

ORIGINAL

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

PRINTED: 11/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  10/29/2014
NAME OF PROVIDER OR SUPPLIER  SOUTH DAKOTA HUMAN SERVICES CENTER - GERIATRIC			STREET ADDRESS, CITY, STATE, ZIP CODE 3616 BROADWAY AVE POST OFFICE BOX 7600 YANKTON, SD 57078	
(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  A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 10/27/14 through 10/29/14. South Dakota Human Services Center - Geriatric was found not in compliance with the following requirements: F248, F281, and F441.	F 000		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES  The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to have sufficient activities for one of three sampled patients (10) placed on transmission-based precautions (used to prevent germs from spreading through close contact with infected skin or bodily fluids). Findings include:  1. Interview on 10/28/14 at 4:00 p.m. with registered nurse (RN) D regarding the type of precautions that were currently in place for resident 10 revealed he was currently on contact and droplet precautions (a combined infection prevention isolation requiring the use of gloves, a gown, and a mask by care staff and visitors.)  Interview on 10/29/14 at 8:40 a.m. with resident 10 regarding his activities revealed:	F 248	F 248: Resident #10's care plan was updated to include a list of meaningful activities to the resident based on his life story information and the Activities assessment. The Therapeutic Recreation Specialist (TRS) will provide daily activity of the resident's choosing to the resident 1 on 1. The TRS will make weekly progress notes in the resident's electronic medical record summarizing the activities provided. Residents who are limited in participating in normal activities due to transmission based precautions are potentially affected.  A policy for the provision of meaningful activities for all residents on medical precautions which limited participation in group activities was created and implemented.  This policy directs TRS staff to compile a list of meaningful activities based on life story information from the resident and family, input from the resident and family, and the Activities Assessment. CNA staff will complete an activity of the residents' choosing daily when TRS staff is not available and document the activity provided in the residents' personal	

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

TITLE

(X6) DATE

*James A. Johnson* Program Director 11-14-14

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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F 248	Continued From page 1 *Interaction with staff occurred mainly with his care or treatments. *He was limited in participation of normal activities that were provided on his unit because of his infection. *He could not remember when he had been able to leave his room.  Review of resident 10's medical record revealed: *He had been admitted in December 2013. *He was alert and oriented. *He had a history of multiple severe bacterial infections on his skin and in his body fluids (blood, wounds, mucus) since his admission. *Some of his infections had been resistant to antibiotic therapy. *He had been placed on contact and droplet precautions when he had those various types of infections, as documented on his current 7/31/14 care plan. *That care plan revealed: -Therapeutic recreation specialists (TRS) "will offer _____ [resident name] 1:1's [one to one] and will notify him of upcoming events and groups." -It was not individualized to his specific needs. *It had not specified what type of activities staff were to have provided or the length of time needed for the activity. *It had not been updated to reflect changes since he had been unable to leave his room to participate in normal activities provided on the unit. *Activity documentation from October 1, 2014 to October 28, 2014 revealed he had: -"Meet and Greet" on seventeen of thirty-one days. -Music on two of thirty-one days. -Bible study one of thirty-one days.	F 248	care record. The TRS will document the activity provided to the resident weekly in a progress note in the residents' electronic medical record. The Program Director will review the weekly TRS progress notes for any resident on medical/ psychiatric restrictions weekly for 3 months then monthly thereafter.  Any identified concerns from the review will be reported to the QA Committee at the next QA meeting and at each QA meeting until the QA Committee advises to discontinue.	12/6/14	

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F 248	Continued From page 2 -"News and Views" on two of thirty-one days. -One day out of thirty-one days he had an unidentified "special event." -"Walks" documented for two of thirty-one days. -"1:1" interaction between staff and the resident was documented as "p.m.'s" but had not listed what type or how long that had occurred.  Interview on 10/29/14 at 11:45 with the therapeutic recreation specialist supervisor regarding activities for resident 10 revealed: *"Meet and greet" consisted of him asking the resident "Good morning. How are you?," and the resident responding back. *The "1:1" documented daily on "p.m.'s" he believed was nursing cares. *He stated he "had poor documentation," and he had been unsure how much or what activities had been offered to the resident. *He agreed the activities provided were not sufficient to maintain or improve the resident's physical and mental health, and his well-being. *He agreed documentation needed to reflect the length of time spent with the resident and what the activity was specifically that had been provided.  Review of the provider's 3/28/14 Treatment Unit Activities Policy revealed: *Activities were to maintain and improve both physical and cognitive functioning. *Therapeutic recreation specialists were responsible to develop a comprehensive therapeutic recreation specific to individual needs.	F 248			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281			

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F 281	<p>Continued From page 3</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>A. Based on observation, interview, record review, and policy review, the provider failed to appropriately check one of one sampled resident's (10) gastrostomy tube (tube used to provide nutrition or medication are unable to swallow safely, or need nutritional supplementation) (G-tube) Findings include:</p> <p>1. Observation on 10/29/14 at 8:00 a.m. of registered nurse (RN) F administering medications through a G-tube for resident 10 revealed:</p> <p>*She gathered her supplies and medications to be administered. *After she had washed her hands and put on gloves she proceeded to connect a syringe to the G-tube. *She pulled the plunger back on the syringe. *She was unable to pull back any residual stomach contents into the syringe. *She proceeded to flush the patient's G-tube and administer his ordered medications.</p> <p>Interview immediately following the above medication administration with RN F with regard to verifying G-tube placement for patient 10 revealed:</p> <p>*She was unaware of the provider's policy on verifying G-tube placement. *She agreed she should have followed the provider's policy on checking placement prior to administering any medications.</p>	F 281	<p>F281:</p> <p>All nursing staff review policy: GASTROSTOMY AND JEJUNOSTOMY FEEDING TUBE - FORMULA/WATER/ MEDICATION ADMINSTRATION and complete a test regarding the policy. Nurse will complete return demonstration of skill competencies on G and J tube placement and use. Residents using a J or G tube could potentially be affected.</p> <p>Education will be provided to all nursing staff and skill competency demonstrated on G and J tube placement in orientation for new nursing staff and annually thereafter.</p> <p>Charge nurse(3) shall complete random observations of nurses correctly checking of G and J tubes once a week for one month then once a month. Results of the review will be reported to the Nurse Manager who will report any identified concerns to QA Committee at the next QA meeting and at each QA meeting until the QA Committee advises to discontinue.</p>	12/6/14

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F 281	<p>Continued From page 4</p> <p>Review of the medical record for resident 10 revealed: *He had been admitted in December 2013. *He had continuous G-tube feedings per physician's order.</p> <p>Review of the provider's 5/5/14 Gastrostomy and Jejunostomy Feeding Tube-Formula/Water/Medication Administration policy revealed placement should be checked by: *Injecting air into the catheter tube and listening over the stomach area through a stethoscope for loud air noises. *Pulling back on the syringe for residual stomach contents after listening for stomach sounds to ensure proper placement.</p> <p>Review of Donna D. Ignatavicius and M. Linda Workman, Medical-Surgical Nursing, 7th Ed., St. Louis, MO 2013, page 1346, revealed, " Check placement before each drug administration."</p> <p>B. Based on record review, observation, and interview, the provider failed to follow physician's order for 1 of 13 sampled residents (1). Findings include:</p> <p>1. Review of resident 1's 10/23/14 physician orders revealed his orders included: **When in bed, and during the night, leave open to air-groin, buttock, and penis. *Keep pressure off left lateral foot and heel. *Reposition every hour. *After meals, elevate feet in chair with 2 pillows under for circulation."</p>	F 281		

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F 281	<p>Continued From page 5</p> <p>Random observations of resident 1 revealed: *On 10/27/14 from 2:00 p.m. until 4:20 p.m. he sat in the day room in his wheelchair. He was not repositioned, and his feet were not elevated. *On 10/28/14 from 6:00 a.m. until 8:20 a.m. he was in bed, and lying on his back. He was not repositioned every hour. *At 8:20 a.m. mental health aide (MHA) A and two unidentified MHAs and registered nurse B came to get him up for breakfast. He had an incontinent brief on. -After breakfast he sat in the dining room in his wheelchair with his feet resting on the floor. They were not elevated in the chair, nor on two pillows. He was not repositioned every hour. -After lunch he continued to sit in the dining room in his wheelchair and he was not repositioned every hour.</p> <p>Review of resident 1's October 2014 treatment record revealed: *There was no documentation his feet were being elevated in the chair daily. *On 10/28/14 they documented they had left his groin, buttock, and penis open to air when he was in bed. -This did not match the observation by the surveyor when the MHAs got him up for breakfast.</p> <p>Review of resident 1's October 2014 one hour turning schedule documentation revealed repositioning had occurred every hour. However, this did not match the above observations made by the surveyor.</p> <p>Interview on 10/29/14 at 10:00 a.m. with the director of nursing revealed the staff should have followed resident 1's physician's orders. Their</p>	F 281	<p>F281:</p> <p>A treatment error was completed for failing to elevate Resident #1's feet according to physician's orders and for not repositioning Resident #1 according to physician's order. Education on the physician's orders was provided to unit staff working with the resident by the Nurse Manager on 10/31/14. All staff will be provided education through in-servicing on following physician's orders, documentation, and residents' right to refuse treatment. All residents could potentially be affected. The policy NURSE DELEGATION/ DIRECTIVES was revised to include "it is the nurse's responsibility to ensure that physician's orders are followed." The policy PHYSICIAN'S ORDERS was created and implemented to direct following of physician's orders. Charge nurse(3) staff will complete random observations of mental health aide staff and nursing (RN/LPN) staff completing physician's orders and ensure they are followed by staff once per week for one month and monthly thereafter. Results of the review will be reported to the Nurse Manager who will report any identified concerns to QA Committee at the next QA meeting and at each QA meeting until the QA Committee advises to discontinue.</p>	12/6/14	

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F 281	Continued From page 6 policy addressed medication errors but had not addressed following physician's orders for repositioning and the above issues effecting resident 1.	F 281			
F 441 SS=E	Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, p. 305, revealed "Nurses should follow health care providers' orders unless they believe the orders are in error."  483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441			

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F 441	<p>Continued From page 7</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 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 record review, observation, interview, and policy review, the provider failed to ensure: *Proper infection control techniques were used during one of one sampled residents (1) dressing changes completed by one of one observed registered nurse (B). *Proper infection control procedures were followed during medication administration by two of two registered nurses (RNs) D and F for one of three sampled residents (10) who were on transmission based precautions (extra precautions used when someone has an infection that is highly contagious and is spread through body fluids, droplets, or particles in the air). *Housekeeping staff had appropriate knowledge of infection control procedures that were to be used when cleaning the room and equipment used by one of three sampled residents (10) who were on transmission based precautions to prevent the spread of infection. *Periodic monitoring of staff had been done to ensure proper infection control technique had been followed. *Three of three medication room refrigerators had not held co-mingled food items and resident care</p>	F 441	<p>F441: All residents were potentially affected by this deficiency. The Sterile Dressing Application Policy and Procedure was reviewed and revised. All nursing staff will be provided education on the policy and procedure through required reading of the Sterile Dressing Application Policy. A test over the policy will also be required of all nursing staff. Completion of a skills competency in sterile dressing application is required of all nurses. Charge nurses (3) will complete random observations of nurses completing wound dressing changes 1 time per week for one month then once monthly thereafter. Results of the review will be reported to the Nurse Manager who will report any identified concerns to QA Committee at the next QA meeting and at each QA meeting until the QA Committee advises to discontinue.</p>		

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F 441	<p>Continued From page 8</p> <p>items with resident's medications. Findings include:</p> <p>1. Review of resident 1's 10/23/14 physician's orders read:            **Soak gauze in Dakins 0/25% solution (antiseptic that kills bacteria), ring the gauze out and dress wound wet to dry daily until follow-up with _____ [name of physician] -- cover with 2 Kerlix (medical gauze) daily.            *Silvadene 1% to left heel ulcer daily -- cover with Telfa (square gauze pad), then fluff Kerlix dressing."</p> <p>Observation on 10/28/14 at 8:20 a.m. revealed RN B and three mental health aides (MHA) including MHA A, and two unidentified MHAs, went into resident 1's room to get him out of bed. RN B was going to do a dressing change to the wound on his left foot. Prior to entering the room they washed their hands and obtained gloves and a gown to put on. The following observation occurred after they entered the room:            *RN B informed the surveyor the resident continued on infection control precautions, because he had such a long history of infections.            *RN B put on two pairs of gloves one on top of the other.            -Entered the resident's bathroom and got a bin that contained wound dressing and personal care supplies.            -Came back into the resident's room and placed the bin with the supplies on the left side of the sink.            -Removed several packages of 4 x 4 gauze from the opened box and removed it from the package. She rumbled them up and placed them in the box they had come out of.            -Unfolded more gauze into a plastic medication</p>	F 441		

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F 441	Continued From page 9 cup and saturated the gauze with the Dakins solution. -Turned to the resident and informed the MHAs of the procedure they should follow in getting this resident up since they were unfamiliar with his routine. *RN A did the following: -Explained and demonstrated how to wash the resident's perineal (buttocks) with Betasept (antiseptic), because he had a history of skin breakdown on his buttock. -Applied a protective ointment to his buttock. -Handed the containers of ointment and Betasept to MHA A to return them to the personal care bin. -Upon completion she removed the soiled incontinence brief the resident and asked MHA A to throw it away. *MHA A then removed her gloves and was putting on new gloves. With one gloved hand she took the soiled incontinent brief and put it in the garbage. She then resumed putting the glove on her other hand without washing her hands or performing any hand hygiene. *RN B removed one set of gloves, leaving only one pair of gloves on. She did not wash her hands or perform any hand hygiene. *RN B then took the bin and placed it on the resident's bed. She then: -Cleaned the area on his foot. -Took the saturated gauze from the Dakins solution and placed it in the open area on the outer aspect of his foot. -Applied the Silvadene 1% to the open area on his foot with her finger. -Continued to complete the entire treatment and applied the new dressing. *During the process RN B removed layers of gloves and reapplied a new set of gloves, but she never washed her hands or used hand gel to	F 441			

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F 441	<p>Continued From page 10</p> <p>sanitize her hands at any time.</p> <p>*RN B had not established a clean area on the resident's bed before doing the dressing change.</p> <p>*MHA A changed her gloves once but did not wash her hands or use hand sanitizer after she handled his soiled incontinence brief.</p> <p>Interview on 10/28/14 at 11:00 a.m. with the above charge nurse/RN C regarding resident 1's dressing change revealed:</p> <p>*It was not proper procedure to substitute a second layer of gloves for handwashing. That should not have occurred.</p> <p>*A clean work area using a disposable pad on the resident's bed should have been established before the dressing change was started.</p> <p>*A tongue depressor should have been used to apply the Silvadene rather than the nurse's gloved finger.</p> <p>Interview on 10/28/14 at 4:00 p.m. with the director of nursing revealed a nurse should:</p> <p>*Not have used a double layer of gloves to replace handwashing.</p> <p>*Have established a clean area on the resident's bed before starting the dressing change.</p> <p>*Have followed the procedure they recently covered in a staff inservice regarding glove use and handwashing.</p> <p>Review of the provider's undated infection control policy revealed:</p> <p>**Handwashing: Employees shall wash hands after touching blood, bloody fluids, secretions, excretions, and contaminated items, whether or not gloves are worn. Wash hands immediately after gloves are removed, between resident contacts, and when otherwise indicated to avoid transfer of micro-organisms to other residents or</p>	F 441	<p>F441: Continued</p> <p>Education will be provided to all staff on proper hand washing and glove use procedure through an in-service and return demonstration of skill competency.</p> <p>Proper hand washing and glove use is reviewed in initial orientation for all new staff and in serviced with all staff annually.</p> <p>Charge nurses (3) will complete random observations of staff to monitor proper hand washing technique and glove use one time per week for one month then once monthly thereafter. Results of the review will be reported to the Nurse Manager who will report any identified concerns to QA Committee at the next QA meeting and at each QA meeting until the QA Committee advises to discontinue.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  10/29/2014
NAME OF PROVIDER OR SUPPLIER  SOUTH DAKOTA HUMAN SERVICES CENTER - GERIATRIC			STREET ADDRESS, CITY, STATE, ZIP CODE 3515 BROADWAY AVE POST OFFICE BOX 7600 YANKTON, SD 57078	
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F 441	<p>Continued From page 11 environments.</p> <p>*Gloves shall be used as an adjunct (in addition to), not a substitute for handwashing.</p> <p>*Employees shall wear gloves when touching blood, body, fluids, excretions, and contaminated items. Apply clean gloves just before touching mucous membranes and non-intact skin. Change gloves between tasks and procedures on the same resident after contact with material that may contain a high concentration of micro-organisms."</p> <p>2. Observation on 10/29/14 at 8:00 a.m. of proper infection control procedures during medication administration for resident 10 by RNs D and F revealed:</p> <p>*RNs D and F put on personal protective equipment (PPE) (gloves, a gown, and masks) prior to entering the resident's room for medication administration.</p> <p>*RN F had not tied her gown around her neck. As she administered the medications the gown slipped off her left shoulder. She proceeded to pull her gown back up with her soiled gloves.</p> <p>*While RN F administered medications through the resident's feeding tube RN D proceeded to inspect his foot for sores.</p> <p>*After she had inspected his foot RN D needed to assist with getting tap water from the sink.</p> <p>*She removed her gloves and proceeded to reach inside her gown to her scrub top pocket and removed hand sanitizer.</p> <p>*While reaching into her pocket her hand touched the front of her gown.</p> <p>*She then opened the hand sanitizer and applied it to her hands.</p> <p>*When finished she touched the front of the gown</p>	F 441	<p>F441: Continued</p> <p>Education on proper donning and doffing of Personal Protective Equipment provided to all staff on 10/31/14 by required reading of a poster demonstrating proper technique from the Centers for Disease Control. The poster was posted on all treatment units in patient care areas. Further education provided at an in-service for all staff and a return demonstration of skill competency required.</p> <p>Proper donning and doffing of PPE will be reviewed with all new staff during initial orientation and will be included in annual skills competency for all staff.</p> <p>Charge nurse staff (3) will complete random observations of all staff completing proper donning and doffing of PPE 1 time per week for one month then once monthly thereafter. Results of the review will be reported to the Nurse Manager who will report any identified concerns to QA Committee at the next QA meeting and at each QA meeting until the QA Committee advises to discontinue.</p>	

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NAME OF PROVIDER OR SUPPLIER  <b>SOUTH DAKOTA HUMAN SERVICES CENTER - GERIATRIC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3515 BROADWAY AVE POST OFFICE BOX 7600 YANKTON, SD 57078</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 12</p> <p>again with her hands, and she placed the sanitizer back in the pocket of her scrub top. *She put on new gloves and helped RN F administer medications to the residents. *Once the medication had been administered RN F left the room.</p> <p>Prior to leaving resident 10's room RN F removed her PPE and placed it in the garbage in the following manner: -She removed her mask with her soiled gloves on, allowing the gloves to touch her hair. -She removed her gown that was tied behind her back with her soiled gloves. -She then removed her gloves and proceeded to the sink to wash her hands. -She scrubbed her hands with soap and water for five to ten seconds and left the room.</p> <p>RN D needed to administer a nebulizer treatment (medication changed from a liquid to a mist and inhaled into the lungs). She picked up the nebulizer machine off the table that was located in the far corner away from the resident's bed. *She then plugged it into the wall by the table. *The nebulizer tubing was unable to reach the resident, so RN D set the nebulizer on the floor between the table and the resident's bed. She began to administer the treatment. *RN F came back into the room to take over administering the nebulizer treatment from RN D. *RN D proceeded to remove her PPE. *She had not washed her hands prior to leaving the room. *She instead reached inside her scrub pocket with her soiled hands, removed her hand sanitizer, and applied it to her hands.</p> <p>RN F continued to administer the nebulizer</p>	F 441			

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F 441	<p>Continued From page 13</p> <p>treatment to the resident while she had administered the treatment:</p> <p>*Her gown kept falling forward off her shoulders. She had not tied it at the back of her neck.</p> <p>-She repeatedly pulled her gown back up onto her shoulders allowing her soiled gloves to touch her scrub top.</p> <p>-She had also reached around her gown with her soiled gloves and pulled her pants up.</p> <p>*After she finished the nebulizer treatment she:</p> <p>-Took off her soiled gloves.</p> <p>-Reached inside her soiled gown and grabbed a bottle of hand sanitizer located in her scrub top pocket.</p> <p>-Opened the bottle and put a small amount of hand sanitizer onto her hands, closed the lid, and placed it back in her scrub pocket.</p> <p>*She then put on new gloves.</p> <p>*The resident's Coban (a self-adhesive dressing being used to protect IV site) had become pinched on his right arm. She tried to remove it with her gloved hands.</p> <p>*Unable to remove it, she then reached inside her gown with her soiled gloves and pulled out a biohazard bag (a special medical zip-lock bag used to put potentially infectious materials or equipment in for transporting) that contained a bandage scissors.</p> <p>*She unzipped the bag, pulled out the scissors, and used it to remove the dressing from his arm.</p> <p>*Once she was finished she placed the scissors back into the biohazard bag, reached inside her gown, and placed it back into her scrub top pocket.</p> <p>*With her soiled gloves she:</p> <p>-Removed her mask allowing the gloves to once again touch her hair.</p> <p>-Reached around to the back of her gown and untied it.</p>	F 441		
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NAME OF PROVIDER OR SUPPLIER  SOUTH DAKOTA HUMAN SERVICES CENTER - GERIATRIC	STREET ADDRESS, CITY, STATE, ZIP CODE 3615 BROADWAY AVE POST OFFICE BOX 7600 YANKTON, SD 57078
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F 441	<p>Continued From page 14</p> <p>-She removed her soiled gloves. -She then washed her hands for five to ten seconds and left the room.</p> <p>*RN F transported the contaminated scissors in the biohazard bag into the medication room. *She pulled the scissors out of the bag with her bare hands and proceeded to wash it in the sink.</p> <p>Interview immediately following the above medication administration with RNs D and F revealed: *They were unaware hand sanitizer alone was not an approved method for hand cleaning when following proper transmission-based precautions. *They agreed they should have washed their hands between tasks. *RN D agreed she should not have set the nebulizer machine on the floor of the resident's room. *RN F agreed she should have tied her gown behind her neck. *RN F agreed she contaminated her clothing when she reached into her pocket for the scissors. *RN F agreed using the scissors stored in her pocket on the resident's Coban dressing would put the resident at high risk for introducing bacteria into his special IV site. That IV site was to remain sterile as it delivered medication directly into the bloodstream through a vein located near his heart. *She further agreed she should not have stored contaminated scissors in her pocket or in a biohazard bag. *She also agreed she should not have brought the contaminated scissors into a clean medication room. *Both nurses agreed their clothing, hands, and hair had become contaminated when they had</p>	F 441		
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NAME OF PROVIDER OR SUPPLIER  SOUTH DAKOTA HUMAN SERVICES CENTER - GERIATRIC			STREET ADDRESS, CITY, STATE, ZIP CODE 3815 BROADWAY AVE POST OFFICE BOX 7600 YANKTON, SD 57078		
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F 441	<p>Continued From page 15</p> <p>not used proper infection control technique while in contact with transmission-based infections.</p> <p>*Both nurses agreed not following transmission-based precautions would potentially spread infection to other residents.</p> <p>*Both nurses stated they had annual infection control training but had not been trained specifically on putting on or taking off PPE.</p> <p>*Both agreed they needed additional training in PPE use.</p> <p>Interview on 10/29/14 at 10:40 a.m. with the infection control nurse revealed:</p> <p>*She reviewed correct PPE use with staff upon being hired.</p> <p>-It had not been a part of yearly training for staff.</p> <p>*She had not performed any type of audits or monitoring to ensure proper use of PPE or infection control technique had been followed for any staff in the facility.</p> <p>*She agreed:</p> <p>-The above observations of cross-contamination by nursing staff should not have occurred.</p> <p>-Additional training would be needed for staff to ensure compliance with infection control procedures and use of PPE.</p> <p>*If a resident required PPE use she would alert other department supervisors to the precautions that were placed. It was then up to those supervisors to review infection control procedures with their staff.</p> <p>*She was unaware of the training other departments had received upon hire regarding infection control.</p> <p>*She was unaware of what training outside contracted staff who helped clean on the units had received regarding infection control and transmission based precautions.</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER  SOUTH DAKOTA HUMAN SERVICES CENTER - GERIATRIC			STREET ADDRESS, CITY, STATE, ZIP CODE 3515 BROADWAY AVE POST OFFICE BOX 7600 YANKTON, SD 57078	
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F 441	<p>Continued From page 16</p> <p>Interview on 10/29/14 at 9:40 a.m. with the director of nursing (DON) regarding resident 10 and staffs' proper use of PPE revealed it had been her expectation: *Infection control policies were to be followed by all staff that came into contact with residents requiring transmission-based precautions. *If staff were unsure about how to use PPE they should refer to the policies for guidance.</p> <p>3. Interview on 10/29/14 at 12:50 p.m. with housekeeper G regarding resident 10's transmission based precautions and her infection control knowledge revealed: *She had been the primary housekeeper for that unit. *She had received some training when she had been hired but had not received any annual training on PPE use. *Her normal practice in putting on and taking off PPE when cleaning the resident's room and equipment stored in his room had been she: -Would put on a gown, mask, and gloves. -Was unsure of the order to remove her PPE. -Stated she would take off her mask and gown in the room. -Would keep her gloves on until she left the room, and then she placed the (soiled) gloves in the pocket in her scrubs. *She further stated she: -Was afraid to touch the door knob with her bare hands. -Was unsure how his bacterial infections could be potentially spread. -Had not known she was contaminating her clothing by putting the gloves in her pocket. -Was unsure if she could wash her hands prior to exiting his room.</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER  SOUTH DAKOTA HUMAN SERVICES CENTER - GERIATRIC			STREET ADDRESS, CITY, STATE, ZIP CODE 3516 BROADWAY AVE POST OFFICE BOX 7600 YANKTON, SD 57078	
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F 441	<p>Continued From page 17</p> <p>Interview on 10/26/14 at 1:20 p.m. with the housekeeping supervisor regarding his staff and transmission-based precautions revealed he:</p> <ul style="list-style-type: none"> <li>*Had been unsure what specific training on infection control his staff received.</li> <li>*Stated they should have received training upon hire and yearly thereafter.</li> <li>*Expected staff to follow necessary precautions for infection control and refer to provider policies for further assistance if needed.</li> </ul> <p>Review of resident 10's medical record revealed:</p> <ul style="list-style-type: none"> <li>*He was admitted in December 2013.</li> <li>*He had a history of multi-drug resistant organism (MDRO) infections.</li> <li>*He intermittently had been placed on transmission-based precautions for multiple infections since his admission.</li> <li>*He had been placed on contact precautions on 8/15/14 for a Clostridium Difficile (C-diff) infection (bacteria overgrowth in the stomach causing diarrhea with mild to severe symptoms).</li> <li>*Hand sanitizer was not to have been used in place of handwashing related to his C-diff infection as noted on the resident's short term care plan dated 8/15/14.</li> <li>*He had been placed on droplet precautions on 9/25/14 for methicillin-resistant staphylococcus aureus (MRSA) infection (resistant bacteria that can be found in blood, body fluids [saliva, wound drainage etc.] or on skin) found in his lungs.</li> </ul> <p>Review of the provider's undated recommendations from the Centers for Disease Control regarding PPE use revealed:</p> <ul style="list-style-type: none"> <li>*Steps in removing PPE were as follows:</li> <li>-Gloves.</li> <li>-Gown.</li> <li>-Mask.</li> </ul>	F 441		

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F 441	<p>Continued From page 18</p> <p>*Hand hygiene should have been performed between steps if hands became contaminated and immediately after removal of all PPE.</p> <p>Review of the provider's 7/8/14 Transmission-Based Precautions policy revealed: *Residents should be placed in a private room. *Gowns and gloves should be worn with contact precautions. *In addition to gloves and a gown a mask should have also been worn if working with a resident on droplet precautions. *Gloves were to have been changed after having contact with infectious material. *All PPE was to have been removed before leaving the resident's room. *Limited movement for the resident of of the room was to have been for essential purposes only. *Hands were to have been washed after gloves were removed or when contaminated gloves had been changed.</p> <p>4. Random observations on 10/28/14 and 10/29/14 from 8:00 am to 4:00 p.m. of all three medication rooms refrigerators revealed: *All three refrigerator freezers contained resident-use ice packs. *All three refrigerators contained various food items of juice and water pitchers, opened milk cartons, and opened pudding packs. *All three refrigerators were to have been used for the storage of medications.</p> <p>Interview on 10/29/14 at 11:30 a.m. with the infection control nurse revealed: *It had been her expectation that food, resident use items, and medications were not to have been stored in the same refrigerator. *She was unaware items had been co-mingled in</p>	F 441	<p>F441 Continued</p> <p>All non- medications were removed from the refrigerators in the medication rooms on 10/30/14. Ice packs were placed in a freezer labeled for ice packs only in a central area. On 10/30/14, new refrigerators were purchased and installed for the storage of medications only.</p> <p>All staff were provided education on the new freezer location for ice packs and that medications were not to be co-mingled with</p>	

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F 441	<p>Continued From page 19 the refrigerators. *There was a high risk for cross-contamination between the above mentioned items and residents.</p> <p>Interview on 10/29/14 at 9:40 a.m. with the DON regarding the above co-mingled food, resident ice packs, and medications revealed it had been her expectation that those items were not to have stored together in the same refrigerators.</p> <p>There was no policy regarding the co-mingling of the above items.</p>	F 441	<p>F441: continued food or fluids by an email. All staff were provided further education by an in-service.</p> <p>The MEDICATION ADMINISTRATION policy was revised to prohibit the co-mingling of medications with food, fluids, or ice packs.</p> <p>The prohibition of co-mingling of medications and other items was added to the monthly kitchen inspection checklist completed by the Charge Nurses. The Charge Nurses give the inspection checklist to the Nurse Manager.</p> <p>Results of the review will be monitored by the Nurse Manager who will report any identified concerns to QA Committee at the next QA meeting and at each QA meeting until the QA Committee advises to discontinue.</p>	12/6/14

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NAME OF PROVIDER OR SUPPLIER  <b>SOUTH DAKOTA HUMAN SERVICES CENTER - GERIATRIC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3515 BROADWAY AVE POST OFFICE BOX 7600 YANKTON, SD 57078</b>	
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 10/29/14. South Dakota Human Services Center - Geriatric (Building 01, Spruce I and II) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jerry J. Johnson</i>	TITLE <i>Program Director</i>	(X5) DATE <i>11-14-14</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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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  43A067	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02  B. WING _____	(X3) DATE SURVEY COMPLETED  10/29/2014
NAME OF PROVIDER OR SUPPLIER  SOUTH DAKOTA HUMAN SERVICES CENTER - GERIATRIC			STREET ADDRESS, CITY, STATE, ZIP CODE 3515 BROADWAY AVE POST OFFICE BOX 7600 YANKTON, SD 57078	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 10/29/14. South Dakota Human Services Center - Geriatric (Building 02, Willow I) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		

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

TITLE

(X6) DATE

*James Z. Johnson*

*Program Director*

*11-14-14*

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.

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10719SD</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/29/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SD HUMAN SERVICES CENTER - GERIATRIC F</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3515 BROADWAY AVE YANKTON, SD 57078</b>
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S 000	Initial Comments  Surveyor: 18560 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 10/27/14 through 10/29/14. SD Human Services Center - Geriatric Program was found not in compliance with the following requirement: S296.	S 000		
S 296	44:04:07:07 Director of dietetic services  A full time dietary manager who is responsible to the administrator shall direct the dietetic services. Any dietary manager that has not completed a Dietary Manager's course, approved the Dietary Managers Association, must enroll in a course within 90 days of the hire date and complete the course within 18 months. The dietary manager and at least one cook must successfully complete and possess a current certificate from a ServSafe Food Protection Program offered by various retailers or the Certified Food Protection Professional's Sanitation Course offered by the Dietary Managers Association, or successfully completed equivalent training as determined by the Health Department. The dietetic manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each...resident are met. If the dietary manager is not a dietitian, the facility shall schedule dietitian consultations onsite at least monthly. The dietitian must approve all menus, assess the nutritional status of...residents with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits. Adequate staff whose working hours are scheduled to meet the dietetic needs of the...residents must be on duty daily over a	S 296		

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

TITLE

(X6) DATE

STATE FORM

6899

WDTJ11

<div style="border: 2px solid black; padding: 5px; display: inline-block;"> <p style="margin: 0;">RECEIVED</p> <p style="margin: 0; font-size: small;">NOV 24 2014</p> <p style="margin: 0; font-size: small;">SD DOH L&amp;C</p> </div>	<p style="font-size: x-small;">If continuation sheet 1 of 2</p>
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Program Director

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10719SD</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/29/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>SD HUMAN SERVICES CENTER - GERIATRIC F</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3515 BROADWAY AVE YANKTON, SD 57078</b>		
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S 296	<p>Continued From page 1</p> <p>period of 12 or more hours in nursing facilities...</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 18560 Based on interview and certificate review, the provider failed to ensure at least one cook had successfully completed and possessed a ServSafe certificate for one of one cook. Findings include:</p> <p>1. Interview and certificate review on 10/28/14 at 9:25 a.m. with the assistant food service director revealed he had a current ServSafe certificate. Further interview revealed there had not been at least one cook who had a current ServSafe certificate. All of the cooks' ServSafe certificates had expired. He stated staff turnover and schedule challenges had hindered the completion of the ServSafe training. He confirmed at least one cook should have completed and been certified in the ServSafe program.</p>	S 296	<p>S 296</p> <p>This deficiency potentially affects all residents. Servsafe Certification for all dietary staff was reviewed by the Dietary Manager and Assistant Dietary Manager. <i>11-20-14</i> Two Full Time Cooks <del>were</del> <i>were</i> scheduled to complete the ServSafe Certification course.</p> <p>The Dietary Manager will review Servsafe Certifications monthly and will send the Program Director a report of ServSafe Certification for staff cooks for three months, then quarterly thereafter. The Program Director will report any identified concerns to the QA Committee at the next QA meeting and each meeting thereafter until the QA committee advises to discontinue.</p>	12/17/14