

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/18/2015
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVENUE NW ABERDEEN, SD 57401
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F 000	<p><i>Addendum noted with an asterisk per 4/10/15 email to facility DON. NPN/SDBH/MF</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 33488 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/17/15 through 3/18/15. ManorCare Health Services, was found not in compliance with the following requirements: F280, F284, F309, F323, F360, and F441.</p>	F 000	<p>Aberdeen Plan of Correction for Annual Survey on March 18, 2015</p> <p>The statements on this plan of correction are not admittances to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take action as set forth in the following plan of correction. The plan of correction constitutes the center's assertion of compliance. All alleged deficiencies cited have been or will be corrected by dates indicated.</p>	
F 280 SS=E	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, and record</p>	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Frances Hartzel</i>	TITLE <i>Administrator</i>	(X6) DATE <i>04/03/15</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.

APR 06 2015

If continuation sheet Page 1 of 20

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 280	<p>Continued From page 1</p> <p>review, the provider failed to revise, update, and individualize care plans for three of six sampled residents (2, 6, and 8) to reflect their current care needs. Findings include:</p> <p>1. Observations on 3/17/15 to 3/18/15 from 8:00 a.m. to 5:00 p.m. and interview on 3/17/15 at 3:30 p.m. with resident 8 revealed:</p> <ul style="list-style-type: none"> *She had poor eyesite and needed glasses. *She used the bedpan to toilet as she was currently too weak to tolerate using the bathroom. *She had oxygen on. <p>Review of resident 8's medical record revealed:</p> <ul style="list-style-type: none"> *Admission on 11/30/14. *Diagnoses of congestive heart failure (inability of the heart to effectively pump blood), chronic kidney disease, chronic obstructive pulmonary disease (a decrease in the functioning of the lungs), and diabetes. *She received oxygen continuously. <p>Review of resident 8's 3/6/15 Minimum Data Set (MDS) assessment revealed she:</p> <ul style="list-style-type: none"> *Needed two staff members to assist her with moving from her bed to a wheelchair or to the bathroom. *Used oxygen. *Needed one staff member to assist her with dressing, bathing, and eating. <p>Review of resident 8's 3/18/15 care plan revealed:</p> <ul style="list-style-type: none"> **"Assist with activities of daily living [ADL] as needed," and "transfer with mechanical lift." -No specific mention was made of how to assist and how many staff were needed. *No mention was made of how the resident was to toilet and who would help her. 	F 280	<p>Manor Care Health Services provides care planning services to residents. Care plans for identified residents 2, 6 & 8 have been reviewed and revised.</p> <p>*administrative director of nursing Residents with changes in functional status or changes in condition requiring changes to the plan of care have the potential to be affected. Care plans for residents with functional status changes or with acute changes in condition have been reviewed by the ADNS, Social Services Director, and IDT and have been revised when indicated.</p> <p>*interdisciplinary team The ADNS, Social Services Director, and IDT have met to review care plan process. Education will be provided to the IDT on updating care plans as changes occur and care planning current needs. Accuracy of comprehensive assessments and timeliness of assessments has been reviewed.</p> <p>*administrative director of nursing Audits will be completed by ADNS or [redacted] five times weekly for four weeks to validate updates are completed as changes occur and then weekly for four weeks with results submitted to QAPI committee by ADNS for review and recommendations.</p> <p>*See page 3. *administrative director of nursing</p>	<p>*4/23/15 NPN/SSDOH/MF</p> <p>NPN/SSDOH/MF</p> <p>*interdisciplinary team NPN/SSDOH/MF</p> <p>NPN/SSDOH/MF</p> <p>*administrative director of nursing NPN/SSDOH/MF</p> <p>*administrative director of nursing NPN/SSDOH/MF</p> <p>*See page 3. NPN/SSDOH/MF</p> <p>*administrative director of nursing NPN/SSDOH/MF</p>
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F 280	<p>Continued From page 2</p> <p>***Uses oxygen at night and can have oxygen during the day if short of breath," and "administer O 2 [oxygen] per physician's order." -Current order was for oxygen both day and night continuously.</p> <p>*Glasses were mentioned but not her poor eyesight or the importance of wearing them for activities.</p> <p>Interview on 3/18/15 at 2:00 p.m. with the MDS coordinator who was in charge of care plans for residents revealed: **Care plans were updated on a daily basis." **Daily staff meetings should have told her what the current resident care needs were." *She agreed resident 8's care plan had not been specific for her activities of daily living nor updated to reflect her current care needs.</p> <p>A random comment on 3/18/15 at 3:15 p.m. by the director of nursing (DON) regarding resident care plans revealed "We just put assist as needed [on the ADL], because there are too many changes to keep up with them all."</p> <p>Surveyor: 35120 2. Review of resident 2's medical record revealed he had: *An original admission date of 3/31/14. *Diagnoses of: -Congestive heart failure (CHF [heart does not pump blood well]). -Cognitive impairment (impaired memory). -Type II diabetes (unable to control blood sugar). -Peripheral vascular disease (decreased blood flow to feet and legs). -Hypertension (HTN [high blood pressure]). -Sleep apnea (episodes of not breathing while</p>	F 280	<p><i>*(Continued from page 2, beginning of 4th paragraph) interdisciplinary team will audit 5 care plans NPN/KDDO/HMF</i></p> <p><i>*(Continued from page 2, end of 4th paragraph) monthly. Educate the interdisciplinary team and all nursing staff. NPN/KDDO/HMF</i></p>	

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F 280	<p>Continued From page 3 sleeping). -Kidney disease (decreased kidney function). -History of falls. -Difficulty walking. *Falls on 11/2/14, 12/23/14, and 2/11/15. The fall in February 2015 had resulted in stitches to his head.</p> <p>Review of resident 2's February 2015 care plan revealed: *There had been no new interventions implemented after his fall. *No mention of his wound that had required stitches.</p> <p>Interview on 3/18/15 at 2:35 p.m. with the director of nursing (DON) revealed: *"The resident had been placed on a bathroom schedule and had been given a geriatric bed." *She agreed the care plan had not been updated to reflect those things.</p> <p>3. Review of resident 6's medical record revealed she had: *An original admission date of 10/2/13. *Diagnoses of: -Hear failure. -Alzheimer's disease (loss of memory). -CHF. -History of falls. -HTN. -Dysphagia (difficulty swallowing). -Difficulty walking.</p> <p>A care plan dated 1/30/14 revealed she needed assistance with: *Bathing and showering as needed. *Daily hygiene, grooming, dressing, and oral care as needed.</p>	F 280			

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F 280	Continued From page 4 *Toileting and incontinent (unable to control bladder and bowel functions) care as needed. *Transfer (moving) and ambulation (walking) as needed. *Reposition and assistive devices as needed. Interview on 3/17/15 at 4:35 p.m. with registered nurse (RN) C revealed resident 6's care plan had "as needed" listed as she might have needed more assistance on various days. Interview on 3/18/15 at 1:25 p.m. with the DON revealed she agreed resident 6's care plan should have reflected a toileting schedule. It should not have been listed as "as needed" since she was unable to use her call light appropriately. Interview on 3/18/15 at 2:00 p.m. with the Minimum Data Set coordinator revealed: *Care plans were to be updated every day after their meetings. *Agreed care plans were not individualized for each resident.	F 280			
F 284 SS=E	483.20(l)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. This REQUIREMENT is not met as evidenced by: Surveyor: 34030	F 284			

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F 284	<p>Continued From page 5 Surveyor: 32335 Based on observation, record review, interview, job description review, and policy review, the provider failed to create a discharge summary and plan of care to assist the residents with adjusting to their new environment for two of three sampled residents (3 and 13) who were planning to leave the facility. Findings include:</p> <p>1. Observation and interview on 3/17/15 from 9:35 a.m. through 9:50 a.m. of resident 3 revealed: *An unidentified certified nursing assistant and contracted physical therapist assisted him with transferring from his wheelchair to his bed. *They then assisted him with rolling onto his right side. *The contracted physical therapist stated they had been working with him, but his therapy had recently ended. *Licensed practical nurse (LPN) A and assistant director of nursing (ADON) F completed a dressing change on his left heel. *After the dressing change LPN A assisted him with getting back into his wheelchair.</p> <p>Interview on 3/17/15 at 9:50 a.m. with resident 3 revealed he was planning on going home at the end of the month.</p> <p>Review of resident 3's 2/26/15 Minimum Data Set (MDS) assessment revealed: *His thinking ability was moderately impaired. *He needed: -Extensive assistance from two staff members for moving in bed, transferring, and toilet use. -Extensive assistance from one staff member for walking, dressing, and personal hygiene. -Total assistance from one staff person for</p>	F 284	<p>Manor Care Health Services will continue to provide discharge planning services to residents who have the potential for discharge. Discharge planning has been revised for identified residents 3 & 13 and community referrals made when indicated and accepted by resident.</p> <p>Residents planning to discharge home have the potential to be affected. * administrative director of nursing The ADNS, Social Services Director, and IDT reviewed current residents who have plans to discharge to home. Discharge needs were identified and community referrals made as indicated. Education provided to IDT regarding discharge planning and community resources available to residents for successful transition home. * interdisciplinary team Audits will be conducted by ADNS - * administrative director of nursing or [redacted] weekly for four weeks to ensure discharge plans are in place and appropriate referrals have been made. Results of audits will be forwarded to QAPI by ADNS - * administrative committee for review and further recommendations * see page 7. Date of compliance is 4/23/15 * interdisciplinary team will audit 5 care plans</p>	<p>x4/23/15 NPN/SDDOH/IME</p> <p>NPN/SDDOH/IME</p> <p>* interdisciplinary team NPN/SDDOH/IME</p> <p>* administrative director of nursing NPN/SDDOH/IME</p> <p>* administrative director of nursing NPN/SDDOH/IME</p> <p>* interdisciplinary team will audit 5 care plans NPN/SDDOH/IME</p>

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F 284	<p>Continued From page 6 bathing.</p> <p>Review of resident 3's medical record revealed he had been admitted into the hospital on 8/5/14 due to fluid retention. He was admitted into the facility on 8/18/14 for rehabilitation services (therapy).</p> <p>Review of resident 3's 3/17/15 care plan revealed: *His focus areas were: -Needing assistance with dressing, grooming, and hygiene related to physical limitations. -Tends to be noncompliant with fluid restriction treatment. -Cognitive (memory) decline related to health status and mood indicators. -At risk for falls due to impaired balance or poor coordination. -Indicators of depression and sadness related to low self esteem and restricted physical activity. -At risk for excess fluid in legs and feet related to heart disease. -Insulin dependent (needed insulin to control blood sugar). -At risk for respiratory impairment related to heart failure. -A diet of low sodium and 2000 milliliter fluid restriction. -At risk for pain related to multiple heart and health issues. -Palliative care as needed due to extensive decline in health status. -At risk for alteration in skin breakdown related to incontinence (involuntary urination) and impaired mobility (moving around). -Has a pressure ulcer (a sore caused by unrelieved pressure that resulted in damage to tissue) on his left heel related to impaired mobility</p>	F 284	<p>x (continued from bottom of page 6.) monthly. Educate the interdisciplinary team and all nursing staff. NPN/SODOH/MF</p>		

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F 284	<p>Continued From page 7</p> <p>and propelling wheelchair with heels. *There was no documentation of post discharge planning regarding any of those areas to address how his needs would be met after leaving the facility.</p> <p>Review of resident 3's interdisciplinary notes revealed: *He would be discharged on 3/30/15 to his home. *On 3/11/15 a nurse's assessment was completed to determine his ability to take his blood sugar and give himself insulin. -He was not able to put the strips into the machine or read the number on the screen. -He was not able to turn the dial on the insulin pen to the correct amount. -He was not able to draw up the correct amount of insulin according to the sliding scale. *On 3/16/15 the team had met with the family. -They had discussed with them that checking his blood sugar was not "going the best." -They had indicated he was able to do his personal activities of daily living. *There was no other documentation regarding how the transition from the facility to his home would be handled.</p> <p>Interview on 3/18/15 at 3:00 p.m. with the ADON and the licensed social worker (LSW) regarding resident 3 revealed: *He needed assistance with transferring from one location to another. *They had not: -Informed the family he could not administer his own insulin. -Contacted home health care, meals on wheels, Lifeline, nor any other providers to assist with the transition home. -Completed a post discharge plan of care.</p>	F 284			

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F 284	<p>Continued From page 8</p> <p>Surveyor: 34030 2. Observation on 3/18/15 at 9:00 a.m. revealed resident 13 leaving for an appointment to have radiation treatment for cancer.</p> <p>Review of resident 13's medical record revealed: *Admission to the facility on 1/29/15 after a hospital stay for pneumonia. *He had been diagnosed in 2014 with cancer, was receiving radiation therapy for it, and was expected to be discharged from the facility after completion of it at the end of March. *Social services notes: -On 2/12/15 "home when done with therapy." -On 3/5/15 "goal is to return home." *A Discharge Planning assessment form in the back of the chart. Nothing was written on it.</p> <p>Review of resident 13's 3/18/15 care plan revealed: **[name of resident] shows potential for discharge and expresses wish to return home again." -"Complete a post discharge plan. Provide copy and review with resident/representative." -"Discuss with patient, family, and/or representative the discharge planning process." -"Investigate need for special equipment, home health services, lifeline, outpatient therapy, physician follow up, resources, etc. Make referrals as needed." *Nothing specific regarding the above had been found in resident 13's medical record to show his plans for discharge had been done.</p> <p>Surveyor: 32335 3. Review of the LSW's 3/11/08 signed job description revealed she should have: *Maintained accurate and timely discharge</p>	F 284		

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F 284	Continued From page 9 planning documentation. *Facilitated communication among the resident and family regarding risk and benefit information to support informed decision-making. *Made appropriate referrals to the community. Review of the provider's 4/2/02 Discharge Planning Services policy revealed: *The SW's objective should have been for the resident or legal representative to make an informed choice about future living arrangements. *The benefits and risks of potential future living arrangements should have been discussed and compared to those of the current placement. *The social worker should have advocated for the resident and facilitated any support the resident might have needed once the decision was made. *The Post Discharge Plan would document the preparation, orientation, and education provided to the resident or family during the pre-discharge phase.	F 284		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Surveyor: 35120	F 309		

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F 309	<p>Continued From page 10</p> <p>Based on record review, interview, and policy review, the provider failed to develop and implement an individualized hospice care plan for one of one sampled hospice resident (11). Findings include:</p> <p>Review of resident 11's medical record revealed: *An admission date of 11/22/14. *Hospice started on 2/11/15. *She had diagnoses of: -Heart disease. -Psychosis (loss of contact with reality). -Bladder hypertonicity (having to urinate frequently). -Depression. -Difficulty walking. -Abnormal posture. -History of falls. -Atrial fibrillation (irregular heart beat). -Hypertension (high blood pressure). -Osteoarthritis (degeneration of the joints). *She had a indwelling urinary catheter (tube inserted into the bladder to drain urine). *Her facility care plan dated 2/11/15 stated, "Hospice staff to visit to provide care, assistance, and/or evaluation." *She had a hospice plan of care dated 2/11/15. It made no mention of what hospice staff were responsible for.</p> <p>Interview on 3/18/15 at 2:00 p.m. with the Minimum Data Set assessment coordinator revealed: *She had been unsure of what hospice responsibilities were when they came to the facility. *Care plans were supposed to be updated daily for any change in a resident's condition. *She agreed the care plan was not integrated</p>	F 309	<p>Manor Care Health Services will collaborate with contracted hospice services to provide quality care to residents. Resident 11 has expired.</p> <p>Residents receiving hospice services can be affected by this practice. * <u>interdisciplinary team</u> NPN/SDDH/MF <u>Education</u> was provided to nursing staff and IDT regarding the need to provide care based on collaboration of services. Education was provided regarding the need to list specific approaches detailing care in care plan.</p> <p>Audits of care plans for hospice / patients will be completed by ADNS or designee weekly for four weeks to ensure collaboration has been completed and results will be forwarded by ADNS or designee to QAPI committee for review and further recommendation. *see page 10 * administrative director of nursing NPN/SDDH/MF Date of compliance is 4/23/15. NPN/SDDH/MF</p> <p>*The role of the hospice team or facility staff will be identified specifically in all care plans. NPN/SDDH/MF</p>	*4/23/15 NPN/SDDH/MF

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F 309	Continued From page 11 between the provider and hospice to identify the role of hospice. Interview on 3/18/15 at 2:40 p.m. with the director of nursing revealed she: *Had been unsure what the responsibility of hospice was. *Agreed the care plan was not integrated to identify the role of hospice and the provider. Review of the 11/1/14 nursing facility agreement with the hospice company revealed: **"Hospice will collaborate with Facility on a coordinated Plan of Care developed jointly between Hospice and Facility. Each Hospice Patient's written Plan of Care must include both the most recent Hospice Plan of Care and a description of the services furnished by Facility to attain or maintain the Hospice Patient's highest practicable physical, mental and psychosocial well-being." "A written Plan of Care will be established and maintained for each person admitted to Hospice, and the care provided to the Hospice Patient will be in accordance with the plan." **"Hospice will be responsible for the professional management and coordination of the Plan of Care." **"Hospice will provide Hospice services to Hospice patients residing in the Facility in the same manner as those provided to other Hospice patients who reside in their own homes. Hospice acknowledges and agrees that it is to provide to Hospice patients: -Medical direction and management of the patient; -Nursing; -Counseling (including spiritual, dietary and bereavement [period of grief and mourning after a	F 309	* (continued from page 11.) Education given to the interdisciplinary team and all nursing staff. NPN/SDD/HMF	

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F 309	Continued From page 12 death]); -Social Work; -Medical supplies, durable medical equipment (medical equipment used at home), and drugs necessary for the palliation (relief) of pain and symptoms associated with the terminal illness and related conditions; and -All other hospice services necessary for the care of the patient's terminal illness and related conditions." Review of the providers undated hospice care policy revealed: ***Hospice will assume responsibility for professional management of the SNF/NF (skilled nursing facility/nursing facility) or ICF/MR (intermediate care facility for the mentally retarded) resident's hospice services provided, in accordance with the hospice plan of care and the hospice CoPs (conditions of participation), and make any arrangements for hospice-related inpatient care in a participating Medicare/Medicaid facility." **A written plan of care must be established and maintained in consultation with SNF/NF/AL or ICF/MR representatives. All hospice care provided must be in accordance with this plan of care. The plan of care must: a. Identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions. b. Reflect the participation of the hospice, the SNF/NF/AL (assisted living) or ICF/MR, and the patient and family to the extent possible. c. Document any hospice approved changes in the plan of care and that changes were discussed with the patient or representative, and SNF/NF/AL or ICF/MR representatives."	F 309			

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F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335</p> <p>Surveyor: 35237 Based on observation and interview, the provider failed to maintain an even sidewalk surface in one of two courtyards (front courtyard) to prevent potential falls. Findings include:</p> <p>1. Observation on 3/17/15 at 3:00 p.m. of the front courtyard revealed: *Three doors to enter and exit the courtyard. -Concrete from those doorways connected to a circular walkway around the area. *From the doorway of the TV lounge: -Between the first and second slabs of concrete there was an approximate one inch difference in surfaces. -The third and fourth slabs of concrete in the circular area to the right had two large diagonal cracks with areas of missing concrete and uneven edges. *From the doorway across from the beauty shop: -The fourth slab of concrete straight out from the door was approximately five feet (ft) by six ft, and was raised up approximately one to one and a half inches above the surrounding concrete slabs</p>	F 323	<p>Manor Care Health Services strives to provide a safe environment for residents who desire to go outside to the courtyard.</p> <p>Residents who desire to spend time in the courtyard have the potential to be affected.</p> <p>*interdisciplinary team NPN/SDCH/MF</p> <p>The Administrator, IDT, and Maintenance Director met to review possible hazards in the courtyard. *see page 15. Signs have been posted to alert those who enter the courtyard of uneven surfaces and uneven surfaces will be painted to alert of hazardous area. NPN/SDCH/MF</p> <p>The Administrator or designee will provide staff education on alerting those who enter the courtyard of uneven surfaces.</p> <p>Safety audits of the courtyard will be completed weekly for two months by Maintenance Director or designee with results forwarded by Administrator or designee to QAPI committee for further review and recommendations. *MONTHLY NPN/SDCH/MF</p> <p>Date of compliance is 4/23/15.</p>	*4/23/15 NPN/SDCH/MF

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F 323	Continued From page 14 on two of the four sides. *From the doorway across from the dining room: -Between the first and second slabs of concrete there was an approximate one and a half inch difference in surfaces. -Across the corner of the second slab there was a large crack, and an uneven surface of that cracked piece to the rest of that slab . Interview on 3/17/15 at 1:15 p.m. with a group of residents revealed they went outside to the courtyard area when it was nice outside. Interview on 3/18/15 at 8:15 a.m. with assistant director of nursing F revealed residents went out to both courtyards by themselves at times. She agreed the uneven surfaces could be a potential trip hazard. Observation and interview on 3/18/15 at 1:00 p.m. in the large courtyard with the maintenance director revealed: *He was aware of the raised concrete. *He agreed there were differences between the surfaces and cracks in the concrete as identified above. *He agreed the residents came out to use the courtyard and those areas could be a potential trip hazard.	F 323	* A licensed contractor will assess the uneven surfaces in the courtyard when the weather permits. NPN/SDDOH/ME	
F 360 SS=D	483.35 PROVIDED DIET MEETS NEEDS OF EACH RESIDENT The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.	F 360		

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F 360	Continued From page 15 This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Surveyor: 35237 Based on interview and recipe review, the provider failed to follow two of two recipes for enhanced diets for residents that needed additional calories. Findings include: 1. Interview on 3/18/15 at 10:10 a.m. with the food service manager and dietitian revealed: *Some residents received an enhanced diet for added calories to help with weight loss or to maintain skin integrity (health). *Usually one item per meal was enhanced. *The cooks used recipes to make the enhanced food items. Review of the provider's recipes for the enhanced diet items revealed: *The enhanced cereal should have included nonfat dry milk, margarine, light brown sugar, and evaporated milk. *The enhanced potatoes whipped should have included evaporated milk, margarine, black pepper, and sour cream. Interview on 3/18/15 at 10:15 a.m. with dietary aide/cook H revealed: *She was a part-time cook. *For the enhanced mashed potatoes she added powdered milk and butter. *She would not add sour cream unless they had it on hand. Interview on 3/18/15 at 10:30 a.m. with cook I revealed:	F 360	Manor Care Health Services strives to provide enhanced foods to meet dietary requirements of residents with nutritional concerns. Residents with nutritional concerns requiring enhanced foods have the potential to be affected. The Dietitian provided education to cooks on preparation of enhanced food items. Recipes were reviewed and inventory of items needed for enhanced recipes was validated. Audits for compliance with enhanced food recipes will be completed by Dietician or Food Service Manager five times weekly for four weeks and then twice weekly for four weeks with results forwarded by Dietician or Food Service manager to the QAPI committee for follow up and review. *MONTHLY NPN/SDO/HMF Date of compliance is 4/23/15.	*4/23/15 NPN/SDO/HMF

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F 360	<p>Continued From page 16</p> <ul style="list-style-type: none"> *He had been a cook for three years. *For the enhanced mashed potatoes he added instant potatoes, powdered milk, butter, and sour cream. *For the enhanced cream of wheat he added brown sugar and evaporated milk. *He was aware there were recipes in a book for the enhanced meal items. *The dietitian had educated him on the book. <p>Interview on 3/18/15 at 2:30 p.m. with the dietitian revealed:</p> <ul style="list-style-type: none"> *She agreed there were discrepancies in what the cooks stated they added and what the enhanced diet recipes recommended. *Staff had not been inserviced on the recipes. *She agreed the recipes should have been followed. 	F 360		
F 441 SS=E	<p>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 -</p> <ol style="list-style-type: none"> (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>(b) Preventing Spread of Infection</p>	F 441		

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F 441	<p>Continued From page 17</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens 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: 34030 Based on observation, interview, and manufacturer's instructions, the provider failed to disinfect one of one whirlpool bathtub and one of two showers after resident's use. Findings include:</p> <p>1. Observation and interview on 3/17/15 at 1:45 p.m. with certified nursing assistant (CNA) E revealed: *She had finished with a resident's shower that had taken place in the tub room on the station one hallway. *She sprayed the disinfectant cleaner A456 II on the surfaces of the shower and chair after giving the resident a shower. *She left the disinfectant on for two to three</p>	F 441	<p>Manor Care Health Services will provide proper disinfection of whirlpool and shower areas.</p> <p>Residents who use the whirlpool and shower areas have the potential to be affected. *administrative director of nursing</p> <p>The ADNS or designee will provide education to nursing assistant staff members regarding cleaning whirlpool and shower and proper use of disinfecting products as per manufacturer's guidelines. *specifically employees E and G</p> <p>Audits of compliance with disinfecting shower and whirlpool equipment will be completed by the Infection Control Nurse or designee three times weekly for four weeks with results forwarded by Infection Control Nurse or designee to QAPI committee for review and recommendations. *monthly</p> <p>Date of compliance is 4/23/15. *cleaning instructions for the whirlpool tub and shower stall are posted in those areas. New staff will be trained by the director of care delivery or designee.</p>	<p>*4/23/15 NPN/SDDH/MF</p> <p>NPN/SDDH/MF</p> <p>NPN/SDDH/MF</p> <p>NPN/SDDH/MF</p>

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F 441	<p>Continued From page 18 minutes before wiping it off. -The label on the bottle showed the time required to disinfect was ten minutes. *She stated that was her cleaning procedure after every resident's shower.</p> <p>Observation and interview on 3/18/15 at 9:15 a.m. with CNA G revealed: *She had finished with a resident's bath that had taken place in the Parker whirlpool bathtub on the station two hallway. *She proceeded to clean the bathtub. *She left the disinfectant on the internal surfaces of the tub for one to two minutes before wiping it off. *She stated that was her cleaning procedure after every resident's bath. *The instructions she had been following were on the counter in that room. *The second page of the instructions had been missing.</p> <p>Review of the second page of the undated manufacturer's instructions for the Parker whirlpool bathtub revealed step 24 "Let the disinfectant agent act for about 10 minutes, during this time scrub all surfaces."</p> <p>Interview on 3/18/15 at 2:45 p.m. with registered nurse F regarding the disinfection of resident's bathtub and showers revealed: *She was in charge of infection control (the tracking and prevention of infections) for the facility. *She would have expected the manufacturer's instructions to have been followed to ensure adequate disinfection of the bathtub and shower had taken place.</p>	F 441			

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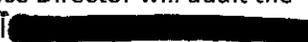
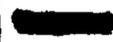
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F 441	Continued From page 19 Interview on 3/18/15 at 3:00 p.m. with the director of nursing revealed she agreed that adequate disinfection of the whirlpool tub and shower had not taken place.	F 441			

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/17/15. ManorCare Health Services (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 upon correction of the deficiency identified at K025 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	<i>Addendums noted with an asterisk per 435115 telephone to facility administrator. CHKSDDH/MF</i> Aberdeen Plan of Correction for Annual Survey on March 18, 2015 The statements on this plan of correction are not admittances to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take action as set forth in the following plan of correction. The plan of correction constitutes the center's assertion of compliance. All alleged deficiencies cited have been or will be corrected by dates indicated.	
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain the 30 minute fire-resistive rating of smoke barrier walls. One of two smoke barrier walls (at resident rooms 108 and 109) had	K 025	 The Maintenance Director will audit the fire/smoke wall   QAPI committee for review and recommendations <i>*semi annually and will report audit results to the CHKSDDH/MF</i> <i>*The unsealed opening in the smoke barrier wall will be sealed by the maintenance supervisor. He will report the completion of this correction to the QA committee. CHKSDDH/MF</i>	<i>*4/1/15 CHKSDDH/MF</i>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Frances Mastel</i>	TITLE <i>Administrator</i>	(X6) DATE <i>04/03/15</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.

APR 06 2015
SD DOH L&C

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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVENUE NW ABERDEEN, SD 57401		
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K 025	Continued From page 1 an unsealed opening around a pipe penetration above the ceiling. Findings include: 1. Observation at 10:30 a.m. on 3/17/15 revealed the smoke barrier wall at resident rooms 108 and 109 had an unsealed opening around a three inch diameter sprinkler pipe penetration above the corridor lay-in ceiling. Interview with the maintenance director at the time of the observation confirmed that finding. He stated the sprinkler piping had been replaced in that building in 2014. This deficiency could potentially affect all seventy-two residents of the facility.	K 025			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435004	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 03/17/2015
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVENUE NW ABERDEEN, SD 57401	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/17/15. ManorCare Health Services (building 02) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of the deficiency identified at K044 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	The two unsealed penetration openings above the west leaf of doors [REDACTED] The Maintenance Director will audit the fire/smoke wall [REDACTED] QAPI committee for review and recommendations.	* 4/1/15 CH/SDDOH/MF
K 044 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain the two hour fire-resistive rating of horizontal exits in one of one location (two-hour fire-rated wall between building 01 and building 02). Findings include: 1. Observation at 11:15 a.m. on 3/17/15 revealed a two-hour fire-rated horizontal exit with 1-1/2 hour fire-rated cross-corridor doors separating building 01 (original building) from building 02 (addition). Further observation revealed two unsealed penetration openings (four inch diameter galvanized sprinkler pipe and a bundle of category 5 computer cables) above the west	K 044	* Will be sealed by the maintenance supervisor. He will report the completion of this correction to the QA committee. CH/SDDOH/MF * semi-annually and will report audit results to the CH/SDDOH/MF	

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

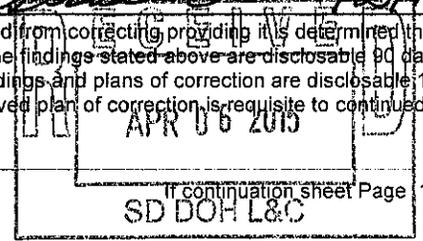
TITLE

(X6) DATE

Francis M. Muel

Administrator 04/03/15

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



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

PRINTED: 03/27/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435004	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____		(X3) DATE SURVEY COMPLETED 03/17/2015
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVENUE NW ABERDEEN, SD 57401		
(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 044	Continued From page 1 leaf of those doors above the lay-in acoustical tile ceiling. Interview with the maintenance director at the time of the observation confirmed that condition. He stated the sprinkler piping had been replaced in 2014. This deficiency could potentially affect all seventy-two residents of the facility.	K 044		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10588	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/18/2015
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVE NW ABERDEEN, SD 57401
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>Initial Comments</p> <p>Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 3/17/15 through 3/18/15. ManorCare Health Services was found in compliance.</p>	S 000		

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

TITLE

(X6) DATE

Francis Hastel

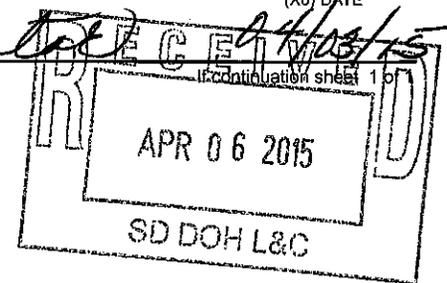
Administrative

4/6/15

STATE FORM

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If continuation sheet 1 of