

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2015
NAME OF PROVIDER OR SUPPLIER SANFORD CARE CENTER VERMILLION			STREET ADDRESS, CITY, STATE, ZIP CODE 20 S PLUM STREET VERMILLION, SD 57069		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS Surveyor: 29354 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/7/15 through 4/8/15. Sanford Care Center Vermillion was found not in compliance with the following requirements: F280, F281, F323, F332, and F441.	F 000	<u>ASSERTION OF DENIAL</u> The facility objects to the allegation of noncompliance for the following cited deficiencies: F280, F-281, F-323, F-332, and F-441. The facility also disagrees with the findings cited.		
F 280 SS=D	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: 32331 Based on observation, record review, interview,	F 280	Submission of the Response and Plan of Correction is <u>not</u> a legal admission that any deficiency exists or that these Statement of Deficiencies were correctly cited, and is also not to be construed as an admission of interest against the Facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in the Response and Plans of Correction. In addition, preparation and submission of the Plans of Correction do not constitute an admission or agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusion set forth in this allegation by the survey agency. Accordingly, the Facility has prepared and submitted these		

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

TITLE

(X6) DATE

[Signature] CEO

5/20/15

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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If continuation sheet Page 1 of 2
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F 280 SS=D	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: 32331 Based on observation, record review, interview,	F 280	The submission of the Plans of Correction within this time frame should in no way be considered or construed as agreement with the allegations of noncompliance of admission by the facility. F280- <u>PLAN</u> 1. Even though the skin condition change and treatment for Resident #4 was not documented on his care plan the nurses discussed in each report the treatment interventions and prevention daily. MDS Coordinator added pressure ulcer to care	

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F 280	<p>Continued From page 1 and policy review, the provider failed to update and revise care plans for:</p> <ul style="list-style-type: none"> *One of one sampled resident (4) with a pressure ulcer (injury to skin and underlying tissue). *One of one sampled resident (1) on isolation precautions. <p>Findings include:</p> <ol style="list-style-type: none"> 1. Interview on 4/7/15 at 9:35 a.m. with the director of nursing (DON) regarding resident 4 revealed: <ul style="list-style-type: none"> *He had a pressure ulcer on his foot. *His shoe had caused the pressure ulcer. <p>Observation and interview on 4/7/15 at 11:55 a.m. with resident 4 revealed he:</p> <ul style="list-style-type: none"> *Was wearing black shoes with a Velcro-closure strap on each shoe. *Stated those shoes were new. *Had problems with skin breakdown on his feet. *Stated he had two bandages on his left foot and one on his right foot. <p>Review of resident 4's medical record revealed:</p> <ul style="list-style-type: none"> *He was admitted on 4/23/12. *He had diagnoses that had included osteoarthritis (a joint disease) and gout (a type of arthritis that involves inflammation of the feet and hands). *A physician's order dated 4/3/15 "Silvadene (silver sulfadiazine) [a medication that stops the growth of bacteria that might infect an open wound] cream 1% [percent]; Amount to Administer: n/a [not available], topical [on top of the skin] Once a Day Silvadene and dressing to ulcer 3rd right toe and plantar [sole of the foot] area of left foot daily x [times] 2 weeks per Dr. _____" *A physician's order dated 4/2/15 "Keflex [an 	F 280	<p>plan for Resident #4 on 4/9/15. Education was provided by DON to MDS Coordinator on 4/8/15 on ensuring care plans are updated. DON also educated nurses by 4/20/15 in event of resident skin change event to notify MDS Coordinator to update care plan. Care Plan audit x 3 bi-weekly will be performed by DON to ensure up to date and accurate with results reported by DON at the quarterly CQI Committee meeting for assessment of further needs.</p> <ol style="list-style-type: none"> 2. Even though CDiff instructions were not addressed in Resident #1's care plan, there was a sign hung on the resident's door instructing staff and 	
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F 280	<p>Continued From page 2</p> <p>antibiotic used to treat infections] 500 mg [milligrams] one po [by mouth] tid [three times per day] x [times] 7 [seven] days for cellulitis R [right] 3rd toe."</p> <p>*The treatment administration record for 4/1/15 through 4/6/15 revealed a 3/31/15 physician's order for:</p> <p>- "Small wound procedure to 3rd and 4th [fourth] toes of left foot daily and as needed until healed. Once a Day 1) 3rd toe; cleanse, apply antibiotic ointment and bandaid 2) 4th toe: apply bandaid to pad red area."</p> <p>- That above order had been discontinued on 4/2/15.</p> <p>Review of resident 4's 3/30/15 care plan revealed:</p> <p>*There had been no documentation regarding any pressure ulcer or his current skin conditions.</p> <p>*There had been no goals or interventions put in place to heal those areas and to have prevented those areas from further breakdown.</p> <p>*There was no mention of the resident's pressure ulcer on that care plan.</p> <p>Review of resident 4's 4/2/15 and 3/25/15 Skin Risk Assessment with the Braden scale (predicts pressure ulcer risk) revealed:</p> <p>*He walked frequently.</p> <p>*He was not at risk of developing pressure ulcers.</p> <p>*His total score was twenty-two that had not put him at risk for developing pressure ulcers.</p> <p>*The above 4/2/15 assessment by registered nurse (RN) G revealed:</p> <p>- He had a 3 millimeter (mm) by 3 mm open area on his left third toe.</p> <p>- Treatment was applied each morning.</p> <p>Review of resident 4's nurses' progress notes</p>	F 280	<p>visitors to use contact precautions (gown, glove and mask) when assisting her with toileting and cares. Staff had been educated upon resident's return from hospital with CDiff on how to take care of resident in report and reminders on 7 day report sheet. MDS Coordinator added CDiff to resident # 1's acute care plan on 4/9/15. DON educated MDS Coordinator 4/08/15 on importance of updating care plans with resident's change in condition. Care Plan audit x 3 bi-weekly will be performed by DON to ensure up to date and accurate with results reported by DON at the quarterly CQI Committee meeting for</p>	
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F 280	<p>Continued From page 3 revealed the following documentation:</p> <ul style="list-style-type: none"> *On 3/31/15 by RN C: <ul style="list-style-type: none"> -A sore toe to his left foot. -The third toe on that foot was red and inflamed with a 3 mm by 3 mm by 1 mm area to the top of the joint. -The fourth toe on that foot had an approximately 1 mm by 1 mm area of redness. *On 4/2/15 by RN G: <ul style="list-style-type: none"> -A 3 mm by 3 mm open area on his left third toe. -Treatment was applied each morning. *On 4/2/15 by RN C: <ul style="list-style-type: none"> -Right third toe remains red with 3 mm by 3 mm area. -"Progress note directed initiation of antibiotic, new wound care, resume wearing his new shoe with Velcro straps and a 2 [two] week follow up." *On 4/2/15 by RN H: <ul style="list-style-type: none"> -"Currently on Keflex 500 mg for cellulitis of right 3rd toe. Dressing in place to right 3rd toe and bandaide noted on bottom of right foot." *On 4/4/15 by licensed practical nurse (LPN) I: <ul style="list-style-type: none"> -He continued on Keflex for a toe infection. <p>Interview on 4/7/15 at 10:30 a.m. with LPN B regarding resident 4 revealed he had daily cream applied and bandage changes to his feet.</p> <p>Interview on 4/8/15 at 8:40 a.m. with the Minimum Data Set (MDS) assessment RN regarding resident 4 revealed:</p> <ul style="list-style-type: none"> *He had a callus (a toughened area of skin) on his foot. -That above area on his foot had a debridement (a surgical removal of dead, damaged, or infected tissue). -He had been on an antibiotic for cellulitis in that area. *He had got the pressure ulcer from his shoe. 	F 280	assessment of further needs.	Completed by 4/30/15
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F 280	<p>Continued From page 4</p> <ul style="list-style-type: none"> *His care plan should have been updated to reflect his skin status changes. *The care plan update could have been completed by any of he nurses. *Her expectation was the care plan should have been updated. <p>Interview on 4/8/15 at 3:15 p.m. with the DON and the licensed social worker regarding resident 4's care plan revealed:</p> <ul style="list-style-type: none"> *Both agreed his care plan needed to have reflected the altered skin status that included the pressure ulcer. *The DON stated her expectation was the care plan should have been updated as soon as possible or within a few days with the altered skin status. *Both confirmed there was no documentation regarding goals and interventions available regarding his skin status and pressure ulcer for the staff. *Both confirmed his care plan was not specific to his needs regarding his altered skin condition. <p>Surveyor: 29354</p> <p>Surveyor: 35120</p> <p>2. Observation on 4/7/15 at 9:17 a.m. outside of resident 1's room revealed a contact precaution sign. There was a plastic container that contained gowns and gloves.</p> <p>Review of resident 1's medical record revealed she had a diagnosis of Clostridium difficile (C-diff [infection that causes diarrhea]).</p> <p>Review of resident 1's 3/23/15 MDS assessment revealed she was occasionally incontinent</p>	F 280		
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F 280	<p>Continued From page 5 (unable to control) of her bowel movements.</p> <p>Review of resident 1's 3/24/15 care plan had no documentation of her current C-diff infection or for isolation precautions.</p> <p>Interview on 4/8/15 at 10:25 a.m. with the DON revealed she agreed the care plan should have been updated to reflect resident 1's current infection and isolation precautions.</p> <p>Review of the provider's Care Plan Policy dated December 2014 revealed: **"Assessing and determining the interdisciplinary care for each resident will be timely, complete, and communicated to all persons involved in the care of that resident." **"A Registered Nurse coordinates each resident's assessment and care planning process." **"Care plans are individualized and incorporate daily routines, personal characteristics and considers resident/family expectations." **"The care planning process continues as goals are defined. Goals need to be realistic and measurable, include a time frame when appropriate, and will reflect the unique needs of the resident. Overall, maintaining the resident's optimal physical, psychosocial, and functional status while minimizing dependence is the ultimate objective."</p>	F 280		
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 281	<p><u>F281 PLAN</u></p> <p>1. This is an isolated incident as upon DON educating RN C of importance of wearing</p>	

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F 281	<p>Continued From page 6 by: Surveyor: 29354</p> <p>Surveyor: 35120 A. Based on observation, interview, and policy review, the provider failed to ensure proper administration of medications to two of two observed residents (17 and 18) by one of two licensed nurses (C). Findings include:</p> <p>1. Observation on 4/7/15 at 3:50 p.m. revealed registered nurse (RN) C: *Took a bottle of eye drops out of the medication cart. *Went into resident 18's room with the eye drops. *Had not put on gloves. *Administered the eye drops to the resident.</p> <p>2. Observation on 4/7/15 at 5:09 p.m. revealed RN C: *Had drawn insulin from a vial in the medication room. *Took the syringe with the insulin in it to resident 17's room. *Had not put on gloves. *Administered the insulin by injection into the resident's abdomen.</p> <p>Interview on 4/8/15 at 10:15 a.m. with the director of nursing revealed she would have expected RN C to put on gloves before administering eye drops and insulin.</p> <p>Interview on 4/8/15 at 11:17 a.m. with RN C revealed he was familiar with the residents. He thought that had been why he had not thought to put gloves on before administering the medications.</p>	F 281	<p>gloves when administering eye drops and insulin injections on 4/8/15, he was unaware he had not put on gloves. RN C stated to DON he always wears gloves when administering eye drops and insulin gloves and was nervous as the surveyors had been observing him all day. DON with history of audits has known RN C to wear gloves appropriately with administration of eye drops and insulin injections. DON educated all nurses on correct use of gloves for administration of eye drops and insulin injections and medication aides for proper use of gloves for administration of eye drops by 4/20/15. Nursing staff will complete audits of administration of eye drops and insulin</p>	

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F 281	<p>Continued From page 7</p> <p>Interview on 4/8/15 at 3:00 p.m. with RN D, education coordinator revealed: *She would have expected RN C to wear gloves while he administered eye drops and insulin. *The provider used the 5th Edition Nurses' Guide to Clinical Procedures book as their guideline for medication administration.</p> <p>Review of the provider's February 2015 Administrative Standard Operating Procedure policy revealed: *3.2.5 "For specific instructions on administration techniques refer to the Nurse's Guide to Clinical Procedures (refer to Index for recent edition). *3.2.5.2 Eye drops. *3.2.5.5.2 Subcutaneous [injection of medication under the skin]."</p> <p>Jean Smith-Temple and Joyce Young Johnson, Nurses' Guide to Clinical Procedures, 5th Edition., Philadelphia, PA., 2006, pp. 158-161 and pp. 206-211 revealed: *The implementation for applying eye drops was to put on gloves to prevent exposure to secretions from the eye. *The implementation for administering a subcutaneous injection was to put on gloves to prevent direct contact with body fluids.</p> <p>Surveyor: 35121 B. Based on record review, interview, and policy review, the provider failed to follow nursing professional standards by not ensuring a physician's order had been obtained for one of one resident (14) closed record review. Findings include:</p> <p>1. Review of resident 14's closed (no longer at</p>	F 281	<p>injections 2 episodes weekly with results reported by the DON at the quarterly CQI meeting for assessment of further needs.</p> <p>2. The order to release the body for resident # 14 was received by LPN E but it was not documented in the record. Since record is closed, for future resident deaths, education was done with nursing staff by DON by 4/20/15 to be sure to obtain an order from the Physician to release the resident's body to wherever it needs to go upon a resident's death. The Death of a Resident Checklist form was updated to include a check for order to release the body from the physician. Audits will be done on all future resident deaths for the 3 months by nursing staff</p>	
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F 281	<p>Continued From page 8 facility) medical record revealed: *He was admitted on 6/11/13. *He had died on 2/21/15. *The nursing note on 2/21/15 at 6:10 p.m. by licensed practical nurse E regarding his death revealed: -The resident stopped breathing. -An unidentified registered nurse noted no respirations or heart rate at that time. -She had left a message for the physician for an update. *The nursing note on 2/21/15 at 7:23 p.m. by RN F revealed the resident's body had been released to a funeral home. *The nursing note on 2/23/15 at 8:01 a.m. by the Minimum Data Set Assessment coordinator regarding his death on 2/21/15 revealed: -He had died in the facility. -The doctor pronounced his death at 6:10 p.m. -The funeral home had been there at 7:00 p.m.</p> <p>Interview on 4/8/15 at 11:30 a.m. with the director of nursing (DON) regarding resident 14's death and staff responsibilities revealed she had expected the nurse to have: *Called the physician to report the resident had no pulse or respirations. *Obtained an order from the physician to release the body.</p> <p>Interview on 4/8/15 at 2:20 p.m. with the DON regarding resident 14's death revealed she agreed: *There was no order to release the body in his chart. *There was no documentation to support an order to release the body had been obtained.</p> <p>Review of the provider's December 2014 Death</p>	F 281	<p>with results reported by the DON to the CQI Committee for assessment of further needs.</p> <p>Completed by 4/30/15</p>	
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F 281	Continued From page 9 of a Resident policy revealed "At the time of death the Nurse will obtain an order to release the body to the funeral home/Mortician."	F 281			
F 323 SS=D	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: 32331 Based on record review, interview, and policy review, the provider failed to ensure the care plans were followed for: *One of six sampled residents (7) who had a fall. Findings include: 1. Interview on 4/7/15 with resident 7's family member revealed she: *Had a fall on 4/5/15. *Was getting physically weaker. *Needed two staff to transfer her with the EZ [easy] lift (a mechanical lift). Review of resident 7's medical record revealed: *An admission date of 8/28/12. *Diagnoses included depressive disorder (an illness that involves body, mood, and thoughts), chronic (long lasting) pain, and history of accidental fall. *She had four falls since 4/29/14.	F 323	F323 - <u>PLAN</u> 1. According to CNA care plan for resident #7 the CNA did follow the care plan as the CNA care plan stated utilize 1-2 assist with stand lift or hoyer lift as needed. CNA care plan did not match paper care plan at time of incident which paper care plan had been updated to say utilize 2 assist at all times with stand lift or hoyer lift. Resident #7's paper and CNA care plan were updated on 4/15/15 to say hoyer lift only with 2 assist. Education was done by DON with CNA on		

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F 323	<p>Continued From page 10</p> <p>*Those falls had included:</p> <ul style="list-style-type: none"> -On 4/5/15, 4/30/14, and 4/29/14 she had been lowered to the floor. -On 2/20/15 she had slid out of her recliner. <p>*A physician's order on 8/28/12 and last updated on 3/3/15 for a "Care Plan: Implement care plan as written by interdisciplinary team."</p> <p>Review of resident 7's 2/25/15 Falls--Fall Risk assessment revealed:</p> <p>*She had:</p> <ul style="list-style-type: none"> -Intermittent confusion, poor recall (memory), judgement, and safety awareness. -Balance problem while standing. -A history of falls. <p>*She was at high risk for falls.</p> <ul style="list-style-type: none"> -Her total score was twenty-two, and that had put her at risk for falls. *A score of ten or higher represented a high risk for falls. <p>Review of resident 7's 3/13/15 care plan revealed:</p> <ul style="list-style-type: none"> *Goal for resident to be free from fall related injuries. *Activities of daily living (basic tasks of everyday life such as eating, bathing, dressing, toileting, and transferring) were extensive. *Utilize EZ stand lift for transfers. **Utilize EZ stand with 2 [two] for all transfers, may utilize hoyer [a type of mechanical lift] PRN [as needed] for weakness." *The handwritten cardboard copy of the Resident Care Plan in front of her typed care plan revealed: *Under the title Transfers: <ul style="list-style-type: none"> -Checked for gait belt (used to transfer a person from one position to another). -Checked for assist with one to two staff 	F 323	<p>4/10/15 regarding always getting updated information on the residents they are caring for. All CNAs were educated by DON by 4/20/15 for using right number of staff for lift device and using right lift. Education Coordinator works with Physical Therapist to do education routinely in her CNA meetings and yearly skills fair for safe transfers and use of lifts. Education was also done by DON on 4/10/15 with MDS Coordinator to ensure paper care plan matches CNA's care plan. Audits to be done by nursing staff of three</p>	

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F 323	<p>Continued From page 11 handwritten on that line. -Checked for lift with stand when needed handwritten on that line and the word "Hoyer" written below that line. *That area had been changed on 4/29/13, 6/18/13, 2/3/14, and 3/11/14 making it difficult to read.</p> <p>Review of resident 7's nurses' notes revealed: *On 3/30/15 licensed practical nurse (LPN) B wrote the Hoyer lift had been used for transfers and the wheelchair (w/c) for transportation. *On 4/5/15 LPN B at 4:35 p.m. revealed: *A certified nursing assistant (CNA): -Had been assisting her out of her bed using the stand lift. -She had started to raise her arms up high and her bottom "was sticking out." -The CNA had been unable to place her into the w/c, and she had been lowered her to the floor. -Her shoes had fallen off her feet. -Her catheter (tube into the bladder) had fallen out. *She had a 0.4 centimeter (cm) by 0.5 cm skin tear to her left great toe and a 0.4 by 0.2 cm skin tear to her second left toe. *A new catheter had been inserted without difficulty.</p> <p>Review of resident 7's 4/5/15 Fall Assessment Investigation Form revealed: *She had been laying in bed and had been awake and alert. *Her bed had been in the high position. *The CNA had been getting her up for the evening meal. *The CNA had strapped her in the stand lift. *She had been eased to the floor. *She had obtained two skin tears to her toes.</p>	F 323	<p>transfers weekly of manual or lift device transfers to ensure care plan is followed. Results of audits will be reported by DON to CQI Committee quarterly for further needs assessment.</p>	Complete by 4/30/15
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F 323	<p>Continued From page 12</p> <p>*Intervention had included educating staff to use two people with transfers.</p> <p>Review of resident 7's 2/25/15 Minimum Data Set (MDS) annual assessment and 12/23/14 MDS quarterly assessment sections C and G revealed she:</p> <p>*Had a Brief Interview for Mental Status (a test that helps determine a resident's cognitive [thinking] understanding) score of three that indicated severe impairment or loss.</p> <p>*She had needed extensive assistance (staff providing weight-bearing support) with two plus persons for:</p> <ul style="list-style-type: none"> -Bed mobility. -Transfer from one place to another. <p>Interview on 4/8/15 at 8:40 a.m. with the MDS coordinator regarding resident 7's 4/5/15 fall revealed:</p> <p>*She had a history of falls.</p> <p>*She was a fall risk.</p> <p>*She confirmed she had needed two staff to transfer on the EZ lift as per the written care plan.</p> <ul style="list-style-type: none"> -She stated the above had been typed on her care plan prior to her last fall on 4/5/15. -She was uncertain on the exact date the above had been placed on the written care plan. <p>*She agreed the care plan needed to have been followed.</p> <p>Interview on 4/8/15 at 1:15 p.m. with the DON regarding the care plans revealed:</p> <p>*The CNAs used the handwritten cardboard copy of the Resident Care Plan in front of the typed copy of each residents' care plan.</p> <p>*Those care plans were placed in a binder for each wing (north, south, and west).</p>	F 323		

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F 323	<p>Continued From page 13</p> <p>Interview on 4/8/15 at 3:35 p.m. with CNA A regarding resident 7 revealed:</p> <ul style="list-style-type: none"> *She was a fall risk *She was a one to two staff assist for transfers with the EZ lift. *The decision to have used one or two staff for a transfer was based on "how she was doing that day." <p>Interview on 4/8/15 at 3:15 p.m. with the DON and the licensed social worker (LSW) regarding resident 7 revealed:</p> <ul style="list-style-type: none"> *She had been physically weaker at times. *The interdisciplinary team (IDT) was responsible for the decision on the: <ul style="list-style-type: none"> -Type of transfer for each resident. -How many people were needed to have assisted with that transfer. *The provider's physical therapist assisted with decision making for the above as needed. *Both agreed the CNAs were responsible for following the written care plan. -That above care plan needed to have been updated and revised as needed. -Both confirmed the care plan for her needed to have been followed. <p>Review of the provider's revised December 2014 Falls, Risk, Promoting a Safe Environment policy revealed:</p> <ul style="list-style-type: none"> *The purpose was to have promoted a safe environment for cognitively (thinking) impaired residents. *Care planning was to have addressed specific interventions to decrease the risk of falls. *All residents were assessed quarterly with a fall risk assessment form and more often, if significant changes, for their risk for falls. *The IDT reviewed all resident's falls on a weekly 	F 323		

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F 323	<p>Continued From page 14 basis to review status, progress, and interventions to promote safety of residents. *Safety interventions would be implemented for the cognitively-impaired residents.</p> <p>Review of the provider's revised December 2014 EZ Stand Lift (operating instructions for) use revealed: *The EZ stand lift was designed to lift residents from a sitting position to a standing position, then transfer to a bed, chair, or toilet. *The lift was designed to be operated safely by one person, however, staff were to be encouraged to ask for assistance at any time.</p> <p>Review of the provider's December 2014 Care Plan policy revealed: **"Assessing and determining the interdisciplinary care for each resident will be timely, complete, and communicated to all persons involved in the care of that resident." **"A Registered Nurse coordinates each resident's assessment and care planning process." **"Care plans are individualized and incorporate daily routines, personal characteristics and considers resident/family expectations." **"The care planning process continues as goals are defined. Goals need to be realistic and measurable, include a time frame when appropriate, and will reflect the unique needs of the resident. Overall, maintaining the resident's optimal physical, psychosocial, and functional status while minimizing dependence is the ultimate objective."</p>	F 323	<p>F332 PLAN</p>	
F 332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of</p>	F 332	<p>1. It is noted that the eye drop bottle was small and hard which</p>	

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F 332	<p>Continued From page 15 medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29354</p> <p>Surveyor: 35120 Based on observation, record review, interview, and policy review, the provider failed to ensure medications were administered with less than 5 percent (%) medication error rate. The provider's medication error rate was 8% for 2 of 25 observed medications administered to two randomly observed residents (18 and 19). Findings include:</p> <p>1. Observation on 4/7/15 at 3:50 p.m. revealed registered nurse (RN) C administered two drops of artificial tears into resident 18's eyes.</p> <p>Review of resident 18's medical record revealed a physician's order for artificial tears one drop to each eye four times a day.</p> <p>Interview on 4/8/15 at 11:17 a.m. with RN C revealed he: *Knew he had administered more than one drop in each eye. *Had a hard time with making sure only one drop came out of the bottles as they were small and hard to handle.</p> <p>2. Observation on 4/7/15 at 5:45 p.m. revealed licensed practical nurse (LPN) B administered one tablet of calcium 600 milligrams (mg) with vitamin D 200 mg to resident 19.</p>	F 332	<p>occasionally made it difficult to administer only one eye drop. However, per manufacturer directions on eye drops for moisture, it says to give 1-2 eye drops per eye so there was no harm to the resident in receiving the extra drop. Education was done by DON for RN C on 4/8/15 on importance of administering eye drops per order. All nursing staff and medication aides were educated by DON by 4/20/15 to administer eye drops per order. Audits to ensure accuracy will be done of 2 medication</p>	
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F 332	<p>Continued From page 16</p> <p>Review of resident 19's medical record revealed a physician's order for calcium 600 mg with vitamin D 400 mg one tablet by mouth twice a day.</p> <p>Interview on 4/7/15 at 5:45 p.m. with LPN B revealed she:</p> <ul style="list-style-type: none"> *Had not looked at the dose on the bottle before administering the medication to resident 19. *Thought all the calcium with vitamin D medication bottles were the same dose as all the calcium with vitamin D orders were usually the 600 mg and 400 mg. *Had administered other doses out of the same bottle to other residents. <p>Interview on 4/7/15 at 5:50 p.m. with the director of nursing revealed:</p> <ul style="list-style-type: none"> *The nurses notified the pharmacist when the stock medications needed to be restocked. *Whoever checked in the stock medications were supposed to verify the correct dose. *She thought the pharmacist sent the provider what he wanted them to use for stock medications despite the physician's order. *She agreed the nurse should have checked the bottle to verify it had been the correct dose. <p>Review of the provider's February 2015 Medication Administration Record (MAR) policy revealed:</p> <ul style="list-style-type: none"> **"Locate medication and compare label with Medication Administration Record three times: <ul style="list-style-type: none"> -When removing from drawer. -Before pouring medication or removing from unit dose cassette. -Before administration." **Check medication against the MAR for the right resident, right medication, right dose, right time, 	F 332	<p>administration episodes by nursing staff weekly with results reported by DON at quarterly CQI Committee meeting for determination of further needs.</p> <p>2. Facility had only been receiving stock bottle of 600mg Calcium with Vitamin D 400mg before incident. After visiting with our pharmacist, DON was told pharmacy did send down stock bottle of 600mg Calcium with Vitamin D 200mg without alerting nursing staff of the difference. There was no harm done to resident in receiving the error in dosage. We now only</p>	
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F 332	Continued From page 17 and right route prior to administration."	F 332	receive 600mg Calcium with Vitamin	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	D 400mg stock bottles from Pharmacy and DON educated LPN B to check all medications against the resident MAR before administering on 4/7/15. DON also educated all nursing staff and medication aides by 4/20/15 on checking all medications against the resident MAR before administering to residents. Audits to ensure accuracy will be done of 2 medication administration episodes by nursing staff weekly with results reported by DON at quarterly CQI	

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F 332 F 441 SS=D	<p>Continued From page 17 and right route prior to administration."</p> <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 - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 332 F 441	<p>Committee meeting for determination of further needs.</p> <p>F441 PLAN</p> <p>1. Education was done on 4/8/15 by DON with RN C on correct procedure for cleaning of glucometer and caring of dirty glucometer. Education was also done with all nurses 1 on 1 by DON by 4/18/15 on proper procedure for cleaning of glucometer and caring of dirty glucometer. Bi-weekly audits of 2 episodes of glucometer use and</p>	Completed by 4/30/15
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2015
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NAME OF PROVIDER OR SUPPLIER SANFORD CARE CENTER VERMILLION	STREET ADDRESS, CITY, STATE, ZIP CODE 20 S PLUM STREET VERMILLION, SD 57069
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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
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F 441	<p>Continued From page 18</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29354</p> <p>Surveyor: 35120 Based on observation, interview, and policy review, the provider failed to properly clean a glucometer (device used to check blood sugar) after one of one resident use (17) according to manufacturer's instructions and facility policy. Findings include:</p> <p>1. Observation on 4/7/15 at 4:00 p.m. of registered nurse (RN) C revealed he: *Brought the glucometer into resident 17's room along with the carrying case it could be stored in. *Used the glucometer to check the resident's blood sugar. *Placed the used glucometer back into the carrying case that contained clean supplies. *Brought the carrying case into the medication room. *Removed the used glucometer and wiped it off with one Sani-cloth AF3 wipe. *Placed the glucometer into the docking station then walked away. *Had not cleaned the carrying case after removing the used glucometer from it.</p> <p>Interview on 4/7/15 at 4:15 p.m. with RN C revealed he was to use the Sani-cloth AF3 to clean the glucometer after he used it.</p> <p>Interview on 4/8/15 at 1:30 p.m. with the director of nursing revealed she: *Thought staff were to use the Sani-cloth AF3</p>	F 441	<p>cleaning for proper procedure by nursing staff with results reported by DON at quarterly CQI meeting for determination of further needs. Policy IC 3-15 Infection Control for Care Center Nursing was updated on 4/23/15 by DON to remove glucometer. Copy attached.</p>	<p>Completed by 4/30/15</p>
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER SANFORD CARE CENTER VERMILLION	STREET ADDRESS, CITY, STATE, ZIP CODE 20 S PLUM STREET VERMILLION, SD 57069
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F 441	<p>Continued From page 19</p> <p>wipes to disinfect the glucometer.</p> <p>*Agreed RN C should not have placed the glucometer in the carrying case before he had properly disinfected it.</p> <p>*Had confirmed the glucometer needed to stay wet for three minutes to be properly disinfected.</p> <p>*Agreed RN C had not properly disinfected the glucometer.</p> <p>Review of the provider's August 2013 Nova Meter Statstrip Policy-POCT glucose revealed: **"Do not spray the meter with a disinfectant solution. Apply the cleaning agent to a soft cloth to wipe the meter surface. i.e.. Saniwipes."</p> <p>Review of the Sani-cloth AF3 germicidal disposable wipes manufacturer's instructions revealed: **"Wipe surface with towelette until clean. *Let air dry. *For disinfecting hard non-porous surfaces, use a wipe to remove heavy soil. *Unfold a clean wipe and thoroughly wet surface. *Treated surface must remain visibly wet for a full three minutes. *Use additional wipes if needed to assure continuous three minute wet contact time."</p> <p>Review of the provider's March 2015 Infection Control in Care Center Nursing Services policy revealed: **Thermometers. *Blood Pressure Cuffs. *Stethoscopes *Otosopes/Ophthalmoscopes. *Glucometers. *Bandage Scissors. *These items should be cleaned with 70% alcohol wipes at least daily."</p>	F 441		
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NAME OF PROVIDER OR SUPPLIER SANFORD CARE CENTER VERMILLION	STREET ADDRESS, CITY, STATE, ZIP CODE 20 S PLUM STREET VERMILLION, SD 57069
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A098	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2015
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NAME OF PROVIDER OR SUPPLIER SANFORD CARE CENTER VERMILLION	STREET ADDRESS, CITY, STATE, ZIP CODE 20 S PLUM STREET VERMILLION, SD 57069
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 4/8/15. Sanford Care Center Vermillion was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE	(X6) DATE 5/22/15
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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.

MAY 22 2015
If continuation sheet Page 1 of 1
SD DOH LSC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10697	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/08/2015
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S 000	<p>Initial Comments</p> <p>Surveyor: 29354 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 4/7/15 through 4/8/15. Sanford Care Center Vermillion was found in compliance.</p>	S 000		

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

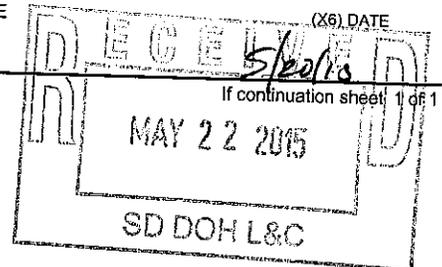
TITLE

(X6) DATE

STATE FORM

6899

QXM811



If continuation sheet 1 of 1