

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2015
NAME OF PROVIDER OR SUPPLIER SEVEN SISTERS LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 HWY 71 SOUTH HOT SPRINGS, SD 57747	
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F 000	INITIAL COMMENTS Surveyor: 26632 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/8/15 through 6/10/15. Seven Sisters Living Center was found not in compliance with the following requirements: F280, F314, F323, F329, F332, F441, and F514.	F 000	Addendums noted with an asterisk per 7/29/15 telephone to facility COO. KW/SDOHH/OJ	
F 280 SS=F	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, interview, record review,	F 280		

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

TITLE

(X6) DATE

John Miller

Administrator

7/3/15

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.

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F 280	<p>Continued From page 1</p> <p>and policy review, the provider failed to review, revise, and individualize care plans for 9 of 11 sampled residents (1, 2, 3, 4, 6, 7, 8, 9, and 10). Findings include:</p> <p>1. The provider failed to ensure the use of repositioning bars had been assessed and care planned for residents 1, 2, 4, 6, 7, 9, and 10. Refer to F323, finding B 1.</p> <p>2. Review of resident 8's 6/9/15 revised care plan revealed: *A focus area for impaired cognitive (memory and judgement loss) function related to her Alzheimer's disease. *A goal that she would not have inappropriate behavior within five minutes of staff intervention. *Interventions included: -Cueing, reorientation, and supervision as needed. -Review medications and record possible causes of cognitive deficit; new medications or dosage increases; anticholinergics (Aricept for memory), opioids (narcotic pain medication), benzodiazepines (anti-anxiety), recent discontinuation, omission or decrease in dose of benzodiazepines; drug interactions, errors, or adverse drug reactions. *There was no specific interventions included for the use of the anti-psychotic medication she had started on 4/8/15.</p> <p>3. Review of resident 3's medical record revealed: *She had been started on risperidone (mood adjustment) 0.5 milligram (mg) every bedtime for agitation related to dementia (memory loss) on 3/4/15. *She had been started on lorazepam</p>	F 280		

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F 280	<p>Continued From page 2 (anti-anxiety) 0.5 mg every twelve hours as needed for anxiety on 5/13/15. *Her trazadone had been discontinued on 5/13/15.</p> <p>Review of resident 3's 10/19/14 revised care plan revealed: *A focus area for her use of trazadone for insomnia which had been discontinued on 5/13/15. *There were no focus areas, goals, or interventions for the use of the lorazepam and risperidone.</p> <p>4. Review of resident 1's 3/22/14 revised care plan revealed: *He had a self-care performance due to his limited mobility. *There was no intervention for his transferring ability between different surfaces such his wheelchair, bed, and the toilet.</p> <p>Interview on 6/9/15 at 1:30 p.m. with certified nursing assistant F revealed resident 1 was transferred with a sit-to-stand lift.</p> <p>Surveyor: 28057 5a. Review of resident 4's medical record revealed his care needs had not been assessed and care planned adequately to ensure he had not developed pressure ulcers after his admission to the facility. Refer to F314, finding 1.</p> <p>b. Observation on 6/9/15 at 7:30 a.m. and at 5:45 p.m. revealed resident 4 was transferred from his bed to his wheelchair using a sit-to-stand lift.</p> <p>Review of his revised 6/9/15 care plan revealed a</p>	F 280	<p>1. Repositioning bars assessed and care planned for Residents 1, 2, 4, 7, 9 and 10 completed on 6/29/15 by DON. Resident 3 and 8 care plans updated 6/29/15 by DON to include interventions for antipsychotic and antianxiety medication use. Resident 1 care plan updated on 6/29/15 for transfer ability by DON. Resident 4 was re-assessed by Physical Therapy on 6/9/15 and Care plan was updated with new transfer status 6/10/15 by MDS Coordinator. Resident 4 reassessed and care plan updated on 6/29/15 by DON for skin integrity/pressure ulcer prevention. Resident 6 was end of life and expired 6/13/15.</p> <p>2. DON and MDS coordinator will audit all Residents care plans for enabler bars, antipsychotic medication use, skin integrity/pressure ulcer prevention and transfer ability by 7/9/15. Any concerns to care plans will be updated by 7/28/15. MDS Coordinator and the Care Team will review care plans during the MDS schedule.</p>		

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F 280	<p>Continued From page 3</p> <p>Hoyer lift was to have been used for his transfers.</p> <p>Interview on 6/10/15 at 9:20 a.m. with the director of nursing confirmed: *Resident 4 was to have been transferred with a sit-to-stand lift. *A Hoyer lift had been used until a day or two ago when new orders had been received. *She agreed his care plan had not been updated to reflect the correct transfer device to be used for his transfers. *She stated the nurse that had taken that order should have updated the care plan.</p> <p>Surveyor: 32573</p> <p>6. Review of resident 6's complete medical record revealed: *A 10/24/14 physician's order stating he had venous stasis lesions (wounds caused by blood circulation problems) to his toes and ankles. *Nursing progress notes from 4/8/15 to 5/27/15 had reflected repeat issues with vascular skin issues with his feet and other skin issues on his buttocks and groin. *All his skin issues were currently healed. *No diagnosis of peripheral vascular disorder (decreased circulation of blood to limbs) had been on his current diagnoses documentation.</p> <p>Review of his current careplan revealed: *A 1/21/14 focus area of at risk for impaired skin integrity related to being chair fast and incontinent (loss of bladder and bowel control). *Interventions had included: -Needs assistance to apply protective garment foam boot to left foot HS (before bed). -Needs a pressure relieving/reducing cushion to protect the skin while up in a chair.</p>	F 280	<p>3. New MDS Coordinator in place and she will oversee all care plans. All nurses re-educated on care plan policy, wound assessment/prevention/treatment/documentation policy, assistive devices policy, transfer needs and antipsychotic medication use. Staff meeting scheduled 07/01/15 and 07/02/15 and all additional staff to be educated by 07/09/15.</p> <p>4. Random audits of 6 resident's care plans reviewing transfer ability, psychotropic medications, enabler bars, geri chairs and skin integrity/pressure ulcer prevention completed by DON or designee weekly x 4, monthly x 3 and then quarterly x 3. Results of audit to be reported by DON or designee to QAPI monthly.</p>	7-28-15
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F 280	Continued From page 4 -Needs a pressure relieving/reducing mattress to protect the skin while in bed. -Encourage good nutrition and hydration in order to promote healthier skin. His careplan had not addressed his vascular skin issues and how to prevent or improve that condition specifically. Interview on 6/10/15 at 1:30 p.m. with the director of nursing revealed resident 6 had reoccurring skin issues with his feet and ankles for years. He would heal and then develop lesions again. She had not been aware he had not had a diagnosis for peripheral vascular disorder on his care plan or any where else other than the one doctor's order. She had not been aware the only intervention on his care plan related to his feet had been a foam boot on one foot at bedtime. She agreed there had been no other documentation in his records that explained how to care for the skin issues with his feet. Review of the revised 1/29/15 Care Plan policy revealed: *The care planning/interdisciplinary team was responsible to review and update the care plans. *It was to be revised as information about the resident and resident's condition changed.	F 280			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having	F 314			

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F 314	<p>Continued From page 5</p> <p>pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on observation, interview, record review, and document review, the provider failed to ensure one of two sampled residents (4) had not acquired an avoidable pressure ulcer (area of skin breakdown, where something keeps rubbing or pressing against the skin) after admission to the facility as evidenced by an ineffective care planning process and failure to follow the skin/wound preventative program. Findings include:</p> <p>1. Observation on 6/9/15 at 7:30 a.m. revealed the resident was in bed. He did not have his foam heel boots on at that time. The nursing assistants had put them on when they had gotten him up.</p> <p>Observation and interview on 6/9/15 at 4:55 p.m. revealed: *Licensed practical nurse (LPN) (D) examined resident 4's right heel. *There had been a scabbed area on the outer aspect of that heel. *The LPN had not measured the area but agreed it had been approximately two centimeters (cm) in diameter. *She had applied Collagenase ointment and a dressing to the heel after she had examined it and found no dressing present on the area. *She stated a dressing was to have been on the scabbed area until it had healed. *The resident's foam boots had not been on while</p>	F 314	<p>1. Resident 4 care plan updated to focus on pressure ulcer prevention and treatment by DON on 6/30/15. Resident assessed on 6/30/15 by DON with full head to toe skin assessment. No skin issues at this time. All skin intact. New Braden scale assessment completed by DON on 6/28/15. Dietary, nursing staff, physician and wife notified there are no skin issues at this time, but resident remains HIGH RISK for pressure ulcers r/t history of wounds to heels and coccyx.</p> <p>2. DON and MDS Coordinator will audit all Residents for Braden scale scores by 7/28/15. Care plans for residents at risk will be reviewed and updated. MDS Coordinator and the Care Team will review care plans during MDS schedule to include Braden scale.</p>	
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F 314	<p>Continued From page 6 he had been in bed.</p> <p>Observation on 6/9/15 at 5:45 p.m. revealed: *Two certified nursing assistants assisted the resident to the bathroom. *The resident's coccyx had no dressing in place. *The skin on the resident's coccyx had no open areas present. *They had put his foam boots on when they had gotten him up.</p> <p>Review of resident 4's June 2015 treatment administration record (TAR) revealed: *Wound care-coccyx apply collagenase and cover with Mepilex Border (a dressing). (Observation above revealed no dressing was in place over the coccyx, and it appeared healed at that time.) -Wear foam boots at all times. -Change on bath days, Monday and Thursday. -Change as needed. *Change small Mepilex with Border dressing on mid-back area on bath days (Monday and Thursday) and as needed until healed. *There had been no treatment listed for the right heel yet observation above revealed LPN D had applied a dressing to that heel.</p> <p>Review of the resident's physician's orders related to his pressure ulcers revealed: *On 12/2/14:"Wound care consult. Air overlay mattress." *New orders that same day "Wound care: Auto turn bed rather than air overlay. Cover wound on coccyx with mepilex change Monday et [and] Thursday." *On 12/2/14 "DC twin mattress apply air overlay." *On 2/9/15 "Wound care wound to coccyx apply collagenase nickel thick then cover with mepilex</p>	F 314	<p>3. All nurses to be re-educated on wound assessment, prevention, treatment and documentation policy by 7/9/15. Wound care nurse will assess all residents with pressure wounds weekly and report status to NSI committee monthly.</p> <p>4. DON or designee to audit 6 resident charts who are at risk or currently have breakdown for skin integrity/pressure ulcer prevention care plans, assessments and treatments. Weekly x 4, monthly x 3 and quarterly x 3. DON or designee will report to QAPI monthly.</p> <p><i>(Nutrition Skin Infection Control)</i> <i>Kw 50004 JJ</i></p>	7-28-15	

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F 314	<p>Continued From page 7 border. Change on bath days." *On 2/17/15 "Wound care to coccyx, continue collagenase nickle thick, covered with Mepilex, change on bath days and PRN [as needed] if soiled." *On 3/6/15 "Wound care consult on resident's heels Bil [bilateral]." *On 3/9/15 "Wound care: Wound to R [right] outer heel cover with collagense [collagenase] the Mepilex border. Wound to L [left] inner heel cover with Mepilex border. Wound to coccyx cover with collagenase then Mepilex border. Change on bath days. Wear foam boots at all times." *On 3/26/15 "Wound care. DC (discontinue) wound care to L inner heel. Wound is heeled [healed]." *On 5/26/15 "DC wound care to R [right] heel Wound is healed."</p> <p>Review of the resident's 9/3/14 Nursing Admission Screening/History form/documentation revealed: *The resident's right and left legs were normal in color and temperature. *Section L Skin had been left blank. *The resident had required staff assistance for transfers, ambulation, locomotion (moving about), toileting, bathing, and hygiene. *No skin breakdown had been noted on admission.</p> <p>Review of his Braden Scale for Predicting Pressure Sore Risk assessments from 9/3/14 through 5/18/15 revealed he had been at risk for developing pressure ulcers.</p> <p>Interview on 6/10/15 at 9:20 a.m. with the director of nursing (DON) confirmed the revised 2/23/15 Physician Protocols 2015, the September 2010</p>	F 314		
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F 314	<p>Continued From page 8</p> <p>Wound Assessment, Prevention, Treatment, Documentation, and the 2/10/12 Braden Scale Worksheet were used to determine how to prevent and treat a pressure ulcer.</p> <p>Review of the provider's 2/10/12 Braden Scale Worksheet revealed if a stage II (shallow open area in the skin) or greater pressure ulcer developed:</p> <ul style="list-style-type: none"> *The care plan was to have been updated. *The EZ graph wound assessment was to have been completed and continued weekly. *The physician was to have been notified. *The wound protocol was to have been initiated. *When it was healed the care plan was to have been updated. <p>Review of the resident's last revised 6/9/15 care plan revealed:</p> <ul style="list-style-type: none"> *A goal that the resident had a potential for skin tears, skin breakdown, and ulcers related to his dementia (memory problem) and being wheelchair bound. *The goal had been the resident would be free from skin tears through the review date. *Areas of skin breakdown and ulcers were to have been monitored and documented. *The resident was to have foam boots on. *It had not addressed the areas of present or previous breakdown. *It had not stated when the resident was to have worn the foam boots. *It had not listed any treatments or prevention for the resident's coccyx or heels other than the foam boots. <p>Review of the September 2010 Wound Assessment, Prevention, Treatment, Documentation</p>	F 314			

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F 314	<p>Continued From page 9</p> <p>n guidelines revealed: *Nursing was to have documented weekly on all wounds. *Those guidelines stated the following was to have been documented: -The location of the wound. -The size to include the length, width, and depth. -Any undermining, tunneling, or sinus tracts. -Any drainage and the amount. -The odor. -The tissue type. -The wound edges.</p> <p>Review of a sampling of the resident's progress notes from 10/7/14 through 6/10/15 revealed the nurses had not documented as expected in the above 2010 Wound Assessment, Prevention, Treatment, Documentation guidelines as stated below as examples demonstrate: *On 11/28/15 the resident had developed an open area on his coccyx the size of a nickel. -The area had slight bloody drainage and redness around the area. -A Mepilex dressing was applied. *On 12/7/14 the resident had two open areas on his coccyx. -One had been bleeding and the other had slough (dead off-color tissue) present. -The wound was red and irritated. *On 12/25/14 the wound was described as being the size of a quarter. *On 1/1/15 the coccyx had slough in the wound bed. *On 1/8/15 the wound appeared to be resolved. -Pink skin had appeared where the wound had been. *On 1/22/15 the wound on the coccyx had re-opened.</p>	F 314			

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F 314	<p>Continued From page 10</p> <ul style="list-style-type: none"> -No treatment was documented as being completed for the wound. *On 1/30/15 the wound on the coccyx had been the size of a dime. -Bloody drainage was present. -It was recovered with a Mepilex dressing. *On 2/5/15 the open area on the coccyx had foul, purulent (pus laden) drainage. -There had been eschar (dead dark tissue) in the middle of the wound and slough surrounding that to the borders of the wound. *On 3/6/15 the resident had skin breakdown on the outside of his right heel that had been open and quarter sized. *His left heel had a nickel sized area that had not opened yet. *Mepilex and foam boots were applied to both heels. -The physician and family were notified of the above. -Wound consultation had been ordered for the resident's heels. *On 3/13/15 it had been documented the Mepilex was soiled, so a new one was applied. -It had not stated where that dressing was located. *On 3/30/15 the coccyx was healed. -The right heel had no dressing and had been scabbed over. *On 4/3/15 the coccyx and right heel had drainage present. -Dressings and ointment had been applied. -The wound on the coccyx was about the size of a dime. *On 4/16/15 the coccyx was healed. <p>Interview on 6/10/15 at 9:20 a.m. with the DON confirmed: *The nurses aides cardex in Point Click Care had</p>	F 314			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 11</p> <p>not directed when or for how long the resident was to have worn the foam boots.</p> <p>*She stated they were to have been on at all times.</p> <p>*She had expected wound documentation to include wound measurements to have been completed every seven to ten days by the wound care nurse.</p> <p>*The other nurses working the floor were expected to document drainage and how the resident tolerated the treatment. (Examples of the nurses documentation above revealed that had not occurred.)</p> <p>*She had not expected them to measure the pressure ulcers.</p> <p>Review of the resident's assessments and documentation by the wound care nurse for his coccyx and heels on the EZ graph Wound Assessment system form from 12/2/14 through 5/20/15 revealed:</p> <p>*It had been documented on 12/2/14 and then not again until 2/12/15.</p> <p>-That had been seventy-two days between documentation.</p> <p>*The next documentation had been on 2/25/15, an interval of thirteen days.</p> <p>*The next documentation had been on 3/9/15, an interval of twelve days.</p> <p>*The next documentation had been on 3/19/15, an interval of nine days.</p> <p>*The other documentation had been seven days or less until 4/1/15 through 4/15/15, and interval of fourteen days.</p> <p>*No documentation regarding the coccyx had been documented on the EX graph by the wound care nurse after that date.</p> <p>*The orders for the treatment to the coccyx had not been discontinued, and the treatment was still</p>	F 314			

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F 314	Continued From page 12 present on the June 2015 TAR. *Documentation for his heels revealed: -Nine days elapsed between documentation from 3/9/15 through 3/18/15. -Fourteen days elapsed from 4/1/15 through 4/15/15. -Sixteen days elapsed from 4/15/15 through 5/1/15. *The left heel was not documented as healed until 3/26/15 and the right heel until 5/26/15, yet no documentation had occurred after 5/1/15.	F 314			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 28057 A. Based on observation, record review, and interview, the provider failed to ensure bed repositioning bars had been used in a safe manner to prevent potential injury for seven of ten sampled residents (1, 2, 4, 6, 7, 9, and 10). Findings include: 1. Random observation on 6/8/15 at 4:15 p.m. through 2:00 p.m. on 6/10/15 revealed: *Resident 4 had two repositioning bars on the upper half of his bed. *Resident 7 had two repositioning bars on the	F 323	1. Assistive devices screening tool created by DON in point click care on 6/26/15. Resident 1, 2, 4, 7, 9, 10 had screening for assistive devices completed by DON on 6/29/15 and care plans were updated for enabler bar use. Resident 6 was end of life and expired 6/13/15. Beauty shop is locked when unattended. Housekeeping carts stored in locked storage area. Chemicals removed from the soiled utility rooms by DON on 6/30/15.		

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F 323	<p>Continued From page 13</p> <p>upper half of his bed. *Resident 2 had one grab bar on the right upper half of his bed.</p> <p>Review of the above residents' care plans revealed: *Resident 4's revised 6/9/15 care plan had no focus, goal, or interventions for the use of repositioning bars while in bed. *Resident 7's revised 6/8/15 care plan had no focus, goal, or interventions for the use of repositioning bars while in bed. *Resident 2's revised 6/9/15 care plan had no focus, goal, or interventions for the use of repositioning bars while in bed.</p> <p>Interview on 6/10/15 from 9:20 a.m. through 10:00 a.m. with the director of nursing (DON) confirmed: *There should have been assessments completed for the use of the repositioning bars. *She agreed the use of the repositioning bars was to have been care planned. *She would look for the assessments for this surveyor's review.</p> <p>Interview on 6/10/15 at 10:30 a.m. with the chief operating officer (COO) confirmed there had been no policy for the use of the repositioning bars.</p> <p>No assessments for the use of the repositioning bars for residents 2, 4, and 7 had been received from the DON by the end of the survey on 6/10/15 at 3:55 p.m.</p> <p>Surveyor: 32573 2. Review of resident 6's complete medical record revealed:</p>	F 323	<p>2. DON and MDS Coordinator will screen all residents with enabler bars or geri chairs for safety. Their care plans will be updated by 7/28/15. Housekeeping supervisor will check all rooms for unsecure chemicals by 7/28/15.</p> <p>3. All nurses to be educated on safety device policy and screening form in PCC by 7/9/15. All staff educated on chemical policy and no chemicals to be stored in utility rooms. Staff educated beauty shop must be locked when not attended and housekeeping carts must be stored in locked storage area. Staff will be inserviced by 7/9/15.</p> <p>4. DON or designee to audit 6 random residents for the use of enabler bars or geri chairs reviewing screening completed and care plan updated. Weekly x 4, monthly x 3 and quarterly x 3. DON or designee will report results to QAPI monthly. Housekeeping supervisor or designee to audit 6 rooms for unsecured chemicals. Weekly x 4, monthly x 3 and quarterly x 3. Housekeeping supervisor or designee will report results to QAPI monthly. Environmental Services will add to</p>		

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F 323	<p>Continued From page 14</p> <p>*His current care plan had an Intervention he used an "enabler bar" for independence.</p> <p>*His current care plan had an Intervention of "totally dependent on staff for locomotion (moving from area to another) using Geri Chair (reclining wheelchair)."</p> <p>*There had been no safety assessment for either of those devices.</p> <p>3. Observation on 6/8/15 at 4:30 p.m. revealed resident 10 had one repositioning bar on her bed.</p> <p>Review of resident 10's complete medical record revealed:</p> <p>*There had been no safety assessment for the repositioning bar.</p> <p>*The repositioning bar had not been addressed on her care plan.</p> <p>Interview on 6/10/15 at 11:10 a.m. with the DON revealed the provider did not have a formal safety assessment process for assistive devices (repositioning bars, bed rails, certain wheel chairs, or seat belts). Staff would have ordered repositioning bars to be put on by maintenance if they determined the resident needed them.</p> <p>4. Observation on 6/8/15 at 4:15 p.m. revealed resident 1 had repositioning bars on both sides of his bed. Review of his medical record revealed no safety assessment for the repositioning bars. The repositioning bars had not been addressed on his care plan.</p> <p>5. Observation on 6/9/15 at 9:00 a.m. revealed resident 9 had repositioning bars on both sides of his bed. Review of his medical record revealed no safety assessment for the repositioning bars. The repositioning bars had not been addressed on his</p>	F 323	<p>weekly preventative maintenance tour that salon door is locked when not attended. ESS will report monthly x 4 quarterly x 3 to QAPI committee.</p>	7-28-15	

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F 323	Continued From page 15 care plan. Surveyor: 26632 B. Based on observation, interview, and policy review, the provider failed to store cleaning and sanitizing chemicals securely: *In one of one beauty shop. *In one of two (south) unlocked storage rooms where two of two housekeeping carts were stored. *In one of two (south) soiled utility rooms. Findings include: 1. Random observations from 6/8/15 from 4:30 p.m. through 5:15 p.m. and 6/9/15 from 10:00 a.m. through 11:30 a.m. revealed: *The beauty shop was unlocked and had: -A plastic container on the counter with a liquid chemical in it and combs were noted to have been soaking in that dangerous liquid chemical. -One tub of Sani-cloth disinfectant wipes. -One bottle of hydrocide (to clean hair from brushes and rollers) in the cupboard. *The north and south unlocked soiled utility rooms had four tubs of disinfectant wipes.	F 323			

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F 323	Continued From page 16 *The two housekeeping carts were stored in the unlocked south hall storage room and had tubs of sanitizing wipes on them. *There were residents who were in the halls by those areas. Several of those residents had decreased safety awareness. *Review of the labels of the above chemicals revealed they would be dangerous if ingested or came in contact with eyes and skin. Interview on 6/10/15 at 11:00 a.m. with the director of nursing confirmed the above findings, and the chemicals should have been locked. She was not aware the beauty shop had been left unlocked. Review of the provider's 7/6/10 Chemical Storage policy included that all chemicals located within resident access areas would have been in a locked cabinet or cart at all times. That included chemicals in the soiled utility rooms, housekeeping carts, tub rooms, and the clean linen/supply room. If any chemicals were found to be in question staff would have locked the chemicals in the cabinets provided.	F 323			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329			

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F 329	<p>Continued From page 17</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632</p> <p>Based on record review and interview, the provider failed to have an appropriate diagnosis for one of five sampled residents (8) prescribed risperidone, an antipsychotic medication (mood altering). Findings include:</p> <p>1. Review of resident 8's medical record revealed: *She had been admitted on 12/13/14. *She had diagnoses that included Alzheimer's dementia (memory problems). *Lorazepam (anti-anxiety) 0.5 milligram (mg) one every twelve hours as needed for anxiety had been ordered on 2/3/15 and discontinued on 4/2/15 by the physician. -Review of her medication administration records from February 2015 through 6/19/15 revealed she had two doses in February, four doses in March, and none in April before it had been discontinued. *A 4/8/15 physician's order was noted for</p>	F 329	<p>1. Resident 8's physician orders reviewed and care plan updated by DON on 6/29/15. Doctor reviewed 6/30/15 current medication list and diagnosis list and updated as indicated.</p> <p>2. All residents on antipsychotic to be reviewed by pharmacist for appropriate diagnosis by 7/28/15. Pharmacist will continue to check for appropriate diagnosis with monthly Pharmacy review.</p> <p>3. All nurses to be re-educated on care plan policy by 7/9/15. Pharmacist will re-educate physicians and CNP's on the need for appropriate diagnosis for all antipsychotics.</p>	

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F 329	<p>Continued From page 18</p> <p>risperidone 0.25 mg twice daily for agitation. *She had not been on risperidone when she had been admitted.</p> <p>Review of resident 8's behavior symptoms certified nursing assistant documentation from 12/1/14 at 9:51 p.m. through 6/10/15 at 9:30 a.m. revealed: *Forty-three instances of wandering documented. *Eight instances of refusing care. *Four instances of frequent crying. *One instance of sexually inappropriate behavior.</p> <p>Review of resident 8's interdisciplinary behavior progress notes from 1/10/15 through 6/5/15 revealed documentation for anxiety, sexually inappropriate interaction with a male resident whom she believed was her husband, and packing her clothing. Those notes had been made by licensed nurses.</p> <p>Review of a 2/18/15 physician's note revealed a plan for resident 8 that included: "Alzheimer's disease. She has been largely stable and the Aricept (memory medication) was discontinued in 12/2014. Since that time we did start some lorazepam as needed for anxiety but otherwise, she has been largely stable. I do not believe further medications would be of great benefit. I do not know that she has been getting lorazepam on a regular basis."</p> <p>Review of a 4/22/15 physician's note regarding resident 8 revealed: *"Today the staff tells me that she is doing well. They did have concerns over increasing behaviors, including the patient removing her clothing in inappropriate locations, such as the dining room. She was started on risperidone two</p>	F 329	<p>4. PMA (Psychotropic Drugs/Mood and Behaviors) committee will review all new admissions and new antipsychotic orders for appropriate diagnosis. PMA committee reviews all antipsychotic medication quarterly and will review for diagnosis also. Findings reported to QPAI monthly by Pharmacist or designee.</p>	7-28-15
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F 329	<p>Continued From page 19</p> <p>weeks ago to see if this would help with her agitation and behaviors. Staff reports to me that while she is still having behaviors occasionally, her agitation is much better." *"I do believe we should continue the risperidone, as we are currently giving it. It is helping with her behaviors and agitation."</p> <p>Review of resident 8's consultant pharmacist drug regimen review form revealed: *A 3/11/15 note "Recent order for PRN [as needed] lorazepam, PRN lorazepam X [times] 2 (Feb)." *A 4/28/15 note "Risperdal recently started for agitation. Will cont. [continue] to monitor." *A 5/16/15 note "Med [medication] chart reviewed. No D/C [discontinued] since last review. Continue to monitor." *A 6/4/16 note "Meds/chart reviewed. Fall risk assessment discussed with provider. No new orders at this time."</p> <p>Review of resident 8's 6/9/15 revised care plan revealed: *A focus area for impaired cognitive (memory and judgement loss) function related to her Alzheimer's disease. *A goal that she would not have inappropriate behavior within five minutes of staff intervention. *Interventions included: -Cueing, reorientation, and supervision as needed. -Review medications and record possible causes of cognitive deficit; new medications or dosage increases; anticholinergics (Aricept for memory), opioids (narcotic pain medication), benzodiazepines (anti-anxiety), recent discontinuation, omission or decrease in dose of benzodiazepines; drug interactions, errors, or</p>	F 329		
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F 329	Continued From page 20 adverse drug reactions.	F 329			
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, interview, and manufacturer's review, the provider failed to ensure medications were administered according to the five rights for medication administration for 4 of 34 medications administered by one of two, licensed practical nurses (LPN) (D) for 2 of 14 residents (13 and 15) resulting in a 11.76 percent (%) medication error rate. Findings include: 1. Observation on 6/9/15 at 3:55 p.m. of LPN D revealed she administered Alphagan P 0.1% one drop to resident 15's right eye. She then administered immediately after the above eye drop, the eye medication Cosopt one drop, and then Lumigain one drop. Review of the manufacturers' administration instructions for the above eye medications revealed there should be a wait time of five minutes between each eye drop.	F 332	1. Resident 15 requests eye drops be given one right after the other. She does not like to wait the recommended timeframe between eye drops. Reviewed resident request with physician and new orders 6/11/15 received to give eye drops one right after the other per resident request. Resident 13 was receiving Tylenol through her G-Tube at the ordered dose of 15.6 mL. This dosage was reviewed with physician and new order received 6/11/15 for 15.0 mL. LPN D re-educated on medication pass policy.		

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F 332	Continued From page 21 Interview on 6/9/15 at 4:30 p.m. with the pharmacist revealed sh agreed the eye medications had not been administered as required by the manufacturers' to ensure each eye medication had time to have been absorbed. 2. Observation on 6/9/15 at 4:00 p.m. of LPN D revealed she administered acetaminophen (pain reliever) liquid 160 milligram (mg) per 5 milliliters (ml) to resident 13. LPN D poured 20 ml of the liquid acetaminophen in a medication cup, and then administered the medication to resident 13 per her feeding tube. Review of resident 13's June 2015 medication administration record revealed she was to have received 15.6 ml of the acetaminophen which equaled 500 mg. She received 640 mg of the medication. Interview on 6/10/15 at 10:30 a.m. with the director of nursing confirmed LPN D had not administered the correct dose of acetaminophen to resident 13. She stated a syringe should have been used to obtain the correct dose of the medication.	F 332	2. Pharmacist will review resident's medications for other liquid medications orders with difficult dose to measure with medication cup. Pharmacist will communicate with nursing the manufacturer recommendations for administration of eye drops. No other residents affected at this time. 3. All nurses and medication aides to be re-educated on medication administration policy by 7/9/15. Pharmacist will continue to check for appropriate dosing with monthly pharmacy review. 4. DON or designee to audit LPN D and 1 random employee medication administration to resident 15 and resident 13 and 4 other residents receiving liquid medications or eye drops weekly x 4, monthly x 3 and quarterly x 3. DON or designee will report to QAPI committee monthly x 3 then quarterly x 3.		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441		7-28-15	

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NAME OF PROVIDER OR SUPPLIER SEVEN SISTERS LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 HWY 71 SOUTH HOT SPRINGS, SD 57747	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 22</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 28057</p> <p>Surveyor: 26632 Based on observation, interview, record review, and policy review, the provider failed to ensure infection control procedures had been followed for: *Two of two-licensed practical nurses (LPN) (C and D) who had performed handwashing, hand sanitizing, and glove use during two of two residents (13 and 14) medication administration.</p>	F 441	<p>1. LPN C re-educated on handwashing, gloving, medication administration and tube feeding policies. LPN D re-educated on handwashing, gloving, wound assessment, prevention, treatment and documentation and blood glucose policy. Whirlpool tub cleaning policy revised, reviewed and posted with CNA F and CAN B. Housekeeping cleaning schedule has been updated to include mopping with quatinary cleaner Monday through Friday in resident's bathrooms and tub rooms. Housekeeper G and Housekeeper E re-educated on revised cleaning schedule.</p> <p>2. COO will review which rooms were potentially affected and housekeeping staff will be in-serviced at staff meeting on 07/01/15 and 07/02/15 on revised cleaning schedule.</p> <p>3. All nursing staff re-educated by 7/9/15 on handwashing, gloving, medication administration, blood glucose policy, whirlpool tub cleaning policy, tube feeding policy, wound assessment, prevention, treatment and documentation policy. All</p>	

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F 441	<p>Continued From page 23</p> <p>*One of two sampled residents (4) who had a dressing change by one of two LPN (D).</p> <p>*One of one LPN (D) during three (3, 9, and 18) observed residents blood glucose testing.</p> <p>*Two of two whirlpool bathtubs (north and south) disinfection.</p> <p>*The disinfection of shared resident's bathrooms and two of two whirlpool bathing room floors.</p> <p>Findings include:</p> <p>1. Observation on 6/9/15 from 12:10 p.m. through 12:30 p.m. of LPN C while she gave medications to resident 13 revealed:</p> <p>*LPN C entered the medication room and retrieved the medications acidophilus (supplement) and Gabapentin (anti-seizure).</p> <p>*Without washing or sanitizing her hands, and without gloves on she opened the capsules of each medication and poured them in a medication cup.</p> <p>*She then washed her hands for less than five seconds before leaving the medication room with the medication cup and went to resident 13's room.</p> <p>*She entered the room, set the medication on the overbed table, put on gloves, filled a container with water, and set the water on the overbed table by the medications.</p> <p>*Turned off the feeding pump and unhooked the tubing from the resident's gastrostomy tube (tube into stomach to deliver food, fluids, and medications).</p> <p>*Instilled 50 cubic centimeters (cc) of water with the medications she had prepared and flushed the tube with another 50 cc of water.</p> <p>*Hooked the tubing back up to the feeding pump.</p> <p>*Opened a can of feeding formula and poured it into the feeding tube pump bag.</p> <p>*Gathered the garbage, took her gloves off,</p>	F 441	<p>housekeeping staff re-educated by 7/9/15 on revised cleaning schedule to include mopping with quaternary cleaner Monday through Friday in resident bathroom floors and whirlpool floors.</p> <p>4. Infection Control Coordinator or designee to audit 6 random residents for proper infection control practices with whirlpool tub disinfecting, resident with shared bathroom floors and whirlpool floors disinfecting, handwashing, gloving, dressing changes, medication passes and cleansing glucometer and tote. Weekly x 4, monthly x 3 and then quarterly x 3. Infection Control Coordinator or designee will report results to NSI committee and QAPI committee monthly.</p> <p><i>*All resident double rooms and whirlpool rooms were potentially affected and housekeeping will be in-service.</i> KW/SOPH/JS</p>	7-28-15

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F 441	<p>Continued From page 24</p> <p>washed her hands for approximately five to seven seconds.</p> <p>*Opened the door and carried the garbage bag out and placed it in the soiled utility room.</p> <p>*Returned to the nurses station and without washing her hands documented the medication administration on the computer.</p> <p>2. Observation on 6/9/15 from 4:00 p.m. through 4:30 p.m. of LPN D while she gave medications and the gastrostomy tube feeding to resident 14 revealed:</p> <p>*She prepared the medications of acidophilus, metoclopramide (reduces nausea), atenolol (blood pressure), levofloxacin (antibiotic), and acetaminophen (pain reliever).</p> <p>*When she prepared the medication she touched pills with her bare hands before she crushed them and placed them into a medication cup.</p> <p>*Took the medication into the resident's room and set the medication cups on the overbed table.</p> <p>*Retrieved a paper towel and placed it on the overbed table and placed the medication cups and 60 cc syringe on it.</p> <p>*Without washing her hands she:</p> <ul style="list-style-type: none"> -Filled a container with water. -Uncovered resident 14's stomach area. -Used the stethoscope to listen to her bowel sounds. -Opened the end of the gastrostomy tube and administered 30cc of water with the medications by gravity through the syringe. -The water with the medications would not flow from the tube into her stomach, so LPN D used the bed controller to raise the head of the bed. -She then poured one can of feeding formula through the syringe and flushed with water. -She rinsed the syringe and put it on the bedside table. 	F 441		

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F 441	<p>Continued From page 25</p> <p>-She then removed her gloves and washed her hands for approximately ten seconds.</p> <p>Surveyor: 28057</p> <p>3. Observation on 6/9/15 at 4:55 p.m. revealed LPN D:</p> <ul style="list-style-type: none"> *Gathered supplies from the medication cart and medication room to place a dressing on resident 4's pressure ulcer. *Had touched door knobs, drawers, and cupboard doors while gathering those supplies. *Entered the resident's room and put gloves on without first washing her hands. *She laid the dressing and the ointment tube on the resident's bed without using a barrier. *Then applied ointment to the bandage and applied the bandage to the resident's pressure ulcer. *She then removed her gloves and washed her hands before she had left the resident's room. *The tube of ointment was returned to a drawer in the medication cart where other residents' medications were stored. <p>Review of the provider's revised 3/26/15 Wound Assessment, Prevention, Treatment, Documentation policy revealed:</p> <ul style="list-style-type: none"> *Hands were to be washed upon entering the resident's room. *Equipment being used was to have been placed on a clean surface. <p>Surveyor: 26632</p> <p>4. Observation on 6/9/15 from 5:00 p.m. through 5:30 p.m. of LPN D during three resident's blood glucose testing revealed she:</p> <ul style="list-style-type: none"> *Placed the glucometer and the tote that held the supplies on a dining room table while she checked resident 9's blood sugar. 	F 441		

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F 441	<p>Continued From page 26</p> <ul style="list-style-type: none"> *Cleaned the glucometer at the medication cart with a hand sanitizer cloth. *Took the glucometer and the tote into resident 16's room and placed it on the overbed table. *Put on gloves, tested resident 16's blood glucose level, removed her gloves, set the tote on the edge of the sink, and washed her hands for approximately five seconds. *Took the glucometer tote to the medication room and used a sanitizing cloth over the glucometer but did not sanitize the tote. *Took the glucometer tote to resident 3's room, placed the tote on the overbed table, put gloves on without washing her hands, and tested her blood glucose level. *Took the glucometer tote to the medication room and wrapped the glucometer in a sanitizing cloth and left it in the tote. *Did not sanitize the tote. <p>5. Interview on 6/10/15 at 9:00 a.m. with the director of nursing revealed:</p> <ul style="list-style-type: none"> *She would have expected LPNs C and D to have washed or sanitized their hands after they had removed their gloves. *She would have expected the glucometer and tote to have been placed on a barrier and sanitized between each resident. *Hands should have been washed for at least twenty seconds. <p>Review of the provider's 1/29/15 Hand Hygiene policy included all employees would have washed their hands before and after:</p> <ul style="list-style-type: none"> *Preparing medications. *Removing gloves. *Gloves would have been changed after each resident encounter. 	F 441		
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F 441	<p>Continued From page 27</p> <p>Review of the provider's revised 1/23/15 Glucose Monitoring/Glucose Cleaning policy did not include any information on how to disinfect the glucometer between residents.</p> <p>6. Observation and interview on 6/9/15 at 10:40 a.m. with certified nursing assistant (CNA) F revealed:</p> <ul style="list-style-type: none"> *The north and south whirlpool tubs were disinfected between each resident. *She would run the disinfectant through the jets, brush it over the tub and tub chair, and then rinse it before the next resident's bath. *She used the tub cleaner at the end of her shift and let that sit for fifteen minutes. *She was not aware the disinfectant was to have stayed on the surface for ten minutes to have been effective. *She thought the tub cleaner was also a disinfectant. *She had been instructed by the tub manufacturer on how to clean and disinfect the tubs. <p>Observation and interview on 6/9/15 at 2:40 p.m. with CNA B revealed:</p> <ul style="list-style-type: none"> *She would use the tub cleaner between each resident's bath and let it stay on the surface for ten minutes. *She would use the disinfectant at the end of her shift and let it stay on the surface for ten minutes. *She was not aware the tub cleaner was not a disinfectant. *She had been instructed by the tub manufacturer on how to clean and disinfect the tubs. <p>Review of the provider's reviewed 4/20/15 Cleaning of Whirlpool and Showers policy included:</p> <ul style="list-style-type: none"> *Between baths turn the knob to the clean cycle 	F 441			

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F 441	Continued From page 28 and wash down for five minutes. *At the end of the day turn knob to disinfect cycle and let sit for ten minutes. 7. Interview on 6/9/15 at 10:20 a.m. with housekeeper G and at 11:10 a.m. with housekeeper E revealed: *They use a quaternary disinfectant product on the resident's bathroom floors and whirlpool floors. *They however did not use that product every day for the shared resident's bathrooms or whirlpool floors. *They only used the disinfectant twice a week on those floors. Review of the provider's undated Cleaning Schedule included: *All floor would have been swept and mopped daily. *There was no indication of what type of products were to have been used for mopping.	F 441			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	1. DON added further information to CNA Point Of Care HS snack charting and scheduled it to be passed at 8:00 p.m. Current snack charting reviewed. CNA's with incomplete HS snack charting educated on importance of passing and documenting HS snacks.		

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F 514	Continued From page 29 This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on interview, record review, and policy review, the provider failed to ensure evening (HS) snacks had been properly documented to show they had been offered to every resident nightly. Findings include: 1. Group interview on 6/9/15 at 2:30 p.m. revealed four of seven residents agreed HS snacks had not been offered every night. On average snacks were offered three times a week. Review of HS snack documentation from 6/4/15 through 6/9/15 revealed forty of forty-five residents had not been offered or given an HS snack at least once during that time period. Interview on 6/10/15 at 9:50 a.m. with the dietary manager revealed staff should have brought around a variety of snacks in the evening before bedtime every night. She was not sure why the documentation had not reflected that. She believed staff just had not been documenting HS snacks every time they offered them. Review of the February 2015 Hour of Sleep Snack Pass policy revealed snacks should have been documented as accepted or refused. Staff should have notified a charge nurse if a resident refused a snack and why.	F 514	2. At Resident Council on 6/24/15 residents were asked if they are being offered HS snacks. Four residents reported they are not always offered an HS snack. One of these residents goes to bed at 6:00 p.m. and was expecting staff to leave a snack at her bedside. She does not want to be awakened. Resident Care Plan updated with her request. HS snacks will be added to the monthly Resident Council agenda. The DSM or designee will interview residents quarterly about receiving HS snacks and preferences. 3. All nursing staff re-educated on HS snack policy by 7/9/15. 4. DSM or designee will continue to ask residents about HS snack pass at Resident Council and team care meetings. Problems will be reported to NSI (Nutrition/Skin/Infection Control) committee monthly by Dietary Manager. DON or designee will audit 6 random residents HS snack pass and documentation weekly x 4, monthly x 3 and then quarterly x 3. DON or designee will report results to QAPI committee monthly.	7-28-15	

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code(LSC) (2000 new health care occupancy) was conducted on 6/09/15. Seven Sisters Living Center was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for New Health Care Occupancies upon correction of deficiencies identified at K048 and K050 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Addendums noted with an asterisk per 7/8/15 telephone to facility COO. CH/SOPDH/JJ	
K 048 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation, document review, and interview, the provider failed to have a written fire plan as required. Findings include: 1. Observation at 10:30 a.m. on 6/09/15 during a fire drill revealed residents in the same smoke compartment were not relocated to an area or room that was smoke tight. Document review of the provider's fire (emergency) plan revealed it was missing the required provision for evacuation of the smoke compartment. Interview with the chief operating officer (COO) during the exit interview at 2:00 p.m. on 6/09/15 revealed staff	K 048	1. Fire Policy and Procedure revised to include: SSLC residents in common areas must be relocated to a smoke tight room or to outside the smoke compartment.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>John Miller</i>	TITLE <i>Administrator</i>	(X6) DATE <i>7/2/15</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.

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(X4) ID PREFIX TAG K 048 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) did not realize the north and south portions of the resident wing area were in the same smoke compartment. The COO acknowledged the finding when the deficiency was identified during the exit interview at 2:00 p.m. Failure to have a fire plan as required increases the risk of death or injury due to fire. The deficiency affected one of eight required provisions in a fire plan. NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Surveyor 18087 Based on observation and interview, the provider failed to ensure all staff were familiar with fire drill procedures. Findings include: 1. Observation at 10:35 a.m. on 6/09/15 revealed the fire drill was held in the south portion of the resident smoke compartment at the spa room. At the conclusion of the drill it was discovered that fifteen residents were observed still located in the

ID PREFIX TAG K 048 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2. All staff will be in-serviced by Environmental Services Supervisor (ESS) on policy and procedure revision by 7/9/15. 3. Audit of procedure will be done at all future fire drills. Fire drills will be conducted monthly on each shift x 3, then quarterly. ESS will report monthly x 3 and then quarterly to the QAPI committee. 7-28-15

(X4) ID PREFIX TAG K 050 SS=C SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Surveyor 18087 Based on observation and interview, the provider failed to ensure all staff were familiar with fire drill procedures. Findings include: 1. Observation at 10:35 a.m. on 6/09/15 revealed the fire drill was held in the south portion of the resident smoke compartment at the spa room. At the conclusion of the drill it was discovered that fifteen residents were observed still located in the

ID PREFIX TAG K 050 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 1. Fire Policy and Procedure revised to include: SSLC residents in common areas must be relocated to a smoke tight room or to outside the smoke compartment. 2. All staff will be in-serviced by Environmental Services Supervisor (ESS) on policy and procedure revision by 7/9/15. 3. Audit of procedure will be done at all future fire drills. Fire drills will be conducted monthly on each shift x 3, then quarterly. ESS will report monthly x 3 and then quarterly to the QAPI committee. CH1 SDDOH/JT

(X5) COMPLETION DATE 7-28-15

* 7/28/15 CH1 SDDOH/JT

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

PRINTED: 06/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435072	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - SEVEN SISTERS B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2015
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NAME OF PROVIDER OR SUPPLIER SEVEN SISTERS LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 HWY 71 SOUTH HOT SPRINGS, SD 57747
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 2 activities area of the north portion of the resident smoke compartment. They had not been relocated to a smoke tight room or outside the smoke compartment during the drill. Interview with the chief operating officer at 2:00 p.m. confirmed that finding. She stated staff did not realize the residents were still located in the same smoke compartment as the fire drill location.	K 050		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10630	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/10/2015
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NAME OF PROVIDER OR SUPPLIER SEVEN SISTERS LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 HWY 71 SOUTH HOT SPRINGS, SD 57747
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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	Initial Comments Surveyor: 26632 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 6/08/15 through 6/10/15. Seven Sisters Living Center was found not in compliance with the following requirement: S166.	S 000		
S 166	44:04:02:17(1-10) OCCUPANT PROTECTION The facility must take at least the following precautions: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents; (3) Provide a call system for each...resident bed and in all toilet rooms and bathing facilities routinely used by...residents. The call system must be capable of being easily activated by the...resident and must register at a station serving the unit; (4) Provide handrails firmly attached to the walls on both sides of all resident corridors in nursing facilities; (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors in nursing facilities. Other exterior doors must be locked or alarmed. The alarm must be audible at a designated nurses' station and may not automatically silence when the door is closed;	S 166	<ol style="list-style-type: none"> 1. Code will be removed from the inside of SSLC main exit door. 2. Access to exit code will be available at the nursing station and next to the entrance button outside the SSLC main door. 3. All staff will be in-serviced on this change by 7/9/15. 4. ESS will add to environmental tour to audit that SSLC main exit door does not have code signage visible to residents. ESS tour will be done monthly and reported to QAPI committee. 	7-28-15

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

John Miller

TITLE

Administrator

(X6) DATE

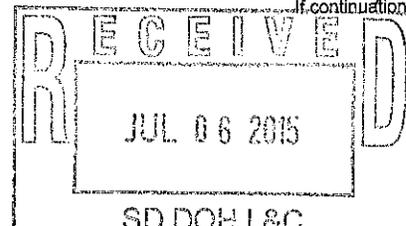
7/2/15

STATE FORM

6899

VO7U11

If continuation sheet 1 of 3



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10630	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2015
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NAME OF PROVIDER OR SUPPLIER SEVEN SISTERS LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 HWY 71 SOUTH HOT SPRINGS, SD 57747
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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 166	<p>Continued From page 1</p> <p>(7) Portable space heaters and portable halogen lamps may not be used in a facility; (8) Household-type electric blankets or heating pads may not be used in a facility; (9) Any light fixture located over a...resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof lamp; and (10) Any clothes dryer must have a galvanized metal vent pipe for exhaust.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 18087 Based on observation, testing, and interview, the provider failed to maintain the electrically activated audible alarm for unattended doors in an active condition for one of five exterior doors (main entrance/exit). Findings include:</p> <p>1. Observation and testing at 8:00 a.m. on 6/09/15 revealed the exit door at the main entrance between the nursing home and the hospital was equipped with a delayed egress magnetic lock. That door would also unlock if the proper code was typed into a keypad. The code to unlock the door was posted on a sign attached to that door. The keypad on the wall nearby had instructions on how to use the code posted on the box which housed the keypad. Once the proper code was entered the magnetic door lock would release. When the door was opened the alarm did not sound. The posted code would allow residents to input the code and leave the building without sounding the door alarm. Interview with</p>	S 166		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10630	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2015
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NAME OF PROVIDER OR SUPPLIER SEVEN SISTERS LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 HWY 71 SOUTH HOT SPRINGS, SD 57747
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S 166	Continued From page 2 the maintenance staff member at the time of the observation confirmed that condition. He stated a wander management system was also in place for certain assessed residents.	S 166		