

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

ORIGINAL

PRINTED: 08/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2014
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NAME OF PROVIDER OR SUPPLIER FIVE COUNTIES NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 405 6TH AVENUE WEST LEMMON, SD 57638
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F 000	<p><i>Amendments noted with an asterisk per email to facility administrator. DWISD/CHIME</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 23059 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/22/14 through 7/24/14. Five Counties Nursing Home was found not in compliance with the following requirements: F225, F280, F281, F318, F323, and F441.</p>	F 000	F225 Number 1 Resident 12 expired on 02/15/2014. There was an investigation and no abuse or neglect was confirmed. Report faxed to Local Ombudsmen, State Ombudsmen, and was sent to Department of Health on 8/22/2014 with the POC packet. 1 Staff Training for Administrator and Social Worker on residents and dignity per procedure for investigations. Signatures of Administrator and Social Worker on document included in the POC pack In-House Training <i>[redacted]</i> to Social Worker, and Administrator on 08/20/2014. Administrator and Social Services were presented abusive investigation policy, procedures, and reports. Social Services is responsible for reviewing pursuant to policy The policy that was sent in the packet on a weekly basis four (4) weeks then quarterly through the QAPI process. QAPI results will be reported to the Administrator weekly for (4) weeks, then quarterly for one year. The QAPI committee will review the results by the Social Worker will use the enclosed form for reporting to DOH.	CA 9/8/14 9/12/14 CA 9/8/14 CA 9/8/14 CA 9/8/14 CA 9/8/14
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p>	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Chad Abel</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8/21/14</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved Plan of correction is requisite to continued program participation.

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F 225	<p>Continued From page 1</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on interview, record review, and policy review, the provider failed to ensure two of three sampled allegations by five residents (4, 12, 13, 14, and 15) of abuse and theft of property had been reported to the state reporting agency (South Dakota Department of Health [SD DOH]). Findings include:</p> <ol style="list-style-type: none"> 1. Review of the provider's file of allegations of abuse or neglect since the previous survey on 6/12/13 revealed an 11/15/13 allegation of abuse against a staff member by resident 4. That allegation had not been reported to the SD DOH prior to the investigation. 2. Review of the same above file revealed an allegation of theft of money by residents 4, 13, 14, and 15. That allegation had not been reported to the SD DOH prior to the investigation. 3. Interview on 7/23/14 at 11:00 a.m. with the social services designee (SSD) revealed she stated she was not aware until the prior two months that allegations of abuse or neglect needed to have been reported to the SD DOH. 	F 225	<p>Number 2 Resident 4, 13, 14, and 15 reported money missing. Upon this knowledge I completed the 5 Day Investigation report 10/18/2013. I called Local Ombudsmen for our facility followed her recommendations and called local police. Police came resident 4 and 14 money was not found, resident 13 and resident 15 money was found. Investigative report has been faxed to Local Ombudsmen, State Ombudsmen, and Department of Health. 08/21/2014.</p> <p>Staff Training for Administrator and Social Worker on residents and dignity per procedure for investigations. Signatures of Administrator and Social Worker on document included in the POC pack In-House Training [REDACTED] to Social Worker, and Administrator on 08/20/2014. Administrator and Social Services were presented abusive investigation policy, procedures, and reports. Social Services is responsible for reviewing pursuant to policy The policy that was sent in the packet on a weekly basis four (4) weeks then quarterly through the QAPI process. QAPI results will be reported to the Administrator weekly for (4) weeks, then quarterly for one year. The QAPI committee will review the results by the Social Worker</p> <p><i>CA 9/8/14</i> <i>CA 9/8/14</i> <i>CA 9/8/14</i> <i>CA 9/8/14</i></p>

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F 225	<p>Continued From page 2</p> <p>She stated she contacted the local ombudsman (licensed social worker employed by the South Dakota Department of Social Services) and assumed that individual had reported concerns to SD DOH. She stated she had recently been educated on the need to report all concerns to SD DOH.</p> <p>Interview on 7/23/14 at 3:15 p.m. with the SSD revealed she had misspoken at the earlier interview and was sure she had reported everything to SD DOH. She confirmed no documentation was present to indicate that reporting had occurred.</p> <p>Interview on 7/23/14 at 3:20 p.m. with the SD DOH complaint coordinator confirmed she had no record the above allegations had been reported to her.</p> <p>Review of the provider's revised 9/27/06 Resident Abuse policy revealed: *Allegations of abuse or potential incidents of neglect were to have been reported to the SD DOH within twenty-four hours. *Those twenty-four hours began when the staff member first knew about the event.</p> <p>Review of the provider's November 2010 Social Services Policy Manual's policy on Reporting Abuse to State Agencies and Other Entities/Individuals revealed: *Any suspected violation or substantiated incident should promptly have been reported to the state licensing/certification agency responsible for surveying/licensing the facility (SD DOH). *Those reports were to have been made within twenty-four hours of the occurrence.</p>	F 225	<p>Number 3 Resident Rights and dignity of abuse investigation and reporting was reviewed with Social Services and Administration on 8/20/14. Implementation of falls investigation log and Resident Grievance/Complaint investigation log will be implemented immediately. Social Services is responsible for reviewing pursuant to policy on a weekly basis four (4) weeks then quarterly through the QAPI process. QAPI results will be reported to the Administrator weekly for (4) weeks, then quarterly for one year.</p> <p><u>THE QAPI COMMITTEE WILL REVIEW THE RESULTS BY THE SOCIAL WORKER.</u></p>	<p>CA 9/8/14</p>

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F 225	Continued From page 3 Review of the provider's undated resident handbook revealed any complaints of abuse or neglect would have been reported to the administrator. The administrator would have investigated that complaint and reported to the SD DOH if warranted.	F 225		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on observation, interview, record review, and policy review, the provider failed to ensure care plans had been reviewed and revised to reflect the current status for seven of ten sampled	F 280	Residents #1, 4, 5, 6, 8 and 10 were assessed using Grab Bar Assessment and grab bars were removed from their beds. The Grab Bar Assessment will be added to the admission check sheet for the charge nurses to complete for all new admissions. The charge nurse will obtain the Physician's order for a grab bar if appropriate. Quarterly reassessments and care plans will be completed by MDS Coordinator. All current residents will be assessed for need for grab bars and appropriate follow-up will be completed by 9-12-14. DON or designee will be responsible for reviewing medical records information weekly X4 weeks then quarterly thereafter through the QAPI process. QAPI results will be reported to the Administrator weekly X4 weeks then Quarterly thereafter for 1 year. Training to nursing staff on grab bars will be done for all nursing staff by DON or designee on the assessment procedure and safety. The QAPI committee will review the results by the MDS case manager RN.	9/12/14 CA 9/8/14

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F 280	<p>Continued From page 4 residents (1, 4, 5, 6, 7, 8, and 10) related to: *Use of grab bars for four of ten sampled residents (1, 4, 5, and 8). *Preventive skin care for one of ten sampled residents (10). *Use of a pacemaker for one of ten sampled residents (10). *Care of current skin issues for one of ten sampled residents (7). *Activities needed to improve or maintain residents' range of motion (ROM) for three of ten sampled residents (4, 6, and 8). Findings include:</p> <p>1. Random observations from 7/22/14 at 7:45 a.m. through 7/23/14 at 5:00 p.m. revealed a grab bar on the outside upper edge of resident 1's bed.</p> <p>Review of resident 1's revised 5/8/14 care plan revealed there was no mention of his use of a grab bar for positioning.</p> <p>Interview on 7/24/14 at 7:55 a.m. with the Minimum Data Set (MDS) coordinator revealed she was not aware the use of grab bars should have been included on the care plan.</p> <p>Surveyor 29162</p> <p>2. Random observation of resident 4's bed from 7/22/14 at 7:45 a.m. and throughout the entire survey revealed there had been grab bars on each side of the upper half of her bed.</p> <p>Review of resident 4's last revised 6/8/14 care plan revealed no mention of those grab bars.</p> <p>3. Observation on 7/23/14 3:00 p.m. of resident 8 revealed she had a grab bar on the upper half of her bed on the side nearest the closet.</p>	F 280	<p>(Pacemakers) Resident #10's pacemaker has been addressed on the care plan. Pacemakers will be added to the Nursing Admission checklist for identification of residents with these devices at the time of admission. All present residents with pacemakers will be identified and care plans completed by 9/12/14. MDS Coordinator or designee will be responsible for maintaining current list of residents with pacemakers and Care Plans completed. We will monitor weekly X4 weeks then quarterly thereafter through the QAPI process. QAPI results will be reported to the Administrator weekly X4 weeks then Quarterly thereafter for 1 year. The QAPI committee will review the results by the MDS case manager RN.</p> <p>F280 F280 (Range of Motion) Residents #4, 6 and 8 will be provided with at least 15 minutes of Restorative Therapy 5 days a week. This will provide these residents with Range of Motion exercises and will begin on 8/25/14, for residents #4, 6, and 8. All present residents and further admissions will be assessed by licensed nurse for Restorative therapy programs needed. A full six days a week restorative program will be initiated by 11/01/14. DON or designee will be responsible for reviewing Restorative Therapy assessments and programs weekly X4 weeks then quarterly thereafter through the QAPI process. QAPI results will be reported to the Administrator weekly X4 weeks then Quarterly thereafter for 1 year. QAPI committee will</p> <p><i>CA 9/8/14</i> <i>CA 9/8/14</i> <i>CA 9/8/14</i></p>

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F 280	<p>Continued From page 5</p> <p>Surveyor 28057</p> <p>4. Observation from 7/22/14 at 7:30 a.m. through 7/24/14 at 8:00 a.m. revealed resident 5 had a grab bar on the outside upper edge of his bed. He was not observed to use the grab bar by this surveyor as he was independent with his transfers. He was sleeping in bed, was in his easy chair, or was in the dining room during all observations of his activity during this survey.</p> <p>Review of his last revised 7/6/14 care plan revealed the use of the grab bar had not been addressed on that care plan.</p> <p>Review of his current physician's orders revealed there had been no order for the use of the grab bar.</p> <p>Review of his progress notes from 5/13/14 through 7/16/14 revealed a quarterly MDS assessment. That assessment had been documented by the registered nurse (RN) assessment coordinator/MDS nurse. She had addressed his use of mobility devices and had stated he was independent with transfers. She had not documented his use of the grab bar attached to his bed during transfers or at any other time.</p> <p>Interview on 7/23/14 at 1:30 p.m. with the MDS nurse confirmed she had not assessed resident 5 or any other resident for their ability to safely use the grab bars attached to their beds. She had not care planned the use of the grab bars as she believed they had not been a restraint. She believed grab bars had needed to be care planned only if they had been a restraint. She stated there was no policy that addressed the</p>	F 280	<p>F280</p> <p>Resident #7's wound was previously identified by Attending Physician as "superficial abrasion" in Physician's progress note on 2/11/14. When Attending Physician revisited resident on 7/08/14 he referred to the area as "Stage 2 pressure ulceration of the left mid-back area." The MD was contacted on 7/16/14 for clarification of this area and responded "That area on his back is an ulcer." MDS case manager RN will ask MD for further clarification of this area for ongoing treatment. Care plan has been for Resident #7 has been updated to include present treatment ordered by MD. MDS Coordinator or designee will be responsible for reviewing Care plans and medical records information weekly X4 weeks then quarterly thereafter through the QAPI process. QAPI results will be reported to the Administrator weekly X4 weeks then Quarterly thereafter for 1 year. QAPI committee will review the results by the MDS case manager.</p>	<p>CA 9/8/14</p> <p>CA 9/8/14</p>	

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F 280	<p>Continued From page 6 assessment and use of the grab bars.</p> <p>Interview on 7/23/14 at 1:30 p.m. with the director of nursing confirmed he had expected grab bars to have been assessed, care planned, and a physician's order received for the use of the grab bars.</p> <p>5. Review of resident 10's medical record revealed she had been admitted on 6/4/14. Review of her admission history on that day revealed she currently had a pacemaker (device implanted to regulate the heartbeat). That pacemaker required routine checks with an outside provider to ensure it was continuing to function appropriately. Review of her 6/9/14 care plan revealed there was no mention of the pacemaker or the need for routine checks.</p> <p>Review of resident 10's 6/11/14 through 7/18/14 physician's progress notes revealed she had concerns with ulcerations on the toes of her right foot. Those ulcerations were currently healed but required ongoing preventive skin care to prevent further break down of those areas. Review of her 6/9/14 care plan revealed there was no mention of the need for preventive skin care.</p> <p>Interview on 7/24/14 at 7:55 a.m. with the MDS coordinator revealed she was not aware use of a pacemaker should have been written on the care plan. She confirmed the preventive skin care should have been on resident 10's care plan. She confirmed the above information was not included on the current care plan.</p> <p>Surveyor: 28057 6. Interview on 7/23/14 at 7:45 a.m. with RN E confirmed resident 7 had an open area on his</p>	F 280			

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F 280	<p>Continued From page 7</p> <p>back. She stated she had it had been skin cancer. She further stated a facsimile had been sent to the physician on 7/16/14 to clarify that as the physician had recently referred to it as a pressure ulcer.</p> <p>Review of resident 7's 7/8/14 physician's progress notes revealed a stage II pressure ulceration of the mid-back. It had also included reference to a new order for the treatment of that pressure ulcer.</p> <p>Review of the resident's medical record revealed a "Fax Communication to Provider" that had asked for a clarification of the nature of the open area on resident 7's back. The response from the physician on 7/17/14 had stated the area on the resident's back was an "ulcer."</p> <p>Review of resident 7's last revised 7/16/14 care plan revealed a focus "The resident has impaired skin integrity relating to skin cancer and has an open area on his left mid back." The goals for that focus had been that the resident would have no complications related to his skin cancer (not the area on his back) and no skin injury during cares through the review date. No goals had addressed the open area on his back specifically. Under the interventions there had been listed a DuoDerm (dressing) to be placed over the open area on his back. The physician was to be kept updated on the healing progress of that area.</p> <p>Review of resident 7's 7/8/14 physician's order revealed an Aquacel dressing was to have been placed on the above open area. It was to be changed every three to five days when it had become saturated. The Aquacel was to have been covered with a Tegaderm or gauze and</p>	F 280		

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F 280	<p>Continued From page 8</p> <p>paper tape. The care plan had not reflected the change in the treatment for the open area on his back.</p> <p>Interview on 7/23/14 at 1:25 p.m. with the MDS RN confirmed the care plan had no measurable goal for the open area on the resident's back. She further confirmed the interventions had not been current.</p> <p>Surveyor: 29162</p> <p>7. Review of resident 4's last revised 6/8/14 care plan revealed range of motion (ROM) (exercises to maintain or improve joint movement) were to have been provided with a.m. and p.m. care daily.</p> <p>Interview with resident 4 on 7/22/14 at 2:00 p.m. revealed the staff that provided morning and bedtime care for her had not been doing the ROM exercises for or with her.</p> <p>8. Review of resident 6's last revised 7/6/14 care plan revealed gentle ROM as tolerated was to have been provided with daily care.</p> <p>Review of resident 6's restorative therapy documentation revealed she had received ROM exercises for a total of thirty minutes on two days since 6/29/14.</p> <p>9. Review of resident 8's last revised 7/16/14 care plan revealed no mention of restorative therapy. Review of the the restorative therapy Group Exercise sheet revealed she had been listed to participate in ROM exercises.</p> <p>Review of resident 8's restorative therapy documentation revealed she had received fifteen minutes or restorative therapy on ten days since</p>	F 280		

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F 280	Continued From page 9 6/29/14. 10. Interview on 7/23/14 at 8:00 a.m. with CNA H revealed they (CNAs) did not do the ROM exercises for the residents. He stated "Restorative therapy does the ROM exercises." 11. Interview on 7/23/14 at 1:00 p.m. with the MDS nurse and director of nursing (DON) revealed they agreed: *ROM exercises should have been care planned for all residents who received it. *The care plan should have accurately stated who was responsible for completing the ROM exercises for the residents. Review of the provider's last revised 2006 Assessments and Care Planning policy revealed: *Care plans were to have been modified according to resident results achieved and goals established. *Problem lists were to have been provided by each discipline at care planning. *Care plans were to be used in the resident's daily care routines. *Changes in resident's conditions were to have been reported to the nurse supervisor and MDS nurse so a review of the resident's care plan could have been made.	F 280			
F 281 SS=D	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:	F 281		9/12/14	

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F 281	<p>Continued From page 10 Surveyor: 28057 Based on observation, interview, record review, and policy review, the provider failed to ensure professional standards had been followed: *For physician's orders for a dressing change and the technique used during that dressing change for one of two observed residents (7) during a dressing change by one of two nurses (registered nurse [RN] F). *For documentation and care provided by nursing staff in a consistent manner for skin breakdown for one of two sampled residents (7) who had skin breakdown (open wound). *By two of three nurses (registered nurse [RN] E) when signing for medications given during two of three observed medication passes. Findings include:</p> <p>1. Observation on 7/23/14 at 5:00 p.m. revealed RN F did not wash his hands before putting gloves on. He then set-up supplies on resident 7's bedside table for a dressing change on his back. He cut a clean piece of Aquacel AG (a bacteria inhibiting dressing) to be placed on the resident's open area on his back. He had soaked the Aquacel AG with saline. He then changed his gloves without washing his hands. He removed the soiled dressing from the resident's back. He again changed his gloves without washing his hands. He applied the saline soaked Aquacel AG to the open area on the resident's back and covered it with a Tegaderm dressing. He wiped the resident's bedside table off with a dry paper towel when he had removed the soiled items from the table. No barrier had been used for the soiled items when they had been placed on the bedside table. No disinfectant had been used to clean the table. He removed his gloves and left the resident's room with the resident's dressing</p>	F 281	<p>F281 Infection Control A. All nursing staff shall follow the infection control policy and procedures as it relates to hand washing/hand hygiene procedures as referenced in facility's Nursing Services: Policy and Procedures Manual for Long Term Care to help prevent the spread of infections & promote healthy safe environment while in performance of skilled nursing care of resident 7. Infection control policy and procedures for all residents were reviewed & compared against facility's infection control policy and procedures, and the following action is advised: 1. Plan of compliance will begin 08/25/14; in-service of facility's infection control policy and procedures will be conducted. Monitoring & auditing of compliance will adhere to the following regiment: daily for one week, weekly for one month, then quarterly for one year. 2. Monitoring of proper infection control policy and procedures will be conducted by MDS Coordinator and or designated person(s) with appropriate written documentation demonstrating the stated action was performed. 3. Auditing of infection control policy and procedures will be audited by DON and MDS Coordinator and or designated person(s) with appropriate written documentation demonstrating the stated action was performed. 4. Results of audit will be reported to the QAPI committee for their review & action(s) to be taken; it will be the responsibility of the MDS Coordinator and or designated person(s) to complete this task.</p>	<p>CA 9/8/14</p>
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F 281	<p>Continued From page 11</p> <p>supply bag. He placed the supply bag back into the medication cart. At that time he cleaned his hands with sanitizer.</p> <p>Review of resident 7's 7/8/14 physician's progress notes revealed a stage II pressure ulceration of the mid-back. It further stated the use of a DuoDerm for the dressing change had kept the ulcer stable but had caused the surrounding tissue to become macerated (the softening and breaking down of tissue caused by prolonged exposure to moisture). The physician had ordered Aquacel in place of the DuoDerm.</p> <p>Review of resident 7's physician's order for 7/8/14 revealed an Aquacel dressing was to have been placed on the open area. It was to be changed every three to five days when it had become saturated. The Aquacel dressing was to have been covered with a Tegaderm or gauze and paper tape.</p> <p>Interview on 7/24/14 at 8:15 a.m. with the director of nursing (DON) confirmed: *The above dressing was to have been Aquacel (a dressing that had not inhibited bacteria growth) not Aquacel AG. *The Aquacel had not been put on dry. *The physician's orders had not stated to use saline to saturate the Aquacel. *Another nurse had informed him it had worked better to saturate the Aquacel with saline instead of applying it dry as ordered. *The nurse should have washed his hands before putting gloves on and whenever he had changed his gloves during the dressing change to prevent contamination.</p> <p>Review of the package insert for Aquacel had</p>	F 281	<p>F281 <u>Skin & Wound Management</u> B. A. All nursing staff shall follow the skin & wound management policy and procedures as it relates to skin & wound care as referenced in facility's <u>Nursing Services: Policy and Procedures Manual for Long Term Care</u> to help prevent skin break down & promote skin integrity while in performance of skilled nursing care of resident 7. Skin & wound care policy and procedures for all residents were reviewed & compared against facility's skin & wound care policy and procedures, and the following action is advised:</p> <ol style="list-style-type: none"> 1. Plan of compliance will begin 08/25/14; in-service of facility's skin & wound management policy and procedures will be conducted. Monitoring & auditing of compliance will adhere to the following regiment: daily for one week, weekly for one month, then quarterly for one year. 2. Monitoring of skin & wound care management will be conducted by MDS Coordinator and or designated person(s) with appropriate written documentation demonstrating the stated action was performed. 3. Auditing of skin & wound care management will be audited by DON and MDS Coordinator and or designated person(s) with appropriate written documentation demonstrating the stated action was performed. 4. Facility standard of skin/wound management will consist of; weekly photographing of skin/wound progress toward healing then elevate need of continued photographing, weekly skin/wound measurements, weekly documentation of using facility's wound/skin record. 5. Results of audit will be reported to the QAPI committee for their review & action(s) to be taken; it will be the responsibility of the MDS Coordinator and or

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F 281	<p>Continued From page 12</p> <p>indicated for wounds with exudate (drainage) the Aquacel was to be placed on the area dry so as to absorb the drainage from the wound. Only dry wounds were to have saline applied to the Aquacel before applying to the wound.</p> <p>2. Review of resident 7's medical record revealed he had been admitted on 9/6/13. His 9/7/13 Admission Skin Assessment revealed he had a scabbed open area on his mid-back. No measurements had been included. Further Skin Assessment forms documented the following: *On 2/24/14 "Resident gets DuoDerm to back Q (every) 3 days until healed. " -No measurements or description was included of the open area on his back. *On 3/10/14 No mention of the open area on the resident's back had been made. *On 4/14/14 "Scab to midback and (an area with skin cancer)". No other documentation had been included.</p> <p>Review of a Non-Pressure Skin Condition Report sheet dated from 4/27/14 through 7/20/14 for resident 7 revealed: *No measurements for the open area on the resident's back. *No description of the wound bed or surrounding tissue.</p> <p>Review of a Weekly Skin Integrity Review form for resident 7 dated from 5/3/14 through 6/11/14 revealed no measurements or description other than cancer spots/wounds.</p> <p>Review of resident 7's care plan last revised on 7/16/14 revealed weekly treatment documentation was to have recorded the measurement of the skin breakdown. It was to</p>	F 281	<p>Urinary Catheter Care.</p> <p>C. All nursing staff shall follow the urinary catheter care management policy and procedures as it relates to catheter care as referenced in facility's Nursing Services: Policy and Procedures Manual for Long Term Care to help prevent the spread of infections & promote healthy safe environment while in performance of skilled nursing care of resident 7. Catheter care policy and procedures for all residents were reviewed & compared against facility's catheter care policy and procedures, and the following action is advised:</p> <ol style="list-style-type: none"> 1. Plan of compliance will begin 08/25/14; in-service of facility's urinary catheter care management policy and procedures will be conducted. Monitoring & auditing of compliance will adhere to the following regiment: daily for one week, weekly for one month, then quarterly for one year. 2. Monitoring of urinary catheter care management will be conducted by MDS Coordinator and or designated person(s) with appropriate written documentation demonstrating the stated action was performed. 3. Auditing of urinary catheter care management will be audited by DON and MDS Coordinator and or designated person(s) with appropriate written documentation demonstrating the stated action was performed. 4. Results of audit will be reported to the QAPI committee for their review & action(s) to be taken; it will be the responsibility of the MDS Coordinator and or designated person(s) to complete this task. 	<p>CA 9/8/14</p>
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F 281	<p>Continued From page 13</p> <p>have included the width, length, depth, type of tissue and exudate, and any other notable changes or observations. It had not asked for the location to be documented.</p> <p>Interview on 7/24/14 at 8:15 a.m. with the director of nursing (DON) confirmed the documentation had not shown consistent documentation of care or the progression of the wound on resident 7's back.</p> <p>Review of the provider's October 2010 Wound Care policy revealed: *Hands were to have been washed before applying gloves. *Change gloves and wash hands after removing the soiled dressing and before applying the clean dressing. *Verify the physician's order for the procedure. *Document all assessment data related to the wound appearance to include the "wound bed color, size, drainage, etc."</p> <p>3. Review of resident 5's July 2014 Medication Administration Record (MAR) revealed: *He had received Lisinopril 2.5 milligrams (mg) one time a day for hypertension every day from 7/1/14 through 7/22/14. *A note on the MAR stated it was to be held (not given) if his blood pressure (B/P) was below 90. *He had received Terazosin hydrochloride 2 mg one time a day at bedtime every day from 7/1/14 through 7/21/14. *It was to have been held if his B/P was below 105 systolic (the first number of a B/P).</p> <p>Review of resident 5's current physician's orders revealed orders for the above medications and cautions as stated above.</p>	F 281	<p><u>Documentation of Medication Administration & Administering Medications F281</u></p> <p>D. All nursing staff shall follow the documentation of medication administration & administering medications policy and procedures as it relates to medication administration as referenced in facility's <u>Nursing Services: Policy and Procedures Manual for Long Term Care</u> to help prevent medication errors & promote accurate documentation; safe administration of medications of <u>resident 5</u>, specific to the administration & documentation of Rx Terazosin <u>to resident 5</u>; all nursing staff shall follow the policy and procedures as referenced in <u>Nursing Services: Policy and Procedures Manual for Long Term Care</u>; subchapter Medications: Administering Medications page 5 paragraph 1 thru 28; explicit to paragraph 8; "The following information must be checked/verified for each resident prior to administering medications: a. Allergies to medications and b. Vital signs, if necessary." Pursuant to provider's order Rx will be held if BP is lower than 105 Systolic; subchapter Medications: Documentation of Medication Administration page 17 paragraph 1 thru 3; explicit to paragraph 3; "Documentation must include as a minimum: a. Name and strength of the drug; b. Dosage; c. Method of administration (e.g., oral, injection (and site), etc); d. Date and time of administration; e. Reason(s) why a medication was withheld, not administered, or refused (as applicable); and f. Signature and title of the person administering the medication;" subchapter Medications: Documentation</p>	<p>CA 9/8/14</p>

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F 281	<p>Continued From page 14</p> <p>Review of resident 5's weights and vitals summary that documented B/Ps from 7/1/14 through 7/22/14 revealed: *His B/P had been documented ten days out of twenty-two days the medications had been given. *On 7/2/14 the resident's B/P had been 98/57. *On 7/16/14 the resident's B/P had been 101/69. *Both of the above resident's B/Ps had been too low to give the above Terazosin on both days according to the physician's orders. *That medication had been given to him on those days.</p> <p>In the resident's progress notes from 7/2/14 through 7/16/14 (none were documented after 7/16/14 through 7/22/14) revealed: *On 7/2/14 no documentation addressed the resident's B/P of 98/57. *On 7/16/14 licensed practical nurse J documented the resident's B/P was 101/69 and his 8:00 a.m. medications were given as ordered. -No other documentation was recorded that day to address if the resident's B/P had gone up before the Terazosin had been given that evening at bedtime.</p> <p>Interview on 7/23/14 at 3:00 p.m. with the DON confirmed he had expected documentation on the MAR and/or the progress notes to have included the reason the medication was held related to the resident's low B/P. He had expected the B/P to have been checked every day before the medications had been given.</p> <p>Review of the provider's 2001 Medication and Treatment policy had not addressed the following of physician orders.</p>	F 281	<p>of Medication Administration page 17 paragraph 1 thru 3; explicit to paragraph 3; "Documentation must include as a minimum: a. Name and strength of the drug; b. Dosage; c. Method of administration (e.g., oral, injection (and site), etc); d. Date and time of administration; e. Reason(s) why a medication was withheld, not administered, or refused (as applicable); and f. Signature and title of the person administering the medication;"</p> <p>subchapter Medications: Documentation of Medication Administration page 17 paragraph 1 thru 3; explicit to paragraph 2; "Administration of medication must be documented immediately after (never before) it is given." Documentation of medication administration & administering medications policy and procedures for all residents were reviewed & compared against facility's documentation of medication administration & administering medications policy and procedures, and the following action is advised:</p> <p>1. Plan of compliance will begin 09/8/14; in-service of documentation of medication administration & administering medications policy and procedures will be conducted. Monitoring & auditing of compliance will adhere to the following regiment: daily for one week, weekly for one month, then quarterly for one year.</p> <p>2. Monitoring of documentation of medication administration & administering medications will be conducted by MDS Coordinator and/or designated person(s) with appropriate written documentation demonstrating the stated action was performed.</p>	CA 9/8/14

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F 281	<p>Continued From page 15</p> <p>A policy was requested on 7/24/14 at 7:15 a.m. from the administrator for physician's orders. None was received.</p> <p>Surveyor: 23059</p> <p>4a. Observation on 7/22/14 beginning at 11:20 a.m. of RN E passing medications to randomly observed residents during the noon medication pass revealed she: *Signed her initials on the medication administration record (MAR). *That signature indicated a medication had been given. *She had signed the MAR prior to the administration of ten of ten medications.</p> <p>Interview with RN E on 7/23/14 at 8:00 a.m. revealed she thought all medications should have been signed off before administration.</p> <p>b. Observation on 7/23/14 beginning at 7:20 a.m. of RN F passing medications to residents revealed he: *Signed his initials on the MAR. *That signature indicated a medication had been given. *He had signed the MAR prior to the administration of fourteen of fourteen medications.</p> <p>Interview on 7/23/14 at 7:55 a.m. with RN F revealed he thought signing off medications prior to giving them was the correct method.</p> <p>c. Review of the provider's 2007 (no month) Medication Administration General Guidelines</p>	F 281	<p>3. Auditing of documentation of medication administration & administering medications will be audited by DON and MDS Coordinator and or designated person(s) with appropriate written documentation demonstrating the stated action was performed.</p> <p>4. Results of audit will be reported to the QAPI committee for their review & action(s) to be taken; it will be the responsibility of the MDS Coordinator and or designated person(s) to complete this task.</p>	<p>CA 9/8/14</p>

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F 281	Continued From page 16 policy revealed the medication was to have been documented immediately after it had been administered. Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, MO., 2013, p. 586, revealed "Record each medication on the patient's MAR as soon as you give medications to a patient." Review of a resolution issued by the South Dakota Board of Nursing at its September 12-13, 2006 meeting revealed: *Approved nursing education programs in the state had verified the standard for documentation of medication administration taught in nursing education was that documentation occurred following the administration of medication. *It was the position of the South Dakota Board of Nursing that the standard for safe administration of medication included the practice of documenting medication following administration to the patient.	F 281			
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Surveyor: 29162	F 318	F 318 Resident #4, 6, 8, and 9 will be provided with at least 15 minutes of Restorative Therapy 5 days a week. This will provide this resident with Range of Motion exercises and will begin on 8/25/14. Resident #4's program will be assessed by licensed nurse. A full six days a week restorative program will be initiated by 11/01/14. DON or designee will be responsible for reviewing Restorative Therapy assessments and programs weekly X4 weeks then quarterly thereafter through the QAPI process. QAPI results will be reported to the Administrator weekly X4 weeks then Quarterly thereafter for 1 year. QAPI committee will review the results by DON.	CA 9/12/14 9/8/14 CA 9/8/14	

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F 318	<p>Continued From page 17</p> <p>Based on record review, interview, and policy review, the provider failed to provide a restorative care program for four of four sampled residents (4, 6, 8, and 9) who received restorative care and had range of motion (ROM) (exercises to maintain or improve joint movement) identified as a problem area. Findings include:</p> <p>1. Review of resident 4's medical record revealed: *A 7/18/14 physician's order for ROM to upper and lower extremities (arms and legs) with an emphasis on the right ankle. *She had only received ROM exercises ten times from July 1, 2014 through July 23, 2014 per restorative therapy documentation **"ROM with a.m. and p.m. care daily" had been listed as an intervention on her last revised 6/8/14 care plan.</p> <p>2. Review of resident 6's medical record revealed: **"Gentle range of motion with daily care" had been listed as an intervention on her last revised 7/6/14 care plan. *She had received ROM exercises only eleven times from July 1, 2014 through July 23, 2014 per restorative therapy documentation</p> <p>3. Review of resident 8's medical record revealed: *A 7/16/14 physician's order for group restorative therapy exercises six times a week. *She had only completed group restorative exercises nine times from July 1, 2014 through July 23, 2014 per restorative therapy documentation.</p> <p>4. Review of resident 9's medical record revealed</p>	F 318			

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F 318	Continued From page 18 a 5/8/14 physician's order for restorative therapy program for group exercises. Per the Minimum Data Set (MDS) assessment coordinator , there had been no documentation in the restorative therapy nursing notes for resident 9. 5. Interview on 7/23/14 at 1:45 p.m. with the Minimum Data Set assessment coordinator and the director of nursing revealed there was not an active restorative therapy program. They agreed the residents needed the restorative therapy. They stated not having enough staff was a concern. Review of the provider's last revised April 2013 Rehabilitative Nursing Care policy revealed rehabilitative nursing care was: *Provided for each resident admitted. *Performed daily for those residents who require daily service that included routine range of motion exercises.	F 318		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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: Surveyor: 29162	F 323		9/12/14

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2014	
NAME OF PROVIDER OR SUPPLIER FIVE COUNTIES NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 405 6TH AVENUE WEST LEMMON, SD 57638		
(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	<p>Continued From page 19</p> <p>Based on observation, record review, interview, and policy review, the provider failed to:</p> <ul style="list-style-type: none"> *Ensure attached grab bars had been assessed for safe use. *Obtain a physician's order for four of four sampled residents (1, 4, 5, and 8) with grab bars on their beds. <p>Findings include:</p> <p>1. Observation on 7/22/14 at 7:45 a.m. through 7/23/14 at 5:00 p.m. revealed resident 4 had a grab bar attached on the upper half of both sides of her bed.</p> <p>Interview with resident 4 on 7/22/14 at 11:30 a.m. revealed she used the grab bars to assist her to move in bed and when she received cares.</p> <p>Review of resident 4's medical record revealed:</p> <ul style="list-style-type: none"> *No assessment that indicated a need for a grab bar. *No safety assessment for the grab bar. *No physician's order for a grab bar. *The use of the grab bar had not been included on her most recent care plan last revised on 6/8/14. <p>2. Observation on 7/23/14 at 11:00 a.m. and at 3:00 p.m. revealed resident 8 had a grab bar attached on the upper half of her bed. That grab bar was on the side of her bed closest to her closet. She stated she used the grab bar to move in bed.</p> <p>Review of resident 8's medical record revealed:</p> <ul style="list-style-type: none"> *No assessment that indicated a need for a grab bar. *No safety assessment for the grab bar. *No physician's order for a grab bar. 	F 323	<p>Residents #4, 8 were assessed using Grab Bar Assessment and grab bars were removed from their beds. The Grab Bar Assessment will be added to the admission check sheet for the charge nurses to complete for all new admissions. The charge nurse will obtain the Physician's order for a grab-bar if appropriate. Quarterly reassessments and care plans will be completed by MDS Coordinator.</p> <p>All current residents will be assessed for need for grab bars and appropriate follow up will be completed by 9/12/14.</p> <p>DON or designee will be responsible for reviewing medical records information weekly X4 weeks then quarterly thereafter through the QAPI process. QAPI results will be reported to the Administrator weekly X4 weeks then Quarterly thereafter for 1 year.</p> <p>QAPI committee will review the results by the DON or designee.</p> <p>Residents #1, 5 were reassessed using Grab Bar Assessment and grab bars were removed from their beds.</p>	<p>CA 9/8/14</p> <p>CA 9/8/14</p>

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F 323	<p>Continued From page 20</p> <p>*The use of the grab bar had not been included on her most recent care plan last revised on 7/6/14.</p> <p>Surveyor: 23059</p> <p>3. Random observations from 7/22/14 at 7:45 a.m. through 7/23/14 at 5:00 p.m. revealed a grab bar on the outside upper edge of resident 1's bed.</p> <p>Review of resident 1's 7/1/14 Minimum Data Set assessment (MDS) revealed he required extensive assistance from two people for bed mobility (repositioning in bed) and transfers.</p> <p>Interview on 7/23/14 at 1:10 p.m. with certified nursing assistants (CNA) G and H revealed resident 1 was not able to use the grab bar to reposition himself. CNA H stated they would sometimes tell him during the night to hang onto the grab bar while they repositioned him.</p> <p>Interview on 7/24/14 at 7:55 a.m. with the MDS coordinator confirmed resident 's health had declined, and he was not capable of using a grab bar to assist himself to reposition. She confirmed no assessment had been completed to determine if use of that grab bar was safe for resident 1 to have on his bed.</p> <p>Surveyor: 28057</p> <p>4. Observation from 7/22/14 at 7:30 a.m. through 7/24/14 at 8:00 a.m. revealed resident 5 had a grab bar on the outside upper edge of his bed. He was not observed to use the grab bar by this surveyor as he was independent with his transfers. He was sleeping in bed, was in his easy chair, or was in the dining room during all observations of his activity during this survey.</p>	F 323		

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F 323	Continued From page 21 Review of his last revised 7/6/14 care plan revealed the use of the grab bar had not been addressed on that care plan.	F 323		
F 441 SS=D	<p>Refer to F280, finding 4. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p>	F 441	<p>F441 Urinary Catheter Care C. All nursing staff shall follow the urinary catheter care management policy and procedures as it relates to catheter care as referenced in facility's</p> <p>Nursing Services: Policy and Procedures Manual for Long Term Care to help prevent the spread of infections & promote healthy safe environment while in performance of skilled nursing care of resident 7. Catheter care policy and procedures for all residents were reviewed & compared against facility's catheter care policy and procedures, and the following action is advised: 1. Plan of compliance will begin 08/25/14; in-service of facility's urinary catheter care management policy and procedures will be conducted. Monitoring & auditing of compliance will adhere to the following regiment: daily for one week, weekly for one month, then quarterly for one year. 2. Monitoring of urinary catheter care management will be conducted by MDS Coordinator and or designated person(s) with appropriate written documentation demonstrating the stated action was performed. 3. Auditing of urinary catheter care management will be audited by DON and MDS Coordinator and or designated person(s) with appropriate written documentation demonstrating the stated action was performed.</p>	9/12/14

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F 441	<p>Continued From page 22</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on observation and interview, the provider failed to ensure sanitary practices were used during: *One of one observed foley catheter (a tube used to drain urine from the bladder) care by one of one randomly observed certified nursing assistant (CNA) (H). *One of two observed residents (7) dressing changes by one of two observed nurses (registered nurse [RN] [F]). Findings include:</p> <p>1. Observation on 7/22/14 at 2:00 p.m. revealed CNA H had emptied resident 7's catheter bag. While providing that care he had: *Put on gloves without first washing his hands thereby contaminating the gloves. *Removed a graduated container (used to measure liquid) from the resident's dresser drawer. *Set the graduated container on the bare floor instead of using a barrier between it and the floor. -That had exposed the container to contamination from the floor. *Then emptied the catheter bag into the graduated container. *Dropped an alcohol swab packet on the floor, picked it up, and used it to clean the catheter tip after it had been on the floor.</p>	F 441	<p>A. All nursing staff shall follow the infection control policy and procedures as it relates to hand washing/hand hygiene procedures as referenced in facility's Nursing Services: Policy and Procedures Manual for Long Term Care to help prevent the spread of infections & promote healthy safe environment while in performance of skilled nursing care of resident 7. Infection control policy and procedures for all residents were reviewed & compared against facility's infection control policy and procedures, and the following action is advised:</p> <p>1. Plan of compliance will begin 08/25/14; in-service of facility's infection control policy and procedures will be conducted. Monitoring & auditing of compliance will adhere to the following regiment: daily for one week, weekly for one month, then quarterly for one year. 2. Monitoring of proper infection control policy and procedures will be conducted by MDS Coordinator and or</p>	<p>CA 9/8/14</p>

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F 441	Continued From page 23 Interview at that same time with CNA H confirmed he should have washed his hands before he had put gloves on his hands. He had not thought about the floor contaminating the graduated container and had not realized a barrier should have been used. Interview on 7/24/14 at 8:15 a.m. with the director of nursing (DON) confirmed hands were to be washed before gloves had been applied or when they had been changed. 2. On 7/23/14 at 10:30 a.m. a policy was requested for catheter care from the administrator and director of nursing (DON). No policy was provided by the exit of the survey on 7/24/14. 3. Observation on 7/23/14 at 5:00 p.m revealed registered nurse F had performed a dressing change on resident 7 using improper hand hygiene and glove use during that dressing change. Refer to F281, findings 1 and 3.	F 441	designated person(s) with appropriate written documentation demonstrating the stated action was performed. 3. Auditing of infection control policy and procedures will be audited by DON and MDS Coordinator and or designated person(s) with appropriate written documentation demonstrating the stated action was performed. 4. Results of audit will be reported to the QAPI committee for their review & action(s) to be taken; it will be the responsibility of the MDS Coordinator and or designated person(s) to complete this task.	CA 9/8/14	

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K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/29/14. Five Counties Nursing Home (building 01) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 7/30/14 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiencies identified at K056, K061, K062, and K069 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 028 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers provide a minimum clear width of 32 inches (81cm) for swinging or horizontal doors. Vision panels are of fire-rated glazing or wired glass panels and steel frames. 19.3.7.5, 19.3.7.7 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and record review, the provider failed to maintain clear door widths of at least 32 inches for one randomly observed	K 028		F

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

TITLE

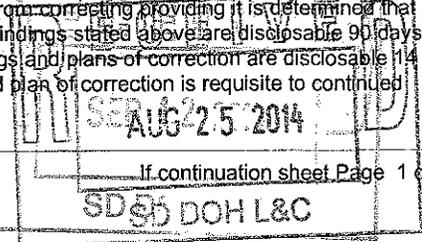
(X6) DATE

Chad Abel

Administrator

8/21/14

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.



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K 028	Continued From page 1 smoke barrier located on the first floor of the original building (between the original building and the 1962 addition). Findings include: 1. Observation on 7/29/14 revealed the cross-corridor doors between the original building and the 1962 addition were only 30 inches wide and did not provide a clear opening width of 32 inches. Review of the previous survey report dated 6/12/13 revealed those doors were the original doors. The building meets the FSES. Please mark an "F" in the completion date column.	K 028		
K 032 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and record review, the provider failed to maintain at least two conforming exits from each floor of the building. The basement had only one means of egress. Findings include: 1. Observation at 11:30 a.m. on 7/29/14 revealed the basement was not provided with two means of egress. One exit stairwell was the only means of egress from the basement. Review of the previous survey dated 6/12/13 confirmed that	K 032		F

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K 032	Continued From page 2 finding.	K 032		
K 034 SS=C	The building meets the FSES. Please mark an "F" in the completion date column. NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and record review, the provider failed to maintain a minimum clear space of 22 inches between the swing of the door and the newel post in one of three stairwells (southwest stair enclosure). Findings include: 1. Observation at 11:00 a.m. on 7/29/14 and record review of the previous survey report dated 6/12/13 revealed the first floor door swung into the southwest stair enclosure. That door in the open position restricted the egress to 17 inches measuring from the latch side of the door leaf to the stair newel post.	K 034		F
K 056 SS=F	The building meets FSES. Please mark an "F" in the completion date column. NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the	K 056		9/12/14

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K 056	<p>Continued From page 3</p> <p>Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure the facility was protected throughout by automatic sprinklers in one randomly observed location (housekeeping room of north wing). Provider also failed to ensure the sprinkler system was provided with the necessary means to ensure valves controlling sprinkler operation were secured or supervised in the open position at the post indicator valve. Findings include:</p> <p>1. Observation at 10:20 a.m. on 7/29/14 revealed a post indicator valve on the west side of the lot where the building was located. That valve controlled the water supply to the buildings sprinkler system. Further observation revealed that valve was not provided with an appropriate means to ensure that valve could not be closed without the provider's knowledge. Interview with the maintenance personnel at the time of the observation revealed he was unaware of that requirement. Review of the sprinkler system inspection company report dated 11/15/13 revealed that valve was checked as being inspected. No note was made indicating that valve was not supervised or locked in the open</p>	K 056	<p>Maintenance placed a padlock on post valve on 8-12-14 to ensure us that it wouldn't be shut off without maintenance's knowledge. Maintenance Director will monitor the locked system annually.</p> <p>The outside valve with the padlock on it will be added to the preventive Maintenance schedule and inspected on a monthly basis to ensure that the valve is in the open position, by the Director of maintenance. The monthly performance monitoring results will be reported to the Administrator and will be part of the QAPI report quarterly.</p>	<i>A</i> <i>9/8/14</i>

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K 056	Continued From page 4 position.	K 056	8-15-14 Called Rapid Fire, located in Rapid City SD. Received 8/21/14 a bid to install sprinkler head in janitorial closet. This will be completed before 9/12/14	
K 061 SS=E	<p>2. Observation at 10:50 a.m. on 7/29/14 revealed a housekeeping room in the north wing nearest the administrator ' s office. Further observation of that room revealed the room was not provided with sprinkler protection. All rooms in a complete automatic fully sprinkled NFPA 13 facility shall be provided with sprinkler protection. Interview with the maintenance staff at the time of the observation revealed he was unaware of that requirement. He further indicated he was new to the job and had never looked in that room.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure the automatic sprinkler system was provided with supervisory attachments for control valves in two randomly observed locations (clean supply storage room and activity storage room both in the basement). Findings include:</p> <p>1. Observation at 10:00 a.m. on 7/29/14 revealed a clean supply storage room in the basement. Further observation revealed that room was protected by a sprinkler system tied to the facility's potable water system. That system</p>	K 061	<p>The motoring of the fire sprinkler system will include this addition annually by Rapid Fire Protection.</p> <p>Sprinkler was installed on 9/3/14.</p> <p>The motoring of the fire sprinkler system will include this addition annually by Rapid Fire Protection. The fire sprinkler system will be monitored monthly by the Director of maintenance, document in the monthly preventative maintenance checklist, and reported monthly to the administrator and quarterly to QAPI.</p> <p>K061 pages 5 of 8 Maintenance has placed chains with padlocks on both valves and strait valves in the Dry Storage and in Activity closet with keys available in case of an emergency located in key box located in the med room at the Nurses Station.</p>	<p>CA 9/8/14</p> <p>9/12/14</p>

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K 061	Continued From page 5 included a control valve, backflow valve, waterflow alarm, approximately forty feet of branchline, and five standard response sprinkler heads. The control valve to that system was not provided with valve supervision. There was no indication indicating that valve was open and no means of locking that valve in the open position. Further observation at 10:10 a.m. revealed the same system was provided on the opposite side of the basement in a surplus and activity supply storage room.	K 061	Maintenance will monitor all sprinkler valves in both rooms that they are secured and locked in the open position. Maintenance will document monthly and log in our preventative maintenance program monthly to administrator and quarterly to the QAPI committee. Director of maintenance will provide staff with written direction of the purpose of the key and the location of the key. The written notice will be put in the employee pay check envelope. This will also be included in new employee information.	CA 9/8/14
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation, record review, and interview, the provider failed to ensure the automatic sprinkler system was inspected, maintained, and tested at regular intervals in accordance with NFPA 25 standards in two randomly observed locations (clean supply storage room and activity storage room both in the basement). Findings include:	K 062	When Rapid fire comes to install new sprinkler head in closet they will inspect valves that have expired inspection dates. All the vales that need to be inspected will be included on the annual inspection by Rapid Fire Protection. The two back flow valves will be tagged and monitored monthly by the Director of maintenance, document in the monthly preventative maintenance checklist, and reported monthly to the administrator and quarterly to QAPI.	9/12/14 CA 9/8/14

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/29/2014
NAME OF PROVIDER OR SUPPLIER FIVE COUNTIES NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 405 6TH AVENUE WEST LEMMON, SD 57638	
(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	Continued From page 6 1. Observation at 10:00 a.m. on 7/29/14 revealed a clean supply storage room in the basement. Further observation revealed that room was protected by a sprinkler system tied to the facility's potable water system. That system included a control valve, backflow valve waterflow alarm, approximately forty feet of branchline, and five standard response sprinkler heads. Further observation revealed an inspection tag on the control valve that was dated September 1997. That system should have been inspected and tested at regular intervals in accordance with NFPA 25 inspection, testing, and maintenance standards. Further observation at 10:10 a.m. revealed the same system was provided on the opposite side of the basement in a surplus and activity supply storage room. Interview with the maintenance staff at the time of those observations revealed he was unaware of the inspection, testing, and maintenance requirements. Review of the sprinkler system inspection company report dated 11/15/13 revealed those systems were not checked as having been inspected or tested.	K 062		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on document review and interview, the provider failed to ensure the kitchen hood fire suppression system was tied to the building fire alarm signaling system for one of one kitchen	K 069	We contacted Nardini Fire Equipment on 8/12/14 out of Bismarck ND, to correct the deficiency. On 8/13/14 Stocks Electric in Lemmon was contacted and will complete the electrical work needed to ensure the Kitchen Hood Fire Suppression System will be tied into the building fire alarm signaling system by Simplex Grinnell.	9/12/14

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K 069	Continued From page 7 hood. Findings include: 1. Document review of the commercial kitchen equipment inspection report dated 4/23/14 revealed the inspection service company had provided information indicating the kitchen hood fire suppression system was not tied into the buildings fire alarm signaling system. Interview with the maintenance personnel at 8:30 a.m. on 7/29/14 at the time of at record review revealed he was unaware of that requirement. He further indicated that he was new to the job and was not familiar with NFPA 96 and the requirements for commercial cooking facilities. Interview with the administrator at 2:30 p.m. on 7/9/14 at the time of the exit interview revealed he was also unaware the commercial kitchen fire suppression system was to be tied to the buildings fire alarm signaling system.	K 069	Maintenance will audit the fire alarm system panel to insure proper functioning of the fire suppression system. The system will be monitored by the Director of maintenance monthly and annually by Nardini Fire Equipment. Results of all monitoring will be reported to the administrator and the results will be recorded at the quarterly QAPI meeting. <i>We are waiting on Simplex Grinnell to give us the date they can program it into the system.</i>	<i>CA 9/8/14</i> <i>CA 9/8/14</i>

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 07/29/2014
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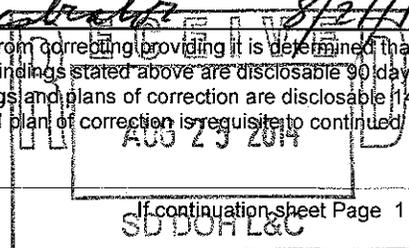
NAME OF PROVIDER OR SUPPLIER FIVE COUNTIES NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 405 6TH AVENUE WEST LEMMON, SD 57638
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/29/14. Five Counties Nursing Home (building 02) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Chad Abel</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8/21/14</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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S 166	<p>Continued From page 1</p> <p>when the door is closed;</p> <p>(7) Portable space heaters and portable halogen lamps may not be used in a facility;</p> <p>(8) Household-type electric blankets or heating pads may not be used in a facility;</p> <p>(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</p> <p>(10) Any clothes dryer must have a galvanized metal vent pipe for exhaust.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 28057 Based on observation, interview, and policy review, the provider failed to ensure one of six exit doors (the double-door leading to the clinic, offices, and kitchen area) had been alarmed, locked, or attended at all times. Findings include:</p> <p>1. Observation on 7/22/14 at 10:05 a.m. revealed the door alarm to the north double-door leading to the clinic, offices, and kitchen was not engaged. It had not audibly sounded when that door had been opened during the observation by this surveyor.</p> <p>Interview on 7/22/14 at 10:05 a.m. with the administrator confirmed the alarm to that door was turned off during the day. He believed they were turned off around 6:00 a.m. or 7:00 a.m. He stated it was not turned back on again until 6:00 p.m. everyday. He stated the door was alarmed by a Wanderguard system at all times. The alarm</p>	S 166		
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S 166	<p>Continued From page 2</p> <p>would sound only if a resident with a Wanderguard bracelet went through the door causing the alarm to be activated. The only residents with a Wanderguard bracelet were those who had been at risk for wandering. He agreed staff were not always in attendance and in view of that door during the day when the alarm was turned off. He had not realized that door had to be alarmed, attended, or locked at all times. He had the staff turn the alarm back on at that time.</p> <p>Further observations from the above time until the morning of 7/24/14 revealed many random staff conversations overheard by the surveyors complaining about the alarm sounding. They were complaining the alarm for that door usually was not on during the daytime hours.</p> <p>Observation on 7/23/14 from 7:15 a.m. until 7:30 a.m. revealed no staff had been present in the offices on the other side of the double-door. The administrator had not arrived yet (his door was located just before the door on the nursing home side of that door). The social worker had not been in her office at that time either. No other offices were in sight of the door.</p> <p>Review of the provider's 7/8/13 Door Alarm policy revealed: *The double-door was to have been alarmed from 7:00 p.m. through 6:30 a.m. *It had directed staff to monitor the door exits and respond in a timely manner when the audible alarms were turned off.</p>	S 166		
S 206	44:04:04:05 PERSONNEL-TRAINING	S 206		9/12/14

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S 206	<p>Continued From page 3</p> <p>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:</p> <ol style="list-style-type: none"> (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. <p>...Additional personnel education shall be based on facility identified needs.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 28057 Based on record review and interview, the provider failed to ensure two of five newly hired sampled employees (C and D) received all ten of the state required orientation programs. Findings include:</p> <ol style="list-style-type: none"> 1. Review of certified nurse assistant C's and licensed practical nurse D's training and orientation records revealed they had not received training for: 	S 206	<ol style="list-style-type: none"> 1. Online training was modified or added to, 8-12-14 to include missing training in Orientation and was also added to selected months for yearly training. This training now correlates with the state requirements. 2. All per Diem employee and will do orientation training in lieu of monthly training to ensure compliance. All other employees will do the monthly/yearly training also. 3. Online training sends emails to employees, Dept. Heads and HR on incomplete training weekly and monthly. HR will monitor using this email and print out, adding completion dates. Reporting will be to the QAPI committee quarterly by HR. <p>Policy on training is in all Personnel Policy Manuals and each Dept. Manuel as Policy #2.15, Mandatory Meetings and In-Services</p> <p>The HR or designee is responsible for reviewing information pursuant to policy on a weekly basis for 4 weeks then quarterly through the QAPI process. Social Services is responsible for reviewing pursuant to policy on QAPI results will be reported to the Administrator weekly for {4} weeks, then quarterly for one year.</p> <p><u>THE QAPI COMMITTEE WILL REVIEW THE RESULTS BY THE HR.</u></p>	<p>CA 9/8/14</p>
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S 206	<p>Continued From page 4</p> <p>*Emergency procedures and preparedness. *Accident prevention and safety procedures. *Incidents and disease subject to mandatory reporting, and the facility's reporting mechanism. *Care of residents with unique needs. *Nutritional risks, and hydration needs of residents.</p> <p>Interview on 7/23/14 at 4:30 p.m. with the administrator confirmed no other documentation was available to support the above missing orientation and training.</p> <p>A policy was requested on 7/24/14 at 7:15 a.m. from the administrator for staff orientation and annual training. None was received. Interview on 7/24/14 at 9:30 a.m. with the administrator confirmed he had been unable to find a policy.</p>	S 206		
S 210	<p>44:04:04:06 EMPLOYEE HEALTH PROGRAM</p> <p>The facility must have an employee health program for the protection of the...residents. All personnel must be evaluated by a licensed health professional for freedom from reportable health communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease which may endanger the health of...residents and fellow employees may not return to duty until they are determined by a physician or the physician's designee to no longer</p>	S 210	<p>1. The New Employee Health 8-13-14 Evaluation form was modified to include printed name to better identify signer. Nurse signature areas were hi-lighted or done in bold.</p> <p>2. HR will accompany employee to nurse's station with form and assure compliance and/or using the orientation checklist already in place.</p> <p>3. A spreadsheet form was created to monitor compliance. Reporting will be to the QAPI committee quarterly by HR.</p> <p>THE QAPI COMMITTEE WILL REVIEW THE RESULTS BY THE HR.</p>	<p>9/12/14</p> <p>CA 9/8/14</p>

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S 210	<p>Continued From page 5</p> <p>have the disease in a communicable stage.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 28057 Based on record review and interview, the provider failed to ensure two of five sampled employees certified nursing assistant (CNA) C and licensed practical nurse (LPN) D had a documented and signed health evaluation completed by a health professional when they had been hired. Findings include:</p> <p>1. Review of CNA C's employee file revealed she had been hired on 4/7/14. Review of her 4/7/14 New Employee Health Evaluation form revealed it had not been signed by a health professional.</p> <p>Review of LPN D's employee file revealed she had been hired on 4/2/14. She had signed her own New Employee Health Evaluation form on 3/27/14.</p> <p>Interview on 7/23/14 at 4:30 p.m. with the administrator confirmed LPN D could not sign her own health evaluation, and a health professional had not signed CNA C's form.</p>	S 210		
S 294	<p>44:04:07:04 Written Menus</p> <p>Any regular and therapeutic menu, including therapeutic diet menu extensions for all diets served in the facility, must be written, prepared, and served as prescribed by each...residents's physician. Each menu must be written at least one week in advance. Each planned menu must be approved, signed, and dated by the dietitian for all facilities. Any menu changes from month</p>	S 294	<p>S294 All menus will be reviewed and signed by RD annually, starting upon her next scheduled visit to facility on August 26th 2014. All new seasonal menus (Spring/Summer or Fall / Winter) will be reviewed and signed by RD when implemented into Five Counties Nursing Home's menu cycle. Review for compliance will be monitored by CDM, CFPP on the work request sheet filled out monthly for THE RD'S scheduled monthly visits to the facility. Dietary Manager will report to QA committee regarding monthly compliance review quarterly for one year.</p> <p>THE POLICY WAS UPDATED FOR AN ANNUAL REVIEW</p>	<p>9/12/14</p> <p>CS 9/8/14</p>

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S 294	<p>Continued From page 6</p> <p>to month must be reviewed by the dietitian and each menu must be reviewed and approved by the dietitian at least annually where applicable. Each menu as served must meet the nutritional needs of the...residents in accordance with the physician's orders and the Recommended Dietary Allowances of the National Research Council.. Tenth Edition, 1989. Records of menus as served must be filed and retained for 30 days.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 29162 Based on menu review, interview, and policy review, the provider failed to verify the written menus used by the provider had been reviewed and dated annually by the registered dietitian (RD). Findings include:</p> <p>1. Review of the written planned menus for Monday 7/21/14 through Sunday 7/27/14 revealed the menus had been copyright menus of Elaine Elston, RD, CDE 2013. Those cyclic menus had been provided as a service through the US Food Service which was the provider's food supply company.</p> <p>Interview on 7/23/14 at 11:00 a.m. with the certified dietary manager (CDM) revealed: *The copyright menus from Elaine Elston, RD had been provided to them by their food supply company. *Their RD reviewed them, made changes as necessary, and then signed off on those copyrighted menus. *The last time she had signed off on those menus had been 2/13/13.</p>	S 294		
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S 294	Continued From page 7 Review of the provider's December 2008 Menus Policy Statement revealed the dietician was to have reviewed and signed off on all menus. That policy did not indicate the need to have those menus reviewed and signed on an annual basis.	S 294		
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