lower buttock, left mid buttock. Healing stage 2 ulcer to right posterior thigh. Related to limited mobility, fecal incontinence, impaired tactile [feeling by touch] sensation, disease process, chemotherapy, dry aging skin in a warm dry environment. Manifested (seen) by complaints of</p>	F 280			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747	
(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 280	<p>Continued From page 14</p> <p>itching. Periodic excoriation on buttocks." -Goal: "No sign or symptom of infection. Regain skin integrity."</p> <p>Review of the provider's undated Skin/Wound Quality Indicator (QI) log regarding resident 12 revealed numerous entries of excoriation of buttocks, a stage two pressure ulcer on right lower buttock, and a stage two pressure ulcer on right lower leg. There had been no documentation of the other sites listed in the problem area of the care plan.</p> <p>5. Review of resident 13's updated 5/8/14 care plan revealed: *Problem area: "Potential for skin breakdown related to peripheral vascular disease (poor blood flow in the legs), diabetes, and disease process manifested (as seen) by stasis ulcer present. Discolored area. Fragile skin." -Interventions for the nurses: "Skin assessment per policy." -Goal: "Regain skin integrity. Decreased wound size. No signs or symptom of infection."</p> <p>Review of the provider's undated Skin/Wound QI log regarding resident 13 revealed entries of actual skin issues. An entry dated 5/27/14 that had been facility acquired (had been a blister on his lower left leg). It measured one centimeter by one centimeter. The log had been left blank for the interventions, dietary notifications, if added to care plan, and if family and physician had been notified.</p> <p>6. Review of resident 14's updated 4/18/14 care plan revealed: *Problem area: "Potential for impaired skin integrity, high risk for heel ulcer related to</p>	F 280		

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 280	<p>Continued From page 15</p> <p>cognitive [thinking] impairment, diabetes, CHF [congestive heart failure]/CAD [coronary artery disease], history of pressure ulcer to coccyx, incontinence, Alzheimer's, COPD [chronic obstructive pulmonary disease], seborrhea capitis [dry scalp], dermatitis [inflammation] scalp and beard."</p> <p>-One of the interventions for nurses had been to perform, "Skin assessment per policy."</p> <p>-Goal: "No skin breakdown. No sign or symptom of infection."</p> <p>Review of resident 14's medical record indicated on 5/3/14 he had a pressure ulcer on his right and lower buttocks which indicated he had an actual skin issue not a potential skin issue.</p> <p>7. Review of resident 3's complete medical record revealed he had a history of pressure ulcers.</p> <p>Review of resident 3's 5/22/14 Skin/Wound QI log revealed he had a rash to both sides of his groin, upper left thigh, and lower left leg. The intervention was documented as other.</p> <p>Review of resident 3's current care plan updated on 3/19/14 revealed: *Potential for impaired skin integrity. *High risk for heel ulcers. *An approach for skin assessments per policy. *His care plan had not been updated to include his current skin condition.</p> <p>8. Review of resident 4's current care plan updated on 5/19/14 revealed there had been no mention of his continuing pressure ulcers to his buttocks. The care plan had not been updated to reflect his current status. Refer to F314, finding 4.</p>	F 280			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 280	<p>Continued From page 16</p> <p>9. Review of resident 15's current care plan updated on 5/27/14 revealed: **"Impaired skin integrity, Stage II [superficial or shallow break in the skin surface] at top of buttocks crease." **Administer medications and treatments as ordered and evaluate for effectiveness." *There had been no documentation the physician had been notified of his current skin condition. *There had been no skin treatments ordered since 4/3/14. Refer to F 314, finding 5.</p> <p>10. Review of resident 16's current care plan updated on 5/27/14 revealed: **Impaired skin integrity, Stage II to right mid buttock and right lower buttock..." *Conflicting documentation on the care plan and the Skin/Wound QI log. *Skin assessment daily per policy with documentation. *Evaluate healing process and revise care plan as needed. *Administer treatments as ordered.</p> <p>Review of resident 16's May 2014 medication and treatment administration records revealed: *A 5/22/14 physician's order for Calazime two times a day to coccyx. *From 5/22/14 to 5/28/14 Calazime had been documented as applied one time on 5/23/14. Refer to F 314, finding 6.</p> <p>11. Review of resident 6's 11/22/13 care plan, updated 4/22/14 revealed: *Problem: Potential for impaired skin integrity. Stage two pressure ulcer behind right ear. *Approach: Included none for the pressure ulcer</p>	F 280		

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 280	<p>Continued From page 17 behind his right ear. *Goal: No skin breakdown.</p> <p>Review of resident 6's quarterly Minimum Data Sets (MDS) revealed: *5/15/13 quarterly Minimum Data Set (MDS) revealed he had one stage two pressure ulcer. *8/13/13 he had one stage two pressure ulcer. *11/3/13 he had one stage two pressure ulcer. *4/21/14 he had two stage two pressure ulcers.</p> <p>12. Review of a resident 8's 3/28/14 care plan for impaired skin integrity revealed no skin breakdown. Review of a 5/19/14 nurses note at 6:39 p.m. revealed an entry for a reddened, blanchable area to his left outer thigh.</p> <p>Continued review of resident 8's medical record revealed he had a bowel impaction with resulting treatments and a re-hospitalization on 5/7/14. He had been hospitalized on 5/1/14 and re-admitted on 5/6/14. The care plan had not been updated in regards to his constipation and bowel impaction.</p> <p>13. Review of the provider's reviewed 1/14/14 Comprehensive Care Planning policy revealed: *All goals would be measurable, realistic, timely, obtainable, and individualized. *Standardized care plans would be utilized as soon as a problem developed. *Care plans would be assigned and handed to the nursing assistant staff on each unit to review, add, or delete pertinent care issues. *The unit supervisor was responsible for all changes in the treatment plan and to ensure information was relayed to the nursing assessment coordinator.</p> <p>Interview on 5/21/14 at 1:30 p.m. with licensed</p>	F 280			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 280	Continued From page 18 practical nurse (LPN) D revealed: *She did not update care plans in the computer. *She was not aware of the hard copies of the care plans, and she also did not update those.  Interview on 5/28/14 at 1:30 p.m. with the director of nursing revealed: *The care plan was to be a working copy to reflect all residents' current status. *Her expectation was the charge nurse, dietary, and all other disciplines should have updated each resident's care plan to reflect their current status.	F 280	F281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS Residents 1, 2,3,4,5, 6, 7, and 8's MARs and TARs have been reviewed. All residents that receive medications and treatments are at risk for missing documentation. Review of the Medication Administration policy has been reviewed and revised to include an additional checklist to ensure PRN medications/treatments are documented for effectiveness. Staff has received education regarding the use of this new checklist and it will be continued to be used along with the PRN MAR already in place.	6/28/14	
F 281 SS=F	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: Based on observation, record review, interview, and policy review, the provider failed to: *Ensure all medication administration records (MAR) and treatment administration records (TAR) had medication and treatment for eight of eight sampled residents (1, 2, 3, 4, 5, 6, 7, and 8). *Ensure medications used on an as needed (PRN) basis had documentation of the effectiveness for seven of eight sampled residents (1, 2, 3, 4, 6, 7, and 8). *Ensure one of one treatment cart and one of two medication carts were locked on the nursing care unit (NCU). Findings include:  1.a. Review of resident 5's March 2014 and April	F 281	Unit supervisors will be tasked with doing monthly chart audits to ensure compliance with this deficiency. These audits will be monitored by the DON who will report to QA.  The medication and treatment carts were checked to ensure that both locking mechanisms were in working order and this was confirmed. Staff on duty and hence forward have been reeducated on the need to lock the carts when not in attendance or in use. Continued education will be provided and on the spot training will be conducted if this is captured again. DON or designee will perform random checks to ensure medication carts are secured daily for 4 weeks, then 3 – 5 times weekly for one quarter, then weekly until the QA committee determines otherwise. Expected Date of Completion: 6/28/14		

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	<p>Continued From page 19</p> <p>2014 MARs and TARs revealed numerous blank documentation boxes. Those boxes were to have been initialed after the resident had received her medications and treatments.</p> <p>b. Review of resident 6's March 2014, April 2014, and May 2014 MARs and TARs revealed numerous blank documentation boxes. Those boxes were to have been initialed after the resident had received his medications and treatments.</p> <p>Review of resident 6's PRN medication documentation sheet revealed entries from 3/16/14 through 5/17/14. Three of the nine entries for PRN medications revealed no results had been charted.</p> <p>c. Review of resident 8's March 2014, April 2014, and May 2014 MARs and TARs revealed numerous blank documentation boxes. Those boxes were to have been initialed after the resident had received his medications and treatments.</p> <p>Review of resident 8's PRN medication documentation sheet revealed entries from 3/20/14 through 5/19/14. Ten of the twenty entries for PRN medications revealed no results had been charted.</p> <p>d. Review of resident 3's March 2014, April 2014, and May 2014 MARs and TARs revealed numerous blank documentation boxes. Those boxes were to have been initialed after the resident had received his medications and treatments.</p>	F 281	Responsible Party: DON or designee will bring to QA on a quarterly basis until advised otherwise.	

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 20</p> <p>Review of resident 3's PRN medication documentation sheet revealed entries from 3/4/14 through 5/19/14. Multiple entries for PRN medications revealed unclear or no results had been charted.</p> <p>e. Review of resident 4's March 2014, April 2014, and May 2014 MARs and TARs revealed numerous blank documentation boxes. Those boxes were to have been initialed after the resident had received his medications and treatments.</p> <p>Review of resident 4's PRN medication documentation sheet revealed entries from 3/6/14 through 5/7/14. Multiple entries for PRN medications revealed unclear or no results had been charted.</p> <p>f. Review of resident 1's March, April, and May 2014 MARs and TARs revealed numerous blank documentation boxes. Those boxes were to have been initialed after the resident had received her medications and treatments.</p> <p>Review of resident 1's PRN medications from 1/13/14 through 5/15/14 revealed five out of seven times there had been no follow-up documented.</p> <p>g. Review of resident 2's March, April, and May 2014 MARs and TARs revealed numerous blank documentation boxes. Those boxes were to have been initialed after the resident had received her medications and treatments.</p> <p>Review of resident 2's PRN medications from 1/13/14 through 5/15/14 revealed seven out of</p>	F 281			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	<p>Continued From page 21</p> <p>eleven times there had been no follow-up documentation.</p> <p>h. Review of resident 7's March, April, and May 2014 MARs and TARs revealed numerous blank documentation boxes. Those boxes were to have been initialed after the resident had received her medications and treatments.</p> <p>Review of resident 7's PRN medications from 4/10/14 through 5/19/14 revealed three of fourteen times there had been no follow-up documentation.</p> <p>2. Observation on 5/19/14 from 5:04 p.m. through 5:25 p.m. revealed one of the two medication carts on NCU had been unlocked with no staff member present. That cart had been parked outside of the dining room. Residents and staff members had been passing by that cart.</p> <p>Surveyor: 32333</p> <p>3. Observation on 5/19/14 at 2:50 p.m. on the NCU of the treatment administration cart revealed: *It had been in the red hallway unattended. *It had been unlocked. *The cart had contained treatment supplies such as needles and wound care supplies. *It had remained unlocked for at least fifteen minutes during the observation.</p> <p>4. Interview on 5/28/14 at 1:30 p.m. with the DON confirmed medication and treatment carts should have remained locked at all times when they were unattended.</p> <p>Surveyor: 26632 Interview on 5/28/14 at 1:30 p.m. with the director</p>	F 281		

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	Continued From page 22 of nursing revealed she expected all medications and treatments to have been signed when given or completed. She also expected PRN medication results to have been documented.  Review of the provider's reviewed 5/22/14 Medication Administration policy revealed: **"The individual administering the medication must ensure that the 7 rights of medication administration are followed before giving the medication." One of those rights included the right documentation. **"Professional standards required after the nurse administered the medication the MAR was completed per policy to verify the medication was given as ordered." **"After administering a medication the nurse records it immediately on the appropriate MAR."  Review of the provider's reviewed 5/22/14 Charting of Medications policy revealed: *All squares were to be completed with the initials of the nurse or medication aide who gave the medication immediately following the administration of the prescribed medication. *MARs were to be checked weekly by the night charge nurse for completion of signatures. *Refused medications were to be noted by circling the nurse or medication aides initials and writing an explanation on the PRN sheet.	F 281			
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 23 and plan of care.  This REQUIREMENT is not met as evidenced by: A. Based on observation, interview, record review, and policy review, the provider failed to ensure effective pain management for one of two sampled residents (1) with pain during personal care. Findings include:  1. Observation on 5/21/14 at 8:30 a.m. of resident 1's personal care provided by certified nursing assistants (CNA) A and B revealed: *He had been assisted to a standing position while CNA B physically held onto him and he held onto the walker. *CNA A provided the personal care and during that care he exclaimed "ouch" and physically pulled away from CNA A and B.  Interview with the resident at the above time revealed he rated his pain as "General." When clarifying the pain further and using the 1 to 10 pain scale he stated it was 5 to 6 which revealed moderate pain.  Review of resident 1's medical record revealed: a. Medication administration records (MAR) had physician's orders for the following months: *March 2014: -Tramadol (pain medication) 50 milligram (mg) one tablet four times a day (QID) by mouth (PO) for severe pain. On 3/21/14 the physician had increased the dose to 100 mg three times a day (TID). -Acetaminophen 325 mg two tablets PO every four hours as needed (PRN) for pain and	F 309	<b>F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b> A. Resident #1 total chart including care plan, MAR, nurses notes, MDS, and policies have been reviewed and/or revised. It is noted that resident #1 died in the facility on 6/13/14. It is also noted that resident #1 had no family for notification. All residents experiencing pain either acutely or chronically may be affected. Review of the Medication Administration policy has been reviewed and revised to include specifics regarding pain medication and assessment.  Staff has received and will continue to receive education about the importance of assessment, treatment, documentation, and notification of provider physician/family for residents experiencing pain. Pain assessments will be monitored by ADON or designee on a weekly basis by reviewing 5 pain assessments and forwarded to DON or designee to report to QAPI on a monthly basis. Pain assessments will be completed on all residents upon admission, quarterly, significant change or as needed. It is the nurse's responsibility to initiate the pain assessment scale, report to provider, family, MDS coordinator, and DON. The nurse will initiate or implement non-pharmacological or pharmacological interventions as ordered.	6/28/14

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A138	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 309	<p>Continued From page 24</p> <p>fever.He had received it once on 3/18/14. *April 2014: -Tramadol 50mg two tablets QID. He had refused twenty-two of the QID scheduled doses. May 2014: -Tramadol 50mg two tablets QID. -He had refused eight of the scheduled doses from 5/1/14 through 5/19/14. -Hydrocodone/APAP (pain medication) 5/325 mg every four hours PRN. -He had received it on 5/9/14 and 5/19/14 -Tylenol 325 mg one to two tabs PO for pain/fever every four to six hours PRN. -He had received it on 5/10/14.</p> <p>Review of the nurses notes from 1/1/14 through 5/21/14 revealed entries made on the following: *2/18/14 as "No symptoms of pain/denies pain." *3/19/14 as "Moderate generalized pain." *3/20/14 as "Moderate all over." *3/21/14 as "Mild." *3/22/14 as "Severe." *3/23/14 as "Severe and radiating." No standardized pain rating score had been used. There had been one note that indicated the physician had been notified of his pain. There had been no documentation of his family having been notified of his pain issues.</p> <p>Review of the 12/29/13 and 3/24/14 Minimum Data Sets (MDS) described his pain as severe.</p> <p>Review of the updated 4/4/14 care plan revealed a problem initiated on 1/3/14: "Potential (at risk for) for chronic pain related to back and hip pain of recent onset." *Interventions dated on 1/3/14 for nurses had been to "Assess physical symptoms, ask about pain regularly, use verbal pain assessment tool,</p>	F 309	<p>B. It is reported that resident had constant loose stools. There was minimal documentation of provider notification and none for family regarding the loose stools. Resident #1 does not have any family to contact. Policy has been implemented to include for 2 loose stools, direct care staff are to report to the charge nurse. The charge nurse is expected to do an assessment to determine the cause. Following the implementation of standing order Loperamide, provider is to be notified as well as family for change in condition. Nursing is to ensure that loose stools are noted on care plan and bowel movements are monitored daily.</p> <p>Unit Supervisors of their respective unit will monitor daily bowel movement (BM) log to identify those residents with 2 or more loose stools and will monitor nurse notes on a weekly basis to ensure that follow-up was done. Weekly audits will continue x 4 and reported to DON or designee who will bring to QA on a quarterly basis. Expected Date of Completion is 6/28/14.</p> <p>The pressure ulcer policy has been updated and revised and is addressed in F314. Please refer to POC F314.</p>		

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 309	<p>Continued From page 25</p> <p>use non-verbal pain assessment tool, investigate other causes of pain, administer pain meds and note effectiveness/adverse effects, and notify physician of changes."                      *Interventions dated 1/3/14 for CNAs were to "Assist with repositioning as needed, assist with ADLs [activities of daily living] as needed, report pain indicators, and report changes in behavior (eg: increased agitation/anxiety)."                      *Interventions dated 1/3/14 for physical therapy (PT) were to "Evaluate and treat as indicated and report changes in ability."                      *Interventions dated 1/3/14 for all staff were to "Encourage fluids and report pain indicators."                      *The goal had been dated 4/4/14 as "Expressed feelings of comfort or of pain relief."                      -The goal time had been "By next review three months."</p> <p>Interview on 5/21/14 at 12:50 p.m. with the assistant director of nursing (ADON) confirmed staff had not been consistent in documenting residents' pain assessments in the same areas within the electronic medical record.</p> <p>Interview on 5/28/14 at 1:30 p.m. with the director of nursing (DON) revealed the provider did not have a policy regarding pain management. She would have expected pain assessments to have been completed quarterly or as needed.</p> <p>B. Based on observation, interview, record review, and policy review, the provider failed to intervene in a timely manner for one of one sampled resident (1) with constant loose stools. Findings include:</p> <p>1. Observation on 5/21/14 at 8:30 a.m. during</p>	F 309			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 309	<p>Continued From page 26</p> <p>personal care revealed resident 1 had been incontinent of liquid foul smelling stool.</p> <p>Review of resident 1's medical record from March 2014 through May 2014 revealed the provider had standing orders for loperamide (medication for loose stools) 2 mg PRN for diarrhea QID for two days.</p> <p>Review of the following MAR revealed: *March MAR: -A 3/13/14 physician's order for loperamide 2 mg PO every other day at breakfast for diarrhea. That physician's order had been discontinued on 3/21/14. -Another physician's order had been obtained on 3/8/14 for loperamide 2 mg PO QID PRN for diarrhea for two days. *April MAR: -A 4/16/14 physician's order for loperamide 2 mg PRN for diarrhea QID for two days. -He had received one dose of that medication. *May 2014 had no indication of loose stools.</p> <p>Review of the updated 4/4/14 care plan revealed a problem initiated on 10/08/13 of a potential for urinary incontinence related to benign prostatic hypertrophy (enlarged prostate), diabetes, history of urinary tract infection (UTI), and history of elevated PSA (prostate hormone). There had been no problem for incontinence of bowel or loose stools.</p> <p>Review of the nurses notes from 1/1/14 through 5/21/14 revealed entries related to loose stools or incontinence of bowel movements (BM) had been made on the following number of days: *January: two days. *February: three days.</p>	F 309			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 309	<p>Continued From page 27</p> <p>*March: ten days. *April: five days. *May: two days.</p> <p>There had been one note that indicated the physician had been notified of the loose stools. There had not been documentation of family notification.</p> <p>Review of the provider's certified nursing assistant documentation from 4/27/14 through 5/27/14 revealed at least daily documentation of numerous loose stools.</p> <p>Review of the 12/29/13 and 3/24/14 MDSs stated the resident had not been on a toileting program. The 12/29/13 MDS stated the resident had been continent of stool. The 3/24/14 MDS stated the resident had been frequently incontinent of stool.</p> <p>Interview on 5/21/14 at 9:00 a.m. with registered nurse C confirmed the resident had diarrhea constantly. It had been related to the Ensure supplement he drank for every meal. She could not provide documentation that another supplement had been tried to relieve the diarrhea.</p> <p>Interview on 5/28/14 at 1:30 p.m. with the DON confirmed there had been no policy on bowel protocol. She confirmed she would have expected the physician to have been updated on the loose stools, and other measures should have been attempted.</p> <p>C. Based on observation, interview, policy review, and record review, the provider failed to ensure documentation of skin issues had been addressed for one of one sampled resident (1) with numerous ulcers. Findings include:</p>	F 309			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 309	<p>Continued From page 28</p> <p>1a. Observation on 5/21/14 at 8:30 a.m. of resident 1 during personal cares revealed: *CNA. A and B had provided personal care and cleansed his skin. *The resident's bottom had ten open ulcers (breaks in the skin) around his rectal opening. *The buttocks and upper thighs were reddish purple in color with skin peeling off.</p> <p>Review of his medical record revealed Braden (assessment to evaluate risk of skin breakdown) scores had been completed: *On 12/25/13 and documented as "20-not at risk for skin breakdown with additional risk factor of diabetes." *On 3/18/14 as "17-mild risk for skin breakdown with additional risk factor of diabetes."</p> <p>Review resident 1's of the updated 4/4/14 care plan revealed: *Problem area: "Potential for impaired skin integrity" had been initiated on 1/3/14. -Interventions for on 10/17/14 for nurses: "Perform skin assessments per policy, administer supplements, administer medications/treatments as ordered and evaluate for effectiveness, use pressure reducing devices; pressure relieving mattress." -Interventions for CNAs had been dated on 10/17/14 to "Assist with hygiene/skin care as needed, report changes to the nurse, and keep skin clean and dry." -Interventions on 10/17/14 for dietary: "Monitor weight, provide additional fluids, and provide nutritional supplements." -Interventions on 10/17/14 for all staff: "Report changes to nurse and offer fluids frequently." -Goal: "No skin breakdown, no signs or symptoms of infection."</p>	F 309			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 309	<p>Continued From page 29</p> <p>-Goal date: "By next review three months."</p> <p>The skin issues were described in the nurses notes from 1/1/14 through 5/21/14 as:</p> <p>"Excoriated from feces contact and improper peri care."</p> <p>"Excoriations left and right buttock, fleshy area."</p> <p>"Excoriations to buttocks bilaterally, mepiplex (special dressing) dressing ordered but unavailable this noc (night)."</p> <p>"Rubbing his bottom to point of making his skin raw and feces remain."</p> <p>"Open area."</p> <p>"Excoriations from incontinence of bowel and bladder."</p> <p>"Desensitized skin present."</p> <p>"Poor skin turgor."</p> <p>"Excoriations on buttocks from persistent incontinence of BM and urine."</p> <p>"Entire buttocks red and excoriated from feces and incontinence of urine."</p> <p>"Resident is very emaciated with many bony prominences. His movement is minimal. His buttocks and perineal area are excoriated with some open areas."</p> <p>There had been no documentation the physician had been notified of the open areas. Also there had been no documentation that family had been updated on his condition.</p> <p>b. Review of the 12/30/13 dietary review for resident 1 revealed his ideal weight range had been 140 to 174 pounds (lb). His weight had been 127 lbs. His BMI (measurement of body fat) indicated he was underweight. The registered dietician (RD) recommended his weight to be at 144 lbs. The record also indicated "He is refusing more meals than eating. Does drink ensure for meal before he smokes. No problems with</p>	F 309			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 309	<p>Continued From page 30</p> <p>chewing or swallowing. No problems with constipation or diarrhea. (resident name) has no teeth, but has no pain or sores with gums or mouth."</p> <p>Review of the 3/28/14 dietary review by the certified dietary manager (CDM) revealed he was on palliative care (symptom management). His weight had been 117 lbs. The RD recommended ideal weight had not changed. The record also indicated: "has not been eating for a while. He eats and drinks his ensures. Has not been smoking."</p> <p>Review of the 3/31/14 RD documentation revealed his weight had been 114 lbs. His diet had been regular with ground meats and supplements. The resident had been eating independently. That note stated, "He has lost weight, 35 pounds from one year ago and 15 pounds since 1/3/14-to his disadvantage. Resident is very thin and emaciated in appearance-he has bony prominences with muscle wasting and no fat pads. He has skin issues on buttocks which are compromised by incontinent bladder and bowel and currently has diarrhea. He is at seriously compromised nutritional status."</p> <p>c. Review of the provider's 1/12/06 Charting for Nursing Care and Special Care Units policy stated:            *Monthly charting is to include but not limited to:            *Mode of transportation.            *Ability to perform Activities of Daily Living (ADL).            *Continence of bowel and bladder.            *Toileting plan.            *Orientation.            *Diet.</p>	F 309			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 31 *Nutritional problems. *Special problems or complaints. *Pain management. *Skin assessment. *Mood and behaviors.*  Review of the provider's 11/5/08 Resident Hydration policy revealed: **All residents will be monitored for risk of dehydration via nursing assessment, RD (registered dietician) consults, and dietary manager review." **Any concerns are to be address(ed) with the dietary manager, dietician, and primary care provider for follow-up." **Any actual or potential problems related to dehydration (incontinence, skin breakdown, immobility, etc.) will [be] noted on each careplan."	F 309			
F 314 SS=K	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747	
(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 314	<p>Continued From page 32</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure there was an effective pressure ulcer management program for 11 of 16 sampled residents (1, 4, 6, 7, 8, 10, 12, 13, 14, 15, and 16) with pressure ulcers. That failure created a situation of immediate jeopardy that had the potential for causing harm to all residents with a pressure ulcer and those at risk for developing a pressure ulcer.</p> <p>NOTICE: Notice of immediate jeopardy was given verbally to the administrator, the assistant director of nursing, and the director of operations on 5/21/14 at 2:12 p.m. The administrator was asked for an immediate plan of correction to ensure all residents with pressure ulcers were effectively managed and for other residents with the potential for pressure ulcer development.</p> <p>PLAN: On 5/21/14 at 5:15 p.m. the interim administrator and director of nursing (DON) provided the surveyors with the written plan of correction (POC). The written POC dated 5/21/14 was accepted by the surveyors. That immediate POC included: *Skin assessments on all residents would be done with next scheduled bath. *Consult with physical therapy for positioning for wheelchair and bed bound residents with active skin conditions such as pressure ulcers or stasis ulcers within forty-eight hours. *Team created of nurse managers, Minimum Data Set (MDS) coordinators, and dietary to spearhead a skin assessment and treatment</p>	F 314	<p>F314 483.25(c) TREATMENT/SERVICES TO PREVENT/HEAL PRESSURE SORES NOTICE: Notice of immediate jeopardy was given verbally to the administrator, the assistant director of nursing, and the director of operations on 5/21/14 at 2:12 p.m. The administrator was asked for an immediate plan of correction to ensure all residents with pressure ulcers were effectively managed and for other residents with the potential for pressure ulcer development.</p> <p>The following plan of correction was implemented and accepted on 5/21/14: 5/21/14 Braden Scale will be completed 1.Skin assessments on all residents will be done on next scheduled bath. 2.Consult with physical therapy for positioning for wheelchair and bed bound residents with active skin conditions (i.e. pressure ulcers or stasis ulcers) within 48 hours. 3.Team created of Nurse Managers, MDS coordinators and dietary to spearhead a skin assessment and treatment team to evaluate ulcers and skin conditions and educate staff about skin care. 4.Complete a head to toe assessment with a change in condition of a resident (increase in ADL assistance, fever of over 100° for two shifts, lethargy, decrease in appetite, increased confusion and increase in agitation). 5.Individualize plan of care for each wound type and resident. 6.Audit impact by monthly QAPI report.</p>	6/28/14

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 314	Continued From page 33 team to evaluate ulcers and skin conditions and educate staff about skin care. *Complete head-to-toe assessment with a change in condition of a resident (increase in activities of daily living assistance, fever of over 100 degrees Fahrenheit, lethargy (sleepiness), decrease in appetite, increased confusion, and increase in agitation.) *Individualize plan of care for each wound type and resident. *Audit impact by monthly quality assurance performance improvement (QAPI) report. *At shift report for nursing care unit and special care unit today at 6:00 p.m. and 6:00 a.m. on 5/22/14 shift change the DON would present a mini in-service to all nurses on duty on Braden scale scoring, turning and repositioning, recognition of skin conditions including measurements, open or closed skin, pressure ulcers versus excoriations and document of same. All other nurses and certified nursing assistants (CNA) would be in-serviced by 5/28/14. *Following in-service by DON and unit nurses would train the CNAs by demonstration of positioning, turning, recognition of skin issues, and review of policy with signature from CNAs. *MDS coordinators would total scores of Braden scores that lacked scoring totals today. *Notify resident's family of any skin issues. *Physician/providers will check pressure sores weekly with the unit nurse. *Utilize the weekly pressure ulcer form which that will be submitted to the SON on a weekly basis. She will scan it into American Data on a monthly basis for purposes of QAPI. *All ointments and creams applied for skin issues must have provider's order. CNAs will not perform skin assessments or dressing changes including but not limited to DuoDerm, wet-to-dry	F 314	7. At shift report for NCU and SCU today at six pm and six am tomorrow shift change the DON will present a mini in-service to all nurses on duty on Braden scale scoring, turning and positioning, recognition of skin conditions including measurements, open or closed skin, pressure ulcers versus excoriation and documentation of same. All other nurses and CNAs will be in-serviced by 5/28/14. 8. Following in-service by DON unit nurses will train the CNAs by demonstration of positioning, turning, recognition of skin issues and review of policy with signature from CNAs. 9. MDS coordinators will total scores of all Braden scales that lack totals today. 10. Notify resident's family of any skin issues. 11. Physician/provider will check pressure sores weekly with the unit nurse. 12. *Utilize the weekly pressure ulcer form which will be submitted to DON on a weekly basis who will scan into American Data on a monthly basis for purposes of QAPI. 13. All ointments and creams applied for skin issues must have a provider's order. CNAs will not perform skin assessments or dressing changes including but not limited to DuoDerm, wet to dry dressings or prescribed treatments. 14. Physician will assess all current pressure/stasis ulcers on 5/22/14. 15. Implement skin care book for all wounds on each unit by 5/22/14. All items noted above had been completed by expected due date as evidence by follow-up survey commencing on 5/27/14. *Please note item #12, our software cannot accommodate scanning into the system at this time.		

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 34</p> <p>dressings, or prescribed treatments. *Physician will assess all current pressure/stasis ulcers on 5/22/14. *Implement a skin care book for all wounds on each unit by 5/22/14.</p> <p>During the survey on 5/21/14 at 6:00 p.m. the surveyors confirmed removal of the immediate jeopardy situation. Findings include:</p> <p>1. Review of resident 4's complete medical record revealed: *On 3/6/13 he had been admitted with a 0.5 centimeter (cm) stage II pressure ulcer on his right buttock. *There had been multiple documentation from March 2013 through May 2014 of conflicting nursing notes of multiple pressure ulcers. *There had been no documentation of what pressure ulcers had healed and what were new pressure ulcers. *There had been conflicting documentation of where the pressure ulcers had been located on the body. *From the nursing documentation there was no way to know if the resident currently had any pressure ulcers. *A 5/20/14 physician's order for topical Calazime skin protectant paste twice a day. May have at bedside.</p> <p>Interview on 5/21/14 at 9:00 a.m. with registered nurse (RN) C regarding resident 4 revealed she was unaware if the resident currently had a pressure ulcer.</p> <p>Interview on 5/21/14 at 9:00 a.m. with CNA E</p>	F 314	<p>The new protocol we have in place is:</p> <ol style="list-style-type: none"> <li>1. Braden scores will be completed upon admission and quarterly thereafter (MDS coordinator)</li> <li>2. All residents with a Braden score of 18 or less with no skin issues will be assessed weekly with documentation also weekly.</li> <li>3. All residents with a Braden score of 18 or less with actual skin issues will be assessed daily with documentation also daily.</li> <li>4. All residents with a Braden score of 19 and above without skin issues will be assessed and documented on monthly.</li> <li>5. All residents with a Braden score of 19 and above with an actual skin issue will be assessed and documented on daily.</li> <li>6. The MD has been visually inspecting any skin issues on a weekly basis since 5/22/14 with orders received or need for follow-up.</li> <li>7. Physical Therapy services have evaluated each resident with skin issues for turning, positioning, or adaptive equipment.</li> <li>8. All nurses received immediate in-service training on 5/21-5/22/14 by the DON and Interim Superintendent.</li> <li>9. CNA staff has received in-service training on turning and positioning, lifting and transferring techniques, and recognition of skin issues to report before 5/28/14.</li> <li>10. The Medical Director has been consulted to include a standard of care for treatment of pressure ulcers.</li> <li>11. Dietary has been consulted for nutritional support for pressure ulcers to include, but not limited to:</li> </ol>		

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	<p>Continued From page 35</p> <p>revealed resident 4 got up at 7:00 a.m. and his incontinence brief was changed at that time. The CNAs or unlicensed assistive personnel (UAP) put on his Calazime ointment. The resident was not on a changing schedule and would usually go five to six hours without being changed. She had not changed his incontinent brief that morning but had the day before. He had a small open area on his buttock the day before.</p> <p>Observation and interview on 5/21/14 at 3:20 p.m. of CNA B and RN C while providing personal care to resident 4 revealed:</p> <p>*The resident had not been offered personal care since 7:00 a.m.</p> <p>*His incontinence brief had been soiled with stool.</p> <p>*A UAP or nurse could apply Calazime onto a pressure ulcer.</p> <p>*The resident was paralyzed and unable to let staff know if he had a soiled incontinent brief.</p> <p>Review of resident 4's current care plan updated on 5/19/14 revealed:</p> <p>*He had a potential for impaired skin integrity (skin breakdown).</p> <p>*A high risk for a heel ulcer.</p> <p>*Limited mobility related to fecal incontinence.</p> <p>*An ulcer on his left distal toe.</p> <p>*Skin assessment to be done per policy.</p> <p>*Daily skin assessments.</p> <p>*Evaluate healing process and revise care plan as needed.</p> <p>*A 2/20/14 goal for no skin breakdown and normal skin turgor.</p> <p>*No mention of pressure ulcers to his buttocks.</p> <p>Review of resident 4's repositioning, toileting, and bedtime snack documentation from 4/27/14 through 5/27/14 revealed:</p>	F 314	<p>a.Fortified foods/FIS diet</p> <p>b.High Calorie/High Protein snacks</p> <p>c.High Calorie/High Protein supplement including protein powders</p> <p>d.Vitamin C source three times daily</p> <p>e.Encourage food/fluid intake</p> <p>f.Food/fluid intake records</p> <p>g.MVI with Minerals</p> <p>h.Zinc, Vitamin A, L-Arginine, Juven supplements as deemed appropriate by Dietitian</p> <p>12.The facility has assigned a registered nurse (RN) as wound care nurse. Her responsibilities will be:</p> <p>a.Identification of new and existing wounds</p> <p>b.Weekly rounds with provider</p> <p>c.Recommendations of treatment modalities</p> <p>d.Documentation including complete assessment at least weekly</p> <p>e.Input of finding into electronic medical record (EMR)</p> <p>f.Input of information into minimum data set (MDS).</p> <p>13.Resident 1 died in the facility on 6/13/14.</p> <p>14.Residents 4, 6, 7, 8, 10, 12, 13, 14, 15, 16's care plans have been revised to include: New physician orders for skin treatments, repositioning and pressure reducing devices, incontinence care, skin assessments, dietary recommendations, SVH protocol for skin protection and physician/family notifications. Goals have been set for each resident.</p> <p>15.All residents are affected.</p> <p>16.The wound care nurse will report weekly assessment findings X 4 weeks to the DON monthly. The DON or designee will bring those findings to QAPI on a monthly basis until QAPI directs otherwise.</p>	

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 314	<p>Continued From page 36:</p> <ul style="list-style-type: none"> <li>*Repositioning had not been documented as offered or completed every two hours.</li> <li>*Toileting (personal care) had not been documented as offered or completed on a routine basis.</li> <li>*Bedtime snacks had not been documented as offered or given every night.</li> </ul> <p>2. Review of resident 15's 5/24/14 nursing notes revealed he had a stage two pressure ulcer, 0.5 inch cracked open area on his coccyx (tailbone area). There had been no documentation of physician notification.</p> <p>Review of resident 15's 4/3/14 physician's orders revealed Calazime ointment to the perineal area as needed and may keep at bedside. No other wound care or treatments had been prescribed after that.</p> <p>Review of the Skin/Wound Quality Indicator (QI) Log for resident 15 revealed:</p> <p>*5/24/14: -History of pressure ulcer. -Facility acquired. -0.5 inch long crack on coccyx. -The treatment was Calazime. -No physician notification documented.</p> <p>*5/25/14: -Facility acquired. -The skin/wound type was documented as other. -0.5 inch long buttocks crack. -The intervention was Calazime. -No physician notification documented.</p> <p>*5/26/14: -Facility acquired. -The skin wound type was documented as an abrasion. -0.5 inch crack on buttocks.</p>	F 314			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 37</p> <p>-The intervention was Calazime.</p> <p>-No physician notification documented.</p> <p>Review of resident 15's current care plan updated on 5/27/14 revealed:</p> <p>"Impaired skin integrity, a stage II pressure ulcer to at top of buttocks crease."</p> <p>*Skin assessments daily with documentation per protocol.</p> <p>*Administer medications/treatments as ordered and evaluate for effectiveness.</p> <p>Review of resident 15's bathing, repositioning, toileting, and bedtime snack documentation from 4/27/14 through 5/27/14 revealed:</p> <p>*Bathing had not been documented as offered or completed two times per week.</p> <p>*Repositioning had not been documented as offered or completed every two hours.</p> <p>*Toileting (personal care) had not been documented as offered or completed on a routine basis.</p> <p>*Bedtime snacks had not been documented as offered or given every night.</p> <p>3. Review of resident 16's 5/22/14 nursing notes revealed he had a stage two pressure ulcer 0.8 cm by 0.3 cm open area on "right upper buttock in crease between both creases."</p> <p>Review of resident 16's 5/22/14 physician's orders revealed Calazime two times a day for a "small area coccyx 0.8 by 0.5cm."</p> <p>Review of resident 16's May 2014 medication and treatment administration record revealed:</p> <p>*A 5/22/14 physician's order for Calazime two times a day to coccyx.</p> <p>*From 5/22/14 to 5/28/14 Calazime had been</p>	F 314			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747	
(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 314	Continued From page 38 documented as applied one time on 5/23/14.  Review of resident 16's 5/22/14 through 5/24/14 Skin/Wound QI Log revealed: *5/22/14: -Stage II pressure ulcer. -On creases of buttocks measuring 0.8 cm by 0.3 cm. *5/23/14: -Facility acquired. -Stage II. -"Slightly closing split cocci area 1 by .5 cm." - The treatment was Calazime ointment. *5/24/14: -"Cocci-area has split large 2 cm by .5 cm." -The treatment was Calazime ointment. *5/25/14: -Facility acquired. -Stage II pressure ulcer. -The site was "buttock." -The size was 1 cm by 1.5 cm. -The treatment was Calazime ointment. *5/25/14 (second entry): -Facility acquired. -Cracks/buttocks/coccyx 1 1/3 " long. -The treatment was Calazime ointment. *5/26/14: -The site was coccyx. -Stage II pressure ulcer. -The size was 1.2 cm by 0.3 cm -The treatment was Calazime ointment. Review of resident 16's 5/25/14 through 5/31/14 Skin/Wound QI Log revealed: *5/25/14: -Facility acquired stage II pressure ulcer. -Site was documented as right buttock. -The size was 1 cm by 1.5 cm. -The intervention was documented as Calazime. *5/25/14 (second entry):	F 314		

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 314	<p>Continued From page 39</p> <ul style="list-style-type: none"> <li>-Skin/wound type was documented as other.</li> <li>-Crack buttocks/coccyx 1 1/8 " long.</li> <li>-The intervention was documented as Calazime.</li> </ul> <p>Review of resident 16's current care plan updated on 5/27/14 revealed:</p> <ul style="list-style-type: none"> <li>**Impaired skin integrity, stage II to right mid buttock and right lower buttock..."</li> <li>*Skin assessment daily per policy with documentation.</li> <li>*Evaluate healing process and revise care plan as needed.</li> </ul> <p>Review of resident 16's bathing, repositioning, toileting, and bedtime snack documentation from 4/27/14 through 5/27/14 revealed:</p> <ul style="list-style-type: none"> <li>*There had been no documentation of bathing.</li> <li>*Repositioning had not been documented as offered or completed every two hours.</li> <li>*Toileting (personal care) had not been documented as offered or completed on a routine basis.</li> <li>*Bedtime snacks had not been documented as offered or given every night.</li> </ul> <p>4. Documentation of skin issues had not been addressed for resident 1 with numerous open areas of the skin. Refer to F309, finding C.</p> <p>5. Review of resident 7's medical record revealed he had been admitted to the facility on 5/17/13 with pressure ulcers on both heels. The care plan had been initiated on 2/27/14. The care plan had not been revised during that time. The treatment indicated on the care plan had been dietary supplement, whirlpools, pressure relieving mattress, application of dressing/ointments as ordered, assist with repositioning, and report</p>	F 314			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 40</p> <p>changes to primary care provider. Wound care had been changed to Aquacel after hospitalization in May 2014, otherwise nothing had been done to the heel areas.</p> <p>Observation on 5/20/14 at 10:00 a.m. of resident 7 revealed: *He had been wearing Prevalon boots on both feet as a preventative measure. The boots had not been indicated on the care plan.</p> <p>Review of the CNA documentation regarding resident 7 for 4/27/14 through 5/27/14 revealed bath documentation had occurred on the following dates: -5/7/14 a bath occurred. -5/21/14 resident refused a bath.</p> <p>6. Review of resident 12's undated Skin/Wound QI log revealed the resident had excoriation on the buttocks since 4/14/14. He also had a stage two pressure ulcer on his right lower buttock since 5/12/14. Treatment had been Mylanta. No other treatment had been initiated for the open area on the right lower buttock.</p> <p>Review of the 5/27/14 care plan addressed areas of left lower buttock, right lower buttock, left mid buttock, and healing stage two on right posterior thigh.</p> <p>Review of the CNA documentation regarding resident 12 for 4/27/14 through 5/27/14 revealed bath documentation occurred on the following dates: 4/27/14, 5/1/14, 5/8/14, 5/22/14, and 5/26/14.</p> <p>7. Review of resident 14's medical record revealed a care plan initiated on 11/5/13</p>	F 314			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 314	<p>Continued From page 41</p> <p>indicating a risk for problems with skin. The nurses notes on 5/14/14 indicated "very excoriated" (excoriated). There was no further documentation until the physician visit on 5/22/14. Another entry on 5/27/14 indicated an "open lesion on left lower buttock and right lower buttock." Neither of those open areas had been placed on the care plan. The Skin/Wound QI log indicated the treatment as barrier cream.</p> <p>Interview on 5/28/14 at 1:30 p.m. with the DON indicated the staff would initiate barrier cream as an initial treatment. That physician's order would come from the standing orders.</p> <p>Review of the CNA documentation from 4/27/14 through 5/27/14 revealed bathing documentation had occurred on 5/9/14.</p> <p>During the extended survey on 5/27/14 the survey team received from the provider a list of residents Braden scores and how often residents would be charted on regarding their skin issues. The form revealed:</p> <p>*Resident 12 should have had a daily nurses note. From 5/22/14 through 5/26/14 there had been three late entries dated on 5/24/14, all of those had been charted within seven minutes of each other.</p> <p>*Resident 13 had no plan in place on frequency of documentation of skin issues. He had one documentation regarding skin issues.</p> <p>*Resident 14 should have had a daily nurses note. From 5/22/14 through 5/26/14 there had been two late entries within a minute of each other. There also had been a missing note for the 5/26/14.</p> <p>Surveyor: 28632</p>	F 314			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 314	<p>Continued From page 42</p> <p>11. Review of resident 6's medical record revealed: *He had developed a stage two pressure ulcer behind both his right and left ears. *That had been caused by oxygen tubing rubbing on his skin. *It was unknown as to when those pressure ulcers had been found and when they had been considered healed. *His Braden score on 5/12/14 was a 15, which meant he had been at risk for pressure ulcer. *He had a low air loss mattress.</p> <p>Review of resident 6's 11/22/13 care plan which had been updated 4/22/14 revealed: *Problem: Potential for impaired skin integrity. Stage two pressure ulcer behind right ear. There was no mention of the pressure ulcer behind his left ear. *Approach: Included none for the pressure ulcers behind his right and left ears. *Goal: No skin breakdown.</p> <p>Review of resident 6's following quarterly MDSs revealed: *5/15/13 he had one stage two pressure ulcer. *8/13/13 he had one stage two pressure ulcer. *11/3/13 he had one stage two pressure ulcer. *4/21/14 he had two stage two pressure ulcers.</p> <p>Review of a quality assurance tool for pressure ulcers related to resident 6 revealed: *On 5/23/14 it was listed as a history of pressure ulcers behind both his right and left ear. *It did not list when those pressure ulcers had been healed. *For the care plan part of that tool there was no treatment listed for any preventative measures.</p>	F 314			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 314	<p>Continued From page 43</p> <p>12. Review of a weekly pressure ulcer QI log for resident 10 revealed: *On 5/22/14 he had a facility acquired area on his left lower buttock listed as a rash. That area measured 7.5 cm by 5.2 cm. *On 5/22/14 he had a facility acquired area on his right lower buttock listed as a rash and was reddened to dark maroon in color. That area measured 5.6 cm by 9.5 cm. *Clotrimazole was to be applied twice daily (BID). *Those areas were measured again on 5/24/14 and the right buttock rash measured 7 cm by 5 cm and the left buttock rash measured 5 cm by 9 cm. *Those areas were measured again on 5/27/14 and the right buttock rash measured 9.4 cm by 11.6 cm and the left buttock rash measured 3 cm by 1.2 cm. There was also dark maroon skin with end of ink pen sized open areas to the left buttock. *Those areas were being treated with clotrimazole BID and Maalox liquid as needed (PRN).</p> <p>Review of an undated guidelines for daily care sheet used by the CNAs under skin care revealed: *Assist with hygiene and general skin care. *Minimize pressure on bony prominences. *Report changes to nurse. *Keep skin clean and dry. *Use pressure relief devices.</p> <p>13. Observation on 5/20/14 of resident 8 revealed: *At 7:30 a.m. he was lying on his back in his bed. The door to his room was closed, and the light was off in his room. He was not responsive to questions.</p>	F 314			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 314	<p>Continued From page 44</p> <p>*At 10:00 a.m. he was lying on his back in his bed. The door to his room was closed, and the light was off in his room. He was not responsive to questions.</p> <p>*At 1:00 p.m. he was lying on his back in his bed. The door to his room was closed, and the light was off in his room. He was not responsive to questions.</p> <p>*At 3:00 p.m. he was lying on his back in his bed. The door to his room was closed, and the light was off in his room. He was not responsive to questions.</p> <p>Review of the CNA charting from 5/18/14 through 5/22/14 revealed he had been repositioned the following times: *5/18/14 at 2:31 a.m., 2:25 p.m., and 10:39 p.m. *5/19/14 at 2:25 a.m., 11:20 a.m., and 3:34 p.m. *5/20/14 at 2:48 p.m. and 11:11 a.m. *5/21/14 at 12:28 a.m., 1:28 p.m., and 9:08 p.m. *5/22/14 at 12:31 a.m. and 11:28 a.m.</p> <p>Review of resident 8's 3/28/14 care plan included: *Problem: Potential for impaired skin integrity related to cognitive impairment, urinary incontinence, and the use of psychotropic (mood altering) medications. *Approach: Skin assessment per policy. Pressure relieving mattress in place. *Goal: No skin breakdown. *The care plan had not been updated for his current status.</p> <p>Interview on 5/20/14 at 3:15 p.m. with licensed practical nurse (LPN) D regarding resident 8 revealed: *He was to have been repositioned every two hours. *He was at risk for developing pressure ulcers.</p>	F 314			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747	
(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 314	<p>Continued From page 45</p> <p>*She did not know when he had last been repositioned.</p> <p>*She did not realize the door to his room was shut.</p> <p>*He had a reddened area to his outer left thigh.</p> <p>*She agreed repositioning was a preventative measure to reduce the risk of pressure ulcers.</p> <p>Surveyor:32333</p> <p>14. Review of the provider's March 2014 Routine Orders For Medications revealed: "DUODERM (wound dressing): PRN (as needed) to open skin area with Stage I or II areas. Change every 3 days or as directed by the provider. Document implementation of DuoDerm in progress notes and the MAR (medication administration record). Place on doctor's list to evaluate the wound for further treatment."</p> <p>Review of the Remedy Calazime skin protectant paste label revealed it "Nourishes skin. Helps treat and prevent diaper rash, wet and cracked skin."</p> <p>Review of the provider's 11/17/06 Whirlpool and Shower Bathing on Nursing Units policy revealed: **"It is the responsibility of each nursing unit to provide whirlpool bathing or assisted showers at least twice a week for each resident. A resident may request either method." **"During this time, staff is to monitor/evaluate skin for broken, red, or open sores. Areas should be addressed by the charge nurse on duty upon report."</p> <p>Surveyor:32572</p> <p>Review of the provider's 11/5/08 Resident Hydration policy revealed: **"All residents will be monitored for risk of</p>	F 314		

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 314	<p>Continued From page 46</p> <p>dehydration via nursing assessment, RD (registered dietician) consults, and dietary manager review."</p> <p>**Any concerns are to be address(ed) with the dietary manager, dietician, and primary care provider for follow-up."</p> <p>**Any actual or potential problems related to dehydration (incontinence, skin breakdown, immobility, etc.) will [be] noted on each care plan."</p> <p>Surveyor: 26632</p> <p>Review of the provider's 12/1/12 Pressure Ulcer Prevention and Treatment policy revealed:</p> <p>*All residents would have been protected from pressure ulcers and have a protocol in place to treat them.</p> <p>*General care issues and interventions included:</p> <ul style="list-style-type: none"> <li>-Protect skin of incontinent residents from exposure to moisture.</li> <li>-Turn and position bed bound residents every two hours if consistent with overall care goals. Use a written schedule for turning and repositioning residents and note on care plan.</li> <li>-Reposition chair of wheelchair bound residents every hour.</li> <li>-Use a pressure reducing device for chair bound residents.</li> <li>-Manage nutrition by consulting with dietician for correct nutritional needs.</li> </ul> <p>Prevention protocols linked to Braden risk scores were:</p> <p>*At risk: Score of 15 to 18.</p> <ul style="list-style-type: none"> <li>-Frequent turning; consider every two hour schedule; use a written schedule.</li> <li>-Maximize residents mobility.</li> <li>-Protect residents heels. Utilize lambs wool, eggcrate, or protective devices as appropriate.</li> </ul>	F 314			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 314	<p>Continued From page 47</p> <p>*Moderate risk: Score of 13 to 14. -Same as above, but provide foam wedges for a thirty degree lateral position.</p> <p>*High risk: Score of 10 to 12. -Same as above, and increase the turning frequency.</p> <p>*Very high risk: Score of 9 or below: -Same as above but use a pressure-relieving surface in addition to standard pressure relieving mattress. -Manage moisture, nutrition, and friction/shear.</p> <p>*Pressure ulcer - evaluation and expected outcomes were: -Residents skin would remain intact. -Pressure ulcers would heal. -Nurses would accurately perform pressure ulcer risk assessment using standardized tool. -Nurses would implement pressure ulcer prevention protocols for residents interpreted as at risk for pressure ulcers. -Nurses would perform a skin assessment for early detection of pressure ulcers on admission.</p> <p>Interview on 5/28/14 at 1:30 p.m. with the director of nursing revealed: *Her expectations of documentation for pressure ulcers and skin conditions were to have been done when the area was found. *That documentation should have included: the type of skin/wound type or stage, the location, measurements, interventions, notification of the physician, family, physical and occupational therapies, dietary, and activities. *Skin assessments were to be done monthly on all residents, unless they had an active skin concern, then they were to have been done weekly. *Repositioning of residents should have been</p>	F 314			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	Continued From page 48 done every hour for residents with an active skin concern and every two hours for residents with a Braden score under 19. *She stated the increased amount of reddened or excoriated perineal areas had not been tracked or trended. She had not realized the amount skin issues, until she had reviewed materials requested by the surveyors. *She did not have any evidence based protocols for the treatment of pressure ulcers, stasis ulcers, or excoriated/reddened areas. *Calazime cream and Maalox liquid was on the standing physician's order sheet. *If the area was open a DuoDerm dressing was to be placed on it.	F 314		6/28/14	
F 323 SS=D	<b>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b>  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to ensure: *Chemicals had remained locked up on the housekeeping carts on two of two units (nursing care unit (NCU) and secured care unit (SCU)). *Two of two soiled linen rooms (NCU and SCU) that contained chemicals for cleaning had remained locked. Findings include:	F 323	<b>F323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b> The facility must ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  1. Observation of the housekeeping cart in the red hallway on the NCU revealed: The cart was unattended; a bucket with multiple cleaning chemicals including bleach germicidal cleaner, Clorox, Kling, and 23 Quat disinfectants cleaner was left out on the cart.  Responsible Discipline: A monthly training/safety meeting is established to educate employees on safe handling and storage of chemicals. First meeting will be held on 18 June 2014.  The Housekeeping Crew Leader will monitor the security of these areas and Housekeeping Carts on a weekly basis and bring to the QA monthly.  2. Random Observations and testing NCU and SCU soiled linen rooms revealed they had not been locked. The soiled linen rooms contained multiple cleaning chemicals. *The door handles on the NCU and SCU soiled linen closets had sprung and needed to be replaced. *If the door handle had been in a certain position when the door was shut it would not lock. Creating an ununlockable area.		

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 49  1. Observation on 5/20/14 at 8:45 a.m. of the housekeeping cart in the red hallway on the NCU revealed: *The cart was unattended. *A bucket with multiple cleaning chemicals including bleach germicidal cleaner, Clorox, Kling, and 23 Quat disinfectant cleaner was left out on the cart. *Residents had been up and down that hallway.  Observation on 5/20/14 at 9:55 a.m. of housekeeper F while he was cleaning the SCU dining room revealed: *He had a bucket of multiple cleaning chemicals on his cart. *He had been cleaning with his back turned to the cart. *Residents had been in that area.  2. Random observations and testing on 5/20/14 of the NCU and SCU soiled linen rooms revealed they had not been locked. The soiled linen rooms contained multiple cleaning chemicals.  Interview and walk-through on 5/26/14 from 8:30 to 8:50 with the plant operations manager confirmed: *The housekeeping cleaning chemicals should have remained locked up in the housekeeping carts when they were unattended. *The door handles on the NCU and SCU soiled linen closets had sprung and needed to be replaced. *If the door handle had been in a certain position when the door was shut it would not lock. Creating an unlockable area.	F 323	Responsible Discipline: The door latch assembly has been replaced at the NCU soiled linen. The door latch assembly has been repaired at the SCU soiled linen and new latch assembly has been ordered. The new latch will be installed on arrival. Door operation will be monitored on a weekly PM. Locking of all soiled linen room doors will be placed in our weekly preventative maintenance program. (PM 01) Responsibilities for PM will be completed by the Senior Building Maintenance Worker. The Senior Building Maintenance Worker reports to the Building Maintenance Supervisor weekly. The Building Maintenance Supervisor reports the findings at the QA Monthly.		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747	
(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 329 SS=D	<p>Continued From page 50 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: Based on interview, record review, and policy review, the provider failed to ensure: *Antipsychotic (medications for mental disorders) medications for two of four sampled residents (4 and 7) had an appropriate diagnosis for use. *One of four sampled residents (4) with an antipsychotic medication had received a gradual dose reduction (GDR). Findings include:</p>	F 329	<p>F329 483.25(I) DRUG REGIMEN IS FREE OF UNNECESSARY DRUGS Resident #4 was found to have been on Seroquel since admission in 4/2013 without the benefit of a gradual dose reduction (GDR). Resident #4 carries a diagnosis of Depression and the Seroquel was used as adjunct therapy with his antidepressant. The Actionable Report of Actions written by the RPh states: SUPPORTIVE DIAGNOSIS: Diagnosis or documentation of symptoms is lacking to support the use of current medications (explain): Patient is on SUPPORTIVE DIAGNOSIS: Diagnosis or documentation of symptoms is lacking to support the use of current medications (explain): Patient is on Quetiapine 25mg QHS for DX of depression. Due to the guidance of CMS F329 regarding Unnecessary Drugs. This order lacks appropriate diagnoses for continued use because the approved diagnoses for this medication are: Schizophrenia, Acute bipolar mania, Acute bipolar depression, or as an adjunct to antidepressants in Major Depressive Disorder. Since this patient lacks one of those diagnoses, this medication should be discontinued. If discontinuation is not attempted, then a well-documented Gradual Dose Reduction should be tried with the two-part goal of eventual discontinuation OR clearly documenting the necessity of this medications continued use for this patient. One last item of note: this patient was admitted on this medication on 3/2013 and no GDR of quetiapine has been attempted since that time.</p>	6/28/14

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 329	Continued From page 51  1. Review of resident 4's complete medical record revealed: *He had been admitted on 3/6/13. *He was admitted with Seroquel (antipsychotic medication) 25 milligrams (mg) for a diagnosis of depression. *His 5/20/14 physician's orders revealed an order for Seroquel 25 mg one tablet daily at bedtime for depression. *He had taken Seroquel 25 mg for over a year. *No recommendations had been made for a gradual dose reduction.  Interview on 5/28/14 at 10:30 a.m. with the director of nursing confirmed resident 4 had no recommendations for a gradual dose reduction for the Seroquel.  Interview on 5/28/14 at 10:00 a.m. with the pharmacist revealed: *He did not recommend GDRs. *The certified nurse practitioner (CNP) had been responsible for recommending GDRs. *He could not find a contact number for the CNP.  2. Review of resident 7's medical record revealed: *He had diagnoses of: -Kidney disease with dialysis (cleaning of the blood by special machines). -Dementia (decline in mental ability). -Diabetes. -Cataract. -Alcohol abuse. -Hypertension. -Pressure ulcer. -Depression.	F 329	Resident 7 returned from an acute care hospitalization on Haldol without an appropriate diagnosis for justification. The medication was formally discontinued on 6/11/14. He had received zero doses of this medication since readmission.  All residents with physician orders for use of antipsychotic medications have the potential to be affected. All current and future residents' medication regimens will be reviewed for use of antipsychotic medications. The review will ensure appropriate diagnoses for use, as well as gradual dose reductions occur if appropriate or indicated.  Monthly drug regimen reviews will be completed with the pharmacist's recommendations forwarded to the provider.  Regimen review results will be monitored monthly with findings brought to the Pharmacy and Therapeutics (P & T) Committee quarterly. P & T is a subcommittee within QA.		

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 329	<p>Continued From page 52</p> <ul style="list-style-type: none"> <li>-Anxiety.</li> <li>-Osteomyelitis (bone infection).</li> <li>-Diabetic retinopathy (complication from diabetes that effects the eyes).</li> <li>-Constipation.</li> <li>-Aortic valve disorder (heart problem)</li> </ul> <p>*He had returned to the provider from the hospital on 5/15/14. *He had a new medication order of haloperidol (antipsychotic medication) 2 mg by mouth every eight hours as needed for agitation.</p> <p>Review of the provider's 3/4/10 Physical and Chemical Restraints policy revealed: **"It is the policy of the [facility name] that every resident has the right to be free from any physical restraint imposed or psychoactive (mood alternating) drug administered for purposes of discipline or convenience and not required to treat the resident's medical symptoms." **Before a resident is place(d) on a psychotropic medication that could be considered a chemical restraint, supportive documentation must be noted in the multidisciplinary notes along with alternative measures attempted and the resident's response." **"The goal of psychotropic therapy should be to reduce or eliminate the mediation (medication) when possible."</p> <p>Interview on 5/21/14 at 9:00 a.m. with registered nurse C confirmed the order had not been clarified for an appropriate diagnosis upon return to provider.</p> <p>Interview on 5/28/14 at 9:34 a.m. with the pharmacist confirmed agitation was not an appropriate diagnosis. The pharmacist on 5/28/14 supplied a copy from the Drug Facts and</p>	F 329			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747	
(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 329	Continued From page 53	F 329	Resident 18's provider was notified on 5/29/14 about his request to have his HS medications given at the supertime medication pass. The physician provided an order acknowledging and permitting the specific HS medications may be given as per resident request.	6/28/14
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, policy review, and record review, the provider failed to maintain a medication error rate less than five percent by one of one registered nurse (RN) (H) during one of two medication pass observations. Findings include:  1. Observation on 5/20/14 at 4:45 p.m. of RN H passing medications to residents in the hallway outside of the dining room in the hallway revealed: *She gave resident 18 the following medications in which the medications. Those medication labels read: -Omeprazole (stomach medication) 20 milligram (mg) by mouth (PO) two times a day (BID). -Baclofen (pain medication) 10 mg PO four times a day (QID) . -Gabapentin (seizure medication) 400 mg PO QID. -Glipizide (diabetes medication) 10 mg 2 tablets PO BID. -Fish Oil 1000 mg 2 capsules PO BID. -Buspirone HCL (anxiety medication) 15 mg PO BID.	F 332	physician provided an order acknowledging and permitting the specific HS medications may be given as per resident request. All resident requests for alternate medication schedules will be forwarded to the individual resident's provider for review. Staff have received and will continue to receive education about ensuring medication administration for residents is conducted in a manner residents are free of significant medication errors. Monthly drug regimen reviews will be completed with the pharmacist's recommendations forwarded to the provider. Monthly medication reviews will be done by unit staff to ensure medications are given as ordered and in a timely manner. Unit staff will forward changes to medication times as appropriate on a weekly basis to the DON/Designee. MDS Coordinators will monitor compliance quarterly during assessment period. DON/designee will bring to QA on a quarterly basis.	

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 332	<p>Continued From page 54</p> <ul style="list-style-type: none"> <li>-Metformin (diabetes medication) 850 mg PO three times a day (TID).</li> <li>-Venlafaxine (antidepressant) ER (extended release) 150 mg PO BID.</li> <li>-Lorazepam (anxiety medication) 1 mg PO hour of sleep (HS).</li> <li>-Tamsulosin (urinary retention) 0.4 mg PO daily.</li> <li>-Trazodone (antidepressant) 100 mg PO HS</li> <li>-Ropenirole (Parkinson's medication) 0.25 mg PO HS</li> <li>-MPAP (acetaminophen) 325 mg PO two tablets BID</li> <li>-Genteal (lubricant) eye drops 1 drop to both eyes QID</li> </ul> <p>Review of the medication administration record (MAR) revealed the labels on the medication blister packs did not match the MAR. Further investigation revealed the initial physician's order did not match the MAR. The physician had ordered lorazepam, Trazodone, and ropenirole to be given at HS. Staff had placed the medication initially on the MAR to be given at HS. Review of the MAR it had been noted within a few days the time had been changed to supper. Those medications have the potential to increase sleepiness and cause falls.</p> <p>Review of the provider's 11/3/05 Medication Administration policy revealed: **Medications must be administered in a timely manner and in accordance with the attending PCP [primary care provider] written/verbal orders." **The individual administering the medication must ensure that the 7 rights of medication administration are followed before giving the medication. Right resident, right route, right dose, right time and date, right medication, right form,</p>	F 332			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 332	Continued From page 55 right documentation." **"Should a drug be withheld, refused, or given other than at the scheduled time, the individual administering the medication must initial and circle the MAR space provided for that particular drug. The reason the drug was not given will be placed on the PRN [as needed] medication sheet."  Interview on 5/21/14 at 3:15 p.m. with the pharmacist confirmed he labeled the medications as the physician had ordered. He was able to show surveyor the initial order. He confirmed nursing had changed the time without notifying the physician for an order. He also stated that 4:45 p.m. had been too early for those medications to be effective.  Interview on 5/27/14 at 4:50 p.m. with RN C and the director of nursing (DON) revealed the resident had requested all of his medications to be given at supper time. She agreed the physician had not been notified of that request. The DON confirmed the physician needed to be notified of the resident's request to have those specific medications given at supper time.	F 332			
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by:	F 364			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 364	<p>Continued From page 56</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure a liquid with nutritive value had been added to thin the pureed foods for one of one observed meal service (supper). Findings include:</p> <p>1. Observation of the supper meal preparation and service on 5/20/14 from 4:30 p.m. through 5:45 p.m. revealed cook G:</p> <ul style="list-style-type: none"> <li>*Placed three frozen breaded chicken strips in the deep fryer.</li> <li>*When they were cooked she placed them in the food processor, added a small amount of gravy with them, and then added hot tap water.</li> <li>*She pureed those chicken strips and placed them in a portable steam table for the special care unit.</li> <li>*She also pureed mixed vegetables and added only the water they had been cooked in.</li> </ul> <p>Review of the menu for the evening meal on 5/20/14 revealed the pureed diet was to have been:</p> <ul style="list-style-type: none"> <li>*Cheesy mushroom chicken pureed.</li> <li>*Penne pasta pureed.</li> <li>*A dinner roll pureed.</li> </ul> <p>Review of the provider's 10/23/13 Alternate Menu Items policy revealed the following items would be available as an alternate to the menu for residents. Those items included:</p> <ul style="list-style-type: none"> <li>*Hamburger on a bun.</li> <li>*Hot dog on a bun.</li> <li>*Chicken strips.</li> <li>*Corn dog.</li> <li>*Grilled cheese sandwich.</li> <li>*Cottage cheese.</li> <li>*Potato salad.</li> <li>*Macaroni salad.</li> </ul>	F 364	<p>F364 (483.35) NUTRITIVE VALUE-APPEAR PALATABLE-PREFER TEMP</p> <p>On or before June 28, 2014, all dietary staff will attend an in-service. The in-service will be conducted by the Dining Services Director, dietitian (or designee). The in-service will cover:</p> <ul style="list-style-type: none"> <li>• Review of facility diet textures, facility diets and menu extensions.</li> <li>• Review of proper technique for pureeing/grinding/chopping vegetables, meats, starches, desserts to ensure safe consumption by residents requiring dysphagia diets.</li> <li>• Review of recipes that provide directions for pureeing, grinding or chopping prepared food for texture diets.</li> <li>• Review that all residents will be offered a choice of the main entrée as well as the always available menu. Residents on dysphagia/texture diets will receive the same meal items on the "regular" diet, unless contraindicated. Items will be prepared to meet the dysphagia/texture guidelines.</li> <li>• Review procedure for offering all residents entrée choices. RCU/SCU residents will select between the main entrée and always available menu for lunch and dinner at the prior meal using tray tickets. Residents who dine in the main dining room will make selection between entrée and always available at time of service.</li> </ul>	6/28/14	

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 364	<p>Continued From page 57</p> <p>*French fries. *Chef salad.</p> <p>Interview on 5/21/14 at 3:30 p.m. with the certified dietary manager (CDM) and the kitchen manager (KM) revealed:</p> <p>*Cook G had used the chicken strips as the cheesy mushroom chicken had chicken with bones in it. *They agreed using hot water did not add any nutritive value to the pureed food. *Had not thought of taking the chicken off the bones and using the cheesy mushroom gravy for the pureed main course. *The KM stated cook G had not prepared enough ahead of time to use the cheesy mushroom chicken for residents who received a pureed diet. *Agreed the menu for the pureed diet had not been followed. *Agreed residents who received a pureed diet had not had a choice of the entree they received.</p> <p>Lisa Eckstein and Katheryn Adams, Pocket Resource for Nutritional Assessment, 2013 Ed., Chicago, IL., 2013, pp. 103 and 106, revealed for a resident with dysphagia (problems with swallowing) can result in serious health consequences as it can interfere with adequate nutrition and hydration. To minimize swallowing problems, and maximize nutrition, hydration, and quality of life for the resident, dietary modifications involve changes in food and/or liquid texture to help compensate for loss of function, to maintain appropriate nutritional and hydration status, and to reduce the risk of aspiration. These may include temperature changes and order of food/liquid presentation changes such as moistening and providing a cohesive bolus (to hold an amount together) by</p>	F 364	<p>Beginning June 28, 2014 the Dining Service Director, dietitian (or designee) will conduct QAPI test tray audits to ensure continued compliance with facility policy. The audits will be conducted weekly. The test tray audits will review the flavor, appearance, temperature, texture, palatability, and presentation of the regular and dysphagia diets. Expected Date of Completion: 6/28/14 The Dining Services Director or designee will report the result of the audits monthly through QAPI who will determine the need for further monitoring</p>		

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 364  F 368 SS=E	Continued From page 58 adding gravy or sauce. 483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME  Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.  There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.  The facility must offer snacks at bedtime daily.  When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure a bedtime snack had been offered to 15 of 16 sampled residents (1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, and 16). Findings include:  1. Observation on 5/28/14 at 7:30 a.m. in the nursing care unit (NCU) in the dining room refrigerator revealed three plastic bags of roast beef, two plastic bags of turkey, and three pieces of cheese that had been plastic wrapped. There was only two eight ounce milk containers and three containers of ice cream.	F 364  F 368	F368 483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME The facility failed to offer, deliver, or provide bedtime snacks for residents 1-7, 9-12 during the review period. Policy and procedure has been reviewed to ensure accuracy with this tag. Meal percentages checklists have been updated to include the offering of bedtime snacks regardless if there is an order for a resident. Resident with specific orders for bedtime snacks will have labels with resident's name in place. Dietary will provide a minimum of 5 choices to offer residents on nursing care units. Unit Supervisor will be responsible to monitor offering of bedtime snacks x 4 weeks and report to DON or designee on a monthly basis. DON will bring to QA on a quarterly basis until advised other wise.	6/28/14	

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 368	Continued From page 59  Review of the provider's CNA documentation of bedtime snacks for 4/27/14 through 5/27/14 revealed: *Resident 5: -Documented refusal of bedtime snacks occurred nineteen times. -There had been documentation three times of a snack taken. -Missing documentation of bedtime snacks occurred eight times.  *Resident 6: -Documented refusal of bedtime snacks occurred twenty-five times. -Missing documentation of bedtime snacks occurred five times. -He was to have received: a banana on Sundays, Tuesdays, and Fridays and three squares of graham crackers with skin milk on Saturdays, Mondays, Wednesdays, and Thursdays.  *Resident 9: -Documented refusal of bedtime snacks occurred four times. -Missing documentation of bedtime snacks occurred twenty-six times.  *Resident 10: -Documented refusal of bedtime snacks occurred twenty-two times. -Missing documentation of bedtime snacks occurred eight times.  *Resident 11: -Documented refusal of bedtime snacks occurred twenty-four times. -Missing documentation of bedtime snacks occurred six times.	F 368			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 368	Continued From page 60  *Resident 3: -Documented refusal of bedtime snacks occurred eight times. -There had been documentation four times of a snack taken. -Missing documentation of bedtime snacks occurred eighteen.  *Resident 4: -Documented refusal of bedtime snacks occurred nine times. -There had been documentation one time of a snack taken. -Missing documentation of bedtime snacks occurred twenty times.  *Resident 15: -Documented refusal of bedtime snacks occurred twenty-two times. -There had been no documentation of a snack taken. -Missing documentation of bedtime snacks occurred eight times.  *Resident 16: -Documented refusal of bedtime snacks occurred twenty-four times. . -There had been no documentation of a snack taken. -Missing documentation of bedtime snacks occurred six times.  *Resident 1: -Documented refusal of bedtime snacks occurred four times. -There had been no documentation of snacks taken. -Missing documentation of bedtime snacks	F 368			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 368	Continued From page 61 occurred twenty-nine times.  *Resident 2: -There had been no documentation of snacks taken. -Missing documentation of bedtime snacks occurred twenty-nine times.  *Resident 7: -Documented refusal of bedtime snacks occurred six times. -Documentation of snacks taken occurred twice. -Missing documentation of bedtime snacks occurred twenty-five times.  *Resident 12: -Documented refusal of bedtime snacks occurred three times. -Documentation of snacks taken occurred three times. -Missing documentation of bedtime snacks occurred twenty-seven times.  *Resident 13: -Documented refusal of bedtime snacks occurred six times. -Documentation of snacks taken occurred once. -Missing documentation of bedtime snacks occurred twenty-six times.  *Resident 14: -Documented refusal of bedtime snacks occurred five times. -Documentation of snacks taken occurred twice. -Missing documentation of bedtime snacks occurred twenty-eight times.  Surveyor: 26632 Review of an undated snack list revealed:	F 368			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 368	<p>Continued From page 62</p> <p>*Residents 3, 4, 6, 7, 12 and 14 had bedtime snacks prepared by the dietary department each day.</p> <p>*The NCU received the following items on Mondays and Thursdays to be used for bedtime snacks: three eight ounce containers of two percent milk, ten cookies, five high calorie cookies, five ounces of roast beef, five ounces of turkey, and ten slices of cheese. The NCU had thirty-two residents.</p> <p>*The special care unit (SCU) received the following items on Tuesdays, Thursdays, and Sundays to be used for bedtime snacks: fifteen soft cookies, seven high calorie cookies, five ounces of roast beef, five ounces of turkey, sixteen ounces of meat salad with mayonnaise, and ten slices of cheese. There had been sixteen residents in the SCU.</p> <p>Review of the provider's reviewed 5/22/14 Frequency of Meals policy revealed:</p> <p>*Each resident should have received at least three meals daily as well as an evening or bedtime snack.</p> <p>*Bedtime snacks were offered routinely to all residents not on diets prohibiting bedtime nourishment.</p> <p>*Snacks of nourishing quality were those that provide substantive protein and/or nutrients in addition to carbohydrates and calories.</p> <p>*The provider had the right to choose snacks that were served at bedtime.</p> <p>Interview on 5/27/14 at 5:15 p.m. with the registered dietician and the certified dietary manager revealed:</p> <p>*The dietary department sent the items listed above for use in the NCU and SCU for snacks.</p> <p>*There were special items that were sent to</p>	F 368			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2508 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 368	Continued From page 63 certain residents, either by their request or due to their need for additional nutrients. *The dietary department did not monitor if snacks were not given to the residents.  Interview on 5/28/14 at 1:30 p.m. with the director of nursing revealed: *Bedtime snacks were to be offered to all residents each night. *Documentation of those snacks offered was to be in the electronic medical record (EMR). *No monitoring of the bedtime snacks was done. *She was not aware residents EMRs had either refused or no documentation entered for the bedtime snacks.  Surveyor: 32573 Interview on 5/27/14 at 4:25 p.m. with CNA L revealed she was unsure if every resident was offered a bedtime snack every evening. She stated a lot of residents went to bed early. The staff would have given residents a snack if they told staff they were hungry. They encouraged residents that missed a meal to have a snack.  Interview on 5/27/14 at 5:15 p.m. with CNA M revealed he would have expected residents that were able to ask for a snack to ask for one in the evening. Giving a bedtime snack depended on if the resident had been awake at the time bedtime snacks were handed out.	F 368			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 64 (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure appropriate handwashing and glove use had been completed by four of five observed dietary staff members (G, I, J, and K) for two of two (lunch and supper) observed meal services in the kitchen. Findings include:  1. Observation on 5/20/14 from 11:00 a.m. through 11:45 a.m. revealed: *Dietary aide (DA) J placed a serving cart by the handwashing sink in the kitchen. *Without washing her hands she put on gloves and retrieved the following: -A loaf of bread, a knife, a package of butter, a plastic tray, and a small bowl. -Unwrapped the butter and placed it in the small bowl. -Touched the butter with her gloved hands. -Took the bowl of butter into the dining room and used the microwave to melt it. -Brought the melted butter back to the serving cart. -Opened the loaf of bread and spread the bread out on the tray. -Buttered the bread and cut them in half. -Touched all the pieces of bread while buttering them and putting them in plastic wrap. -She did not change her gloves or wash her hands during that entire process.	F 371	F371 (483.35i) FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY On or before June 28, 2014 all dietary staff will attend an in-service. The in-service will be conducted by the Dining Services Director (or designee). The in-service will cover: • Review of hand washing, glove use and safe food handling policies • Review of safe food handling practices • Review of the statement of deficiency • Review of the plan of correction  Beginning June 28, 2014 the Dining Service Director, dietitian (or designee) will conduct QAPI hand washing and glove use audits to ensure continued compliance with facility policy. Random hand washing/glove use audits will be conducted weekly within the dining department and dining rooms. Expected Date of Completion: 6/28/14 The Dining Services Director or designee will report the result of the audits monthly through QAPI who will determine the need for further monitoring.	6/28/14

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 65</p> <p>*DA I without washing his hands or using gloves: -Retrieved a large bowl from the serving line. -Opened the door to the refrigerator and retrieved a bag of lettuce, pieces of ham, and cheese. -Used his bare hands to place lettuce, ham, and cheese into the bowl. -Also dished potato salad, macaroni salad, cottage cheese, and lettuce into small bowls and placed them on the shelf on the tray line. -Touched that food with his bare hands while placing it in bowls.</p> <p>*DA K without washing his hands: -Placed cottage cheese in bowls using a scoop and placed the scoop on the lid of the container. -Placed macaroni salad in bowls using a scoop and placed the scoop on the lid of the cottage cheese container. -Those scoops were touching each other. -His fingers would touch the inside of the bowls and the food while dishing it up.</p> <p>2. Observation on 5/20/14 from 4:30 p.m. through 5:45 p.m. revealed: *Cook A while serving food from the tray line: -Used one glove on her right hand to retrieve frozen hamburgers, chicken strips, and french fries from the freezer. -Touched the freezer handle and packaging with that gloved hand before touching those food items. -Repeated that process many times. -Also used the same tongs to serve buns and retrieve the chicken strips and french fries from the deep fryer. *She would wash her hands after using the one glove, but did not wash for fifteen to twenty seconds and would at times turn the water off with her wet hands or with her elbow. *DAs I and K also repeated the above process</p>	F 371			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 66 during the evening meal.  Interview on 5/21/14 at 3:30 p.m. with the certified dietary manager and the kitchen manager revealed: *They agreed the above observations were not completed per policy. *They had educated all staff several times on handwashing and glove use. *Did not do any audits of handwashing or glove use.  Review of the provider's reviewed 3/27/14 Hand Washing Policy for the Dietary Department revealed: *Hands would be washed: when coming on duty, whenever moving from food preparation area to food service area, and when ever moving from dirty dish room to the clean end or to food service area. *Hands should have been washed before and after using gloves. *The sink, faucet handles, and paper towel dispenser was considered contaminated and should have been touched with bare hands after washing hands.	F 371			
F 441 SS=F	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 -	F 441			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 67</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</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: Based on observation, interview, record review, and policy review, the provider failed to ensure: *An effective infection control program had been maintained. *There was a procedure for the disinfection of the whirlpool tubs. *Appropriate handwashing and glove use by one of two observed certified nursing assistant (CNA) (B) while performing personal care for one of one</p>	F 441	<p><b>F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b></p> <p>The infection control program was inefficient and did not address tracking and trending as it relates to infections on the nursing care units. Room numbers, resident names, and identified pathogens will be noted on the Infection Report through American Data. DON or designee will contact the programmer to ensure that this is accomplished. Causes of infections will be tracked and trended utilizing the simple room number, identified infection, and color coding (blue for UTI, pink for eye infection, green for pressure ulcers, etc.). Results will be compiled on a monthly report and reported to QAPI by DON or designee. Education has and will continue to be given to nursing staff regarding reporting of infections and the Infection Surveillance Log will be initiated for every infection regarding of lab testing. These reports will be maintained by DON or designee to use as an audit tool for compilation of results.</p> <p>3. CNA B cannot return to this observation and correct the practice using appropriate hand hygiene and glove use while providing personal care for resident 4.</p> <p>All residents receiving personal care have the potential to be affected by the failure of staff to follow appropriate hand hygiene and glove use.</p>	6/28/14	

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 68</p> <p>sampled resident (4). *CNA charting stations had been maintained in a sanitary manner on two of two hallways (red hall and blue hall) in the nursing care unit (NCU). Findings include:</p> <p>1. Review of the provider's 1/1/14 through 5/19/14 Infection Report revealed: *No unit or resident room number had been documented. *No pathogen had been identified on the report.</p> <p>Interview on 5/21/14 at 9:35 a.m. with the assistant director of nursing (ADON) confirmed they did not trend infections. They did not track the resident room number or the pathogen. They brought that information to quality assurance meetings, but they did not establish any goals. They did not track and trend infections to find the possible cause of the infections.</p> <p>2. Observation and interview on 5/20/14 at 9:00 a.m. with CNA O while she verbalized how she would clean the whirlpool tub revealed: *She put one capful of Sunshine's whirlpool hard surface disinfectant into the whirlpool tub. *She filled the whirlpool tub up above the chair with water. *She scrubbed the whirlpool tub and let the diluted disinfectant sit for ten to fifteen minutes.</p> <p>Review of the Sunshine whirlpool hard surface disinfectant's label revealed the disinfectant should have been diluted one ounce of disinfectant per one gallon of water. It had a ten minute contact time to disinfect a surface.</p> <p>Observation and interview on 5/20/14 at 10:00 a.m. with CNA P while she verbalized how to</p>	F 441	<p>CNA B and all staff responsible for direct resident care have received and will continue to receive education for the use of appropriate hand hygiene and glove use for the assigned task. To ensure compliance, DON or designee will monitor for appropriate hand hygiene and glove use 3 to 5 times weekly for one month, then weekly for one quarter, then as directed by the QA committee. Monitoring results will be shared with the QA committee at a minimum of quarterly, then as directed by QA.</p> <p>Whirlpool disinfection was inadequate, incomplete, or inconsistent. Instructions have been developed based on manufacturer's recommendation to include: 1. TO DISINFECT EACH WHIRLPOOL UNIT: A. AFTER USING THE WHIRLPOOL UNIT, DRAIN AND REFILL WITH FRESH WATER TO JUST COVER THE INTAKE VALVE. B. ADD 1 OUNCE OF SUNSHINE'S WHIRLPOOL/HARD SURFACE DETERGENT/DISINFECTANT FOR EACH GALLON OF FRESH WATER ADDED. START THE PUMP TO CIRCULATE THE SOLUTION. WASH DOWN THE SEAT OF THE CHAIR LIFT AND ANY RELATED EQUIPMENT AND ANY UNCOVERED SURFACES ON THE UNIT WITH CLEAN RAG WITH THE SOLUTION. TREATED SURFACES MUST REMAIN WET FOR 10 MINUTES. AFTER THE UNIT HAS BEEN THOROUGHLY DISINFECTED, DRAIN AND RINSE SURFACES WITH FRESH WATER. WIPE DRY WITH CLEAN RAG OR ALLOW TO AIR DRY. C. THIS MUST BE DONE AFTER EVERY BATH AND</p>	6/28/14	

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747	
(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 441	<p>Continued From page 69</p> <p>clean the whirlpool tub revealed: *She filled the tub up with water. *She poured in an unmeasured amount of Sunshine hard surface disinfectant into the whirlpool tub. *She let the disinfectant sit in the whirlpool tub for five to ten minutes.</p> <p>Interview on 5/21/14 at 9:35 a.m. with the ADON stated there was no procedure to follow for the disinfection of the whirlpool tubs.</p> <p>Interview on 5/21/14 at 9:45 a.m. with the secured care unit supervisor who was also responsible for CNA training revealed she would have expected the whirlpool tubs to have been disinfected after each use. She had no procedure for the CNAs to follow.</p> <p>Review of the provider's 11/17/06 Whirlpool and Shower Bathing on Nursing units policy revealed "a. After using the whirlpool unit, drain and refill with fresh water to just cover the intake valve. b. Add one ounce of Sunshine's whirlpool/hard surface detergent/disinfectant for each gallon of fresh water added. Start the pump to circulate the solution. Wash down the seat of the chairlift and any related equipment and any uncovered surfaces on the unit with clean rag with the solution. Treated surfaces must remain wet for ten minutes. After the unit has been thoroughly disinfected, drain and rinse surfaces with fresh water. Wipe dry with clean rag or allow to air dry. c. This must be done after every bath and completely at the end of the day."</p> <p>3. Observation on 5/21/14 at 3:20 p.m. of CNA B while performing personal care for resident 4 revealed she:</p>	F 441	<p>COMPLETELY AT THE END OF THE DAY.</p> <p>All nursing assistants have and will continue to receive education regarding whirlpool disinfection to maintain compliance. ADON or designee will be responsible to maintain checklists and education on an ongoing basis. Audits and checklists will be provided to the DON or designee and will present to QA on quarterly basis. EXPECTED DATE OF COMPLIANCE: 6/28/14</p> <p>4. The soiled CNA charting stations were cleaned on 6/18/14. Care and maintenance that includes cleaning of the charting stations was placed on the cleaning schedule to be done nightly and as needed. To ensure compliance, the MDS nurse or designee will monitor and report findings to DON/Designee who will report findings to QA. Checklist have been developed to include: 1) Turn off screen and apply gloves per policy protocol 2) Hold can of cleaner 6" away from screen 3) Spray directly onto screen 4) Wipe screen with minimum pressure with Screen Shammy 5) Polish screen gently until dry</p> <p>Expected Date of Compliance: 6/28/14</p>	

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 441	<p>Continued From page 70</p> <ul style="list-style-type: none"> <li>*Had gloves on.</li> <li>*Emptied the resident's catheter bag into a container.</li> <li>*Emptied the container of urine into the toilet.</li> <li>*Removed her gloves.</li> <li>*Put on new gloves and did not wash her hands.</li> <li>*She proceeded to change the resident's incontinence brief.</li> </ul> <p>Interview on 5/28/14 at 1:30 p.m. with the director of nursing revealed she would have expected staff to wash their hands for fifteen to twenty seconds before putting on gloves and after glove removal.</p> <p>Review of the provider's reviewed 5/22/14 Handwashing policy revealed: **"All personnel shall follow established hand washing procedure to prevent the spread of infection and disease to other personnel, residents, and visitors." *Handwashing for fifteen seconds should have been performed before putting on gloves.</p> <p>4. Random observations from 5/19/14 through 5/21/14 of the CNA charting stations on the red and blue hallways in the NCU revealed they were been visibly soiled and had fingerprints on them. The CNA charting station on the blue hallway had a white smear across an area of the screen.</p> <p>Interview on 5/28/14 at 8:50 a.m. with the physical plant manager revealed they had no cleaning schedule for the CNA charting stations. He agreed they had been soiled and needed to be on a cleaning schedule.</p>	F 441			
F 490 SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING	F 490			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 490	Continued From page 71  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the facility was operated and administered in a manner that attained or maintained the highest practicable physical, mental, and psychosocial well-being of all 48 residents. Findings include:  1. Interview on 5/21/14 at 2:30 p.m. with the interim administrator confirmed the overall operation and administration of the facility was her responsibility.  Interviews, observations, record reviews, and policy reviews throughout the course of the survey revealed the administration had not ensured all residents attained and/or maintained their highest practicable physical, mental, and psychosocial well-being. Refer to F157, F176, F241, F252, F280, F281, F309, F314, F323, F329, F332, F364, F368, F371, F441, F493, F514, and F520.	F 490	F490 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING Audit tools are being developed with weekly and/or monthly timelines until QAPI deems acceptable. Audits of F157, F176, F241, F252, F280, F281, F309, F314, F323, F329, F332, F364, F368, F371, F441, F493, F514, and F520 will be reviewed weekly and/or monthly by Administrator or designee who in turn will report to the Secretary of Veterans Affairs on a quartly basis. Expected Date of Compliance: 6/28/14	6/28/14	
F 493 SS=E	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN  The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the	F 493			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747	
(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 493	Continued From page 72 management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility  This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review, the governing body failed to ensure the facility was administered in a manner that ensured: *Physicians and/or families were notified in a timely manner in regards to changes in condition related to pressure ulcers, weight loss, other skin issues, and a change/decline in condition for 8 of 16 sampled residents (1, 4, 8, 12, 13, 14, 15, and 16). *The policy was followed for resident self-administration of medications for 4 of 8 sampled residents (6, 9, 10, and 16) in the special care unit (SCU). *Dignity had been maintained for all residents using the toilet and handwashing facilities in 52 of 52 residents' rooms. *A homelike environment for all residents residing in the facility. Exposed plumbing, exhaust, return air piping, and cable runs were visible in the ceilings and along the walls in corridors, residents' rooms, and residents' use areas. *Care plans had been updated to reflect the current status for 15 of 16 residents (1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, and 16). *All medication administration records and treatment administration records had documentation of medication and treatment documentation for 8 of 8 sampled residents (1, 2, 3, 4, 5, 6, 7, and 8.	F 493	F493 483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT  1. All resident care items and findings noted in F tags F157, F176, F241, F252, F280, F281, F309, F314, F323, F329, F332, F364, F368, F371, F441, F493, F514, and F520 have been addressed. Policies and/or training has been completed with any and all staff involved in the task. 2. Administrator or designee will sit on quarterly QA meetings. 3. Weekly and/or monthly audits will be reviewed by administration. The administrator or designee will report to Secretary of Veterans Affairs quarterly.	6/28/14

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 493	Continued From page 73 *Ensure medications used on an as needed basis had documentation for their effectiveness for 7 of 8 sampled residents (1, 2, 3, 4, 6, 7, and 8). *One of one treatment cart and 1 of 2 medication carts (blue hall) was locked on the nursing care unit. *Effective pain management for 1 of 2 sampled residents (1) with pain during personal cares. *Interventions were done in a timely manner for 1 of 1 sampled resident (1) with constant loose stools. *Documentation of skin issues had been addressed for 1 of 1 sampled residents (1) with numerous ulcers. *An effective pressure ulcer management program for 9 of 16 sampled residents (1, 4, 6, 7, 10, 12, 13, 14, and 15) with pressure ulcers. That failure created a situation of immediate jeopardy that had the potential for causing harm to all residents with a pressure ulcer and for those at risk for developing a pressure ulcer. *Chemicals had remained locked on the housekeeping carts on 2 of 2 units (nursing care unit and secured care unit). *Cleaning chemicals were locked up in 2 of 2 soiled linen rooms (nursing care unit and secured care unit). *Antipsychotic medications for 2 of 4 sampled residents (4 and 7) had an appropriate diagnosis for use. *A gradual medication dose reduction for an antipsychotic medication had been done for 1 of 4 sampled residents (4). *A medication error rate less than five percent by 1 of 1 registered nurse during 1 of 2 medication pass observations. *A liquid with nutritive value had been added to thin the pureed foods for 1 of 1 observed meal service (supper).	F 493			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 493	<p>Continued From page 74</p> <p>*A bedtime snack had been offered to 16 of 17 sampled residents (1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, and 17).</p> <p>*Appropriate handwashing and glove use had been completed by 4 of 5 observed staff members (G, I, J, and K) for 2 of 2 observed meal services in the kitchen.</p> <p>*An effective infection control program had been maintained.</p> <p>*A procedure for the disinfection of 2 of 2 whirlpool tubs.</p> <p>*Appropriate handwashing and glove use by 1 of 2 observed certified nursing assistants (B) while performing personal care on one of one sampled resident (4).</p> <p>*Certified nursing assistants charting stations had been maintained in a sanitary manner on 2 of 2 hallways (red hall and blue hall) in the nursing care unit.</p> <p>*The facility was operated and administered in a manner that attained or maintained the highest practicable physical, mental, and psychosocial well-being of 16 of 16 sampled residents.</p> <p>*Scheduled baths were documented for 15 of 16 residents (1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, and 16).</p> <p>*An effective quality assurance (QA) program had been maintained to identify concerns and to develop and implement corrective action.</p> <p>Findings include:</p> <p>1. Interviews, observations, record reviews, and policy reviews throughout the course of the survey from 5/19/14 through 5/21/14 and from 5/27/14 through 5/28/14 revealed the governing body had not ensured the safe management and overall well-being of all 48 residents. Refer to F157, F176, F241, F252, F280, F281, F309, F314, F323, F329, F332, F364, F368, F371,</p>	F 493			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 493	Continued From page 75 F441, F490, F514, and F520.	F 493	F514 483.75(I)(1) RECORDS-COMPLETE-ACCURATE-ACCESSIBLE The facility failed to document bathing in the records as given, declined, or offered. Previous record keeping had been maintained in a "CNA to Do" book prior to implementation of computer software program. Since the implementation of the software, nursing assistants are trained to document bathing however, there are several places to chart and at best, documentation has been inconsistent or absent. CNAs will be re-educated on correct documentation of bathing for the nursing care units and be monitored on a weekly basis by the Unit Supervisors of each respective unit x 4 weeks. The unit supervisors will forward these audits to the DON or designee to bring to QA on a quarterly basis. Expected Date of Completion: 6/28/14	6/28/14
F 514 SS=E	483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure 15 of 16 residents (1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, and 16) had scheduled baths documented. Findings include:  1. Review of the 4/25/14 through 5/27/14 certified nursing assistant documentation for the above listed residents revealed limited to no documentation for baths given or refused during that time period for those residents.  Interview on 5/28/14 at 1:30 p.m. with the director of nursing confirmed they did not have a policy on bathing frequency. She confirmed they "Attempted to bathe the residents twice a week, unless a resident requested a bath only once a	F 514		

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	Continued From page 76 week. If a bath was skipped or missed it would not be picked up the next day, the resident would have to wait until the next scheduled bath day."  Surveyor 32333 Review of the provider's 11/17/06 Whirlpool and Shower Bathing on Nursing Units policy revealed: "It is the responsibility of each nursing unit to provide whirlpool bathing or assisted showers at least twice a week for each resident. A resident may request either method."  Review of the provider's 1/10/08 Nursing Philosophy and Mission Statements revealed the "Mission of nursing is to provide quality nursing care to all residents. This care will be provided in a kind, understanding manner utilizing current concepts of professional practice in a harmonious environment with the resident as the center focus of all our activities."	F 514			
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.	F 520			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 520	<p>Continued From page 77</p> <p>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.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to ensure an effective quality assurance (QA) program had been maintained to identify concerns, to develop, and to implement corrective action. Findings include:</p> <p>1. Review of the previous survey on 4/25/13 revealed the following deficiencies had been cited: F241, F252, F371, F441, and F495.</p> <p>During the current survey the following deficiencies had been cited and/or recited (*): F157, F176, *F241, *F252, F280, F281, F309, F314, F323, F329, F332, F368, F364, *F371, *F441, F490, F493, F514, and F520.</p> <p>Interview on 5/20/14 at 3:50 p.m. with the director of nursing (DON) confirmed she was responsible for the QA program. She stated the current program consisted of auditing last years survey areas. Staff had been educated on the quality assurance performance improvement (QAPI) process. Front line staff were not involved in the QA committee. Staff and department managers that attended the QA committee meetings had</p>	F 520	<p>F520 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>The facility was cited for continued and ongoing issues noted as deficient in previous studies which should have been corrected or a plan of action put in place. F241 and F252 have been granted a waiver from the State of South Dakota and will not be corrected until the new facility is built. The other tags noted on the survey are monitored on a quarterly basis through checklists and audits within the QA committee until threshold is met. Once the threshold is met, the study is completed and no longer reviewed. With the implementation of Quality Assurance and Performance Improvement (QAPI), the facility will be able to be more proactive in finding solutions rather than reactive following a survey. Each department will have a representative and all departments will work together through root cause analysis or Performance Improvement Projections (PIPs) to resolve or offset issues. Expected Date of Completion: 6/28/14</p>	6/28/14	

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/28/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747		
(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 520	<p>Continued From page 78</p> <p>been the DON, medical director, physical plant, housekeeping, laundry, dietary, pharmacy, and the administrator. She stated that QA met quarterly, and when the QAPI was instituted it would meet monthly. She confirmed the current style of QA was a reactive style and was not proactive and preventative.</p> <p>Interview on 5/28/14 at 1:30 p.m. with the DON confirmed the current style of QA did not track and trend issues. They had not been looking for what had initially caused an issue.</p> <p>Review of the provider's 2/3/05 Quality Assurance Committee policy revealed:            **The purpose of the Quality Assurance Committee is to monitor, analyze, collect data, and resolve problems that would inhibit or prohibit quality of care for its residents."            **Each discipline will monitor specific and on going problems within their department."            **Each discipline will pinpoint specific issues and monitor for resolution."</p> <p>Interview on 5/27/14 at 4:35 p.m. with charge nurse D revealed she had not been very involved with the QA program. The director of nursing was responsible for most of the QA program.</p> <p>Interview on 5/28/14 at 9:30 a.m. with CNA N revealed she thought if she had any suggestions for QA she would take them to the charge nurse working at that time. She believed the charge nurse would bring it to the QA committee if it was a good idea.</p>	F 520			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A136	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  05/20/2014
NAME OF PROVIDER OR SUPPLIER  MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS  A licensing survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 5/20/14. The Michael J. Fitzmaurice South Dakota Veterans Home 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 5/27/14 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 K033 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 033 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1  This STANDARD is not met as evidenced by: Based on observation, interview, and testing, the provider failed to maintain two of two conforming	K 033	K033 NFPA 101 LIFE SAFETY CODE STANDARD Exit Components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 Observation revealed the 90 minute fire-rated door at the northwest stair enclosure on the second floor would open by pushing the door. It was noticed that the door was not latched.	

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

TITLE

(X6) DATE

*Brad Robinson*

*Superintendent*

23 JUN 14

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

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 033	Continued From page 1 exit stair enclosures (northwest and southwest) with conforming fire-rated doors on the second floor. Findings include:  1. Observation at 1:30 p.m. on 5/20/14 revealed the 90 minute fire-rated door at the northwest stair enclosure on the second floor would open by pushing on the door. It was noticed the door was not latched. The door was equipped with a "dog" feature that had been utilized and prevented the panic bar latch from engaging the door frame. Fire-rated doors must not be prevented from latching into the door frame.  Interview with the physical plant manager at the time of the observation confirmed that condition. He stated accessible door-opening controls had been added to allow residents easier access to open the door from both sides.  Testing of the door at the time of the observation with the panic bar "dog" feature released revealed the door worked as required both with the accessible controls and without the controls.  Further interview with the physical plant manager revealed the the southwest stair enclosure 90 minute door on the second floor was similiary configured.	K 033	K 033 Continued:  Responsible Discipline: Both the northwest and southwest stairwell doors have been locked in position so the doors latch each time. The capability to lock the latching mechanism open has been permanently disabled. All other stairwell doors have the ability to latch when closed. Latching of all stairwell doors are in our weekly preventative maintenance program. (PM 01) Responsibilities for PM will be completed by the Senior Building Maintenance Worker. The Senior Building Maintenance Worker reports to the Building Maintenance Supervisor weekly. The Building Maintenance Supervisor reports the findings at the QA Monthly.	6/28/14
K 034 SS=C	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:	K 034		

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2600 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 034	Continued From page 2 Based on measurement, observation, and interview, the provider failed to maintain two of two conforming exit stairs (northwest and southwest) with the correct tread depths and riser heights. Findings include:  1. Observation at 1:45 p.m. on 5/20/14 revealed the tread height and depth for the northwest and southwest stair enclosures were nine inches for the risers and nine and one half inches for the treads. Those steps were not consistent in tread width and riser height. Interview at the time of the observation with the physical plant manager revealed that condition had existed since the stair enclosures had been constructed. Review of the last survey conducted on 4/25/13 confirmed that condition existed.	K 034	<b>K034 (page 2 of 4) NFPA 101 LIFE SAFETY CODE STANDARD</b> Stairways and smoke proof towers used as exits are in accordance with 7.2.19.2.2.4, 19.2.2.4.  Observation revealed the tread height and depth for the northwest and southwest stair enclosures were nine inches for the risers and nine and one half inches for the treads. Those steps were not consistent in tread width and riser height.  Responsible Discipline: (Administration to respond)	F	
K 062 SS=C	The building meets the FSES. Please mark an "F" in the completion date column. <b>NFPA 101 LIFE SAFETY CODE STANDARD</b> 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: Based on observation and record review, the provider failed to maintain sprinklers for the main entrance. Sprinkler coverage did not extend out to the combustible canopy. Findings include:  1. Observation at 1:45 p.m. on 5/20/14 revealed the automatic sprinkler protection did not extend	K 062		6/28/14 F <i>24 JWH</i> <i>BTR</i> <i>Per Mr. Holden.</i>	

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	<p>Continued From page 3</p> <p>into the attached canopy at the front (main) entrance. The canopy was approximately 15 feet by 150 feet. It was constructed of 1 foot by 8 feet planks and heavy timber supports/beams, and had a metal roof. Review of the previous surveys dated 4/25/13, 2/07/12, and 1/25/11 revealed the condition had not been cited at those times. Interview with the physical plant manager revealed the building had a Fire/Smoke Zone Evaluation (FSES) Worksheet for Health Care Facilities completed on 1/25/11 for that condition.</p> <p>Interview with the physical plant manager at 3:00 p.m. on 5/20/14 revealed he thought the FSES document exempted the provider from correcting the deficiency until the new facility (under construction and scheduled to be completed near the end of 2015) was ready for occupancy.</p> <p>The facility meets the FSES. Please mark an "F" in the completion date column to indicate the facility's intent to correct the deficiencies identified in K000.</p>	K 062		

ORIGINAL

PRINTED: 06/09/2014  
FORM APPROVED

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10523</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER <b>MICHAEL J FITZMAURICE SD VETERANS HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA HOT SPRINGS, SD 57747</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S 000	Initial Comments  Surveyor: 18087 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 and from 5/27/14 through 5/28/14. Michael J. Fitzmaurice SD Veterans Home was found not in compliance with the following requirement: S166, S199, S206, and S322.	S 000	S16644:04:02:17 (1-10) OCCUPANT PROTECTION Responsible Discipline: Door alarms will be installed on the 2 doors on the west end of nursing care unit at the stair enclosures. *Security Cameras have been installed to view all exit doors from the NCU Nurse's Station. The Director of Nursing, Director of Operations, Physical Plant Manager, Superintendent and Charge Nurses have the ability to view these cameras. *All residents are assessed on admission for elopement risk and quarterly thereafter. Those residents identified at risk are required to wear a Roam	8/1/14
S 166	44:04:02:17(1-10) OCCUPANT PROTECTION  The facility must take at least the following precautions: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents; (3) Provide a call system for each...resident bed and in all toilet rooms and bathing facilities routinely used by...residents. The call system must be capable of being easily activated by the...resident and must register at a station serving the unit; (4) Provide handrails firmly attached to the walls on both sides of all resident corridors in nursing facilities; (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors in nursing facilities. Other exterior doors must be locked or alarmed. The alarm must be audible at a designated	S 166	Alert© pendant or bracelet to alert staff of attempts at departure from the unit. All residents on the nursing care units have Physical Therapy assessments completed upon admission and quarterly thereafter to determine their ambulation and mobility ability. *We have a secured unit with keyed entry doors and an exit door alarm system. *SCU also has security cameras in place at the exit doors. *All residents are assessed on admission and quarterly for elopement risk. The DON will coordinate with the Physical Plant Manager to ensure all above systems are operational weekly. The Physical Plant Manager will be bring findings to QAPI monthly.	

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

*Bradley T. Robinson*

STATE FORM

021199

TITLE

*Superintendent*  
KPL011

R D	RECEIVED
	1 Aug 14 AUG 06 2014 SD DOH L&C

Attachment Sheet 1 of 6

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10523</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>MICHAEL J FITZMAURICE SD VETERANS HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA HOT SPRINGS, SD 57747</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 166	<p>Continued From Page 1</p> <p>nurses' station and may not automatically silence when the door is closed;            (7) Portable space heaters and portable halogen lamps may not be used in a facility;            (8) Household-type electric blankets or heating pads may not be used in a facility;            (9) Any light fixture located over a...resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof lamp; and            (10) Any clothes dryer must have a galvanized metal vent pipe for exhaust.</p> <p>This Rule is not met as evidenced by:            Surveyor: 18087            Based on observation and interview, the provider failed to install electrically activated audible alarms for eight of eight unattended exit doors (three on the ground floor, three on the first floor, and two on the second floor). Findings include:</p> <p>1. Observation on 5/20/14 beginning at 10:30 a.m. revealed the northwest and southwest exit doors on the second floor were not equipped with alarms that activated the required alarm for all residents. Alarms were provided for residents equipped with wandering devices. Not all residents were equipped with wandering devices. Interview with the physical plant manager at the time of the observation confirmed that finding. He stated the remaining exit doors on the first and second floor did not have the required alarm either.</p>	S 166		

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10523</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MICHAEL J FITZMAURICE SD VETERANS HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA HOT SPRINGS, SD 57747</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 199	Continued From Page 2	S 199		
S 199	<p>44:04:04:04 PERSONNEL</p> <p>The facility must have a sufficient number of qualified personnel to provide effective and safe care. Staff members on duty must be awake at all times. Supervisors must be 18 years of age or older. Written job descriptions and personnel policies and procedures must be made available to personnel of all departments and services. The facility may not knowingly employ any person with a conviction for abusing another person. The facility must establish and follow policies regarding special duty or staff members on contract.</p> <p>This Rule is not met as evidenced by: Surveyor: 32573 Based on record review, record review, and interview, the provider failed to screen one of five randomly reviewed staff (1) for convictions of abuse. Findings include:</p> <p>1. Review of dietary aide (DA) 1's employee file revealed: *He had been hired on 2/6/14. *A background check or reference check to screen for abuse convictions had not been available. *He was a contract employee from CBM Food Services, Inc. (CBM).</p> <p>Review of the facility and outside company's contract dated through June 2014 revealed the contract company had been responsible for providing services that met state and federal requirements.</p> <p>Interview on 5/28/14 at 12:55 p.m. with the</p>	S 199	<p>S199 44:04:04:04 PERSONNEL DA (1) is no longer employed by the past food service company (CBM). New food service contractor hired DA (1) and completed background checks on all employees prior to hiring. New food service contractor has policy in place to do background checks on all employees. Dietary manager will monitor employment records individually upon hire to ensure background checks are completed. The Dietary Manager will report to QA monthly such findings until advised to discontinue. Date of Expected Completion: 6/28/14</p>	6/28/14

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10523</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>MICHAEL J FITZMAURICE SD VETERANS HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA HOT SPRINGS, SD 57747</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 199	Continued From Page 3  dietary manager revealed all the facility dietary staff was contracted through CBM. CBM did not perform background checks on their employees. She had been unable to provide documentation that DA I had been screened for convictions of abuse before beginning work at the facility.	S 199		
S 206	44:04:04:05 PERSONNEL-TRAINING  The facility must have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs must cover the required subjects annually. These programs must include the following subjects: (1) Fire prevention and response. The facility must conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills must be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) ...Resident rights; (7) Confidentiality of...resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of...residents with unique needs; and (10) Dining assistance, nutritional risks , and hydration needs of...residents.  ...Additional personnel education shall be based on facility identified needs.  This Rule is not met as evidenced by: Surveyor: 32573 Based on record review and interview, the	S 206	S206 PERSONNEL-TRAINING Employees C, D, E, F, and G have received training by 6/8/14 on the following: • Proper use of restraints/information regarding restraints • Dining Assistance, nutritional risk, and hydration • Confidentiality of resident information Employee training files will be monitored by the Human Resources Specialist on a quarterly basis and report to QA quarterly until advised to discontinue. Expected Date of Completion: 6/28/14	6/28/14

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10523</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MICHAEL J FITZMAURICE SD VETERANS HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA HOT SPRINGS, SD 57747</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 206	Continued From Page 4  provider failed to ensure all mandatory education for five of five sampled staff members (C, D, E, F, and G) had been completed and documented. Findings include:  1. Record review on 5/28/14 of employee files of those hired between November 2013 and April 2014 revealed staff C, D, E, F, and G had not received mandatory training on the following topics: *Proper use of restraints: all five sampled staff. *Dining assistance, nutritional risks, and hydration needs of residents: all five sampled staff *Confidentiality of patient or resident information: staff E.  Interview on 5/28/14 at 12:55 p.m. with the dietary manager revealed dining assistance, nutritional risks, and hydration needs had not been covered at new employee orientation or during annual in-service training.  Interview on 5/28/14 at 2:10 p.m. with the director of nursing revealed proper use of restraint training had not been given to any staff, because they did not use restraints. Confidentiality of patient or resident information training was only given to nursing staff.	S 206		
S 322	44:04:08:04.01 CONTROL AND ACCOUNTABILITY OF MEDICATIONS  Written authorization by the attending physician must be secured for the release of any medication to a...resident upon discharge or transfer. The release of medication must be documented in the...resident's record, indicating quantity, drug name, and strength.	S 322		

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10523</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>MICHAEL J FITZMAURICE SD VETERANS HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 MINNEKAHTA HOT SPRINGS, SD 57747</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 322	Continued From Page 5  This Rule is not met as evidenced by: Surveyor: 32573 Based on record review and interview, the provider failed to ensure a physician's order was received to release medications to one of one sampled resident (17) upon transfer. Findings include:  1. Review of resident 17's closed record revealed she had been admitted on 3/11/14 and transferred to Residential Living Services (RLS) on 4/7/14. At the time of transfer her medications had been sent with her. No physician's order was found in her record to release those medications at discharge.  Interview on 5/28/14 at 10:30 a.m. with the director of nursing confirmed there was no order in resident 17's chart for release of those medications when she transferred to RLS. She confirmed a physician's order should have been obtained prior to her transfer.	S 322	S322 44:04:08:04:01 CONTROL AND ACCOUNTABILITY OF MEDICATIONS Facility failed to obtain discharge orders including disposition of medications for a resident being transferred from Nursing Care Unit to Residential Living Services (Independent Living) at this facility. Discharging unit is responsible for obtaining discharge orders including disposition and destination of resident, procurement or disposal of medication, and independent or staff assistance. Discharge checklist will be generated for each discharge. Once completed, the checklist will be forwarded to the ADON. ADON will monitor checklists on a monthly basis and forward to DON for QA purposes. DON will bring to QA at least quarterly until advised otherwise. Expected Date of Completion: 6/28/14	6/28/14