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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 01/27/2016 |
| NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE COMMUNITY | | | STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028 | |
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| F 000 | <p><i>* Addendum noted with an asterisk per 3/13/16 per telephone with facility administrator. DK/SDDOHJEL</i></p> <p>Surveyor: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/26/16 through 1/27/16. Riverview Healthcare Community was found not in compliance with the following requirements: F159, F164, F176, F241, F246, F248, F250, F280, F281, F283, F311, F314, F325, F371, and F441.</p> | F 000 | <p>Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.</p> | |
| F 159 SS=E | <p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> | F 159 | <p>F159</p> <p>1. Residents 1, 4, 9, 15, 17, 18, 19, 20, 21, and 22 with \$50.00 or greater in the trust account is banked in an interest bearing account. All residents are at risk.</p> | 3/15/16 |

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

TITLE

(X6) DATE

[Signature]

Administrator

2/19/16

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.

FEB 22 2016

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| F 159 | <p>Continued From page 1</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 36413 Based on resident trust account ledger review, interview, and resident handbook review, the provider failed to ensure one of one trust account was interest bearing for 10 of 19 residents' (1, 4, 9, 15, 17, 18, 19, 20, 21, and 22) accounts with balances exceeding \$50.00. Findings include:</p> <p>1. Interview on 1/27/16 at 1:30 p.m. with the business office manager revealed: *The above ten residents had more than \$50.00 in their current trust accounts. *The trust accounts were not interest bearing. *The arrangement they had with their bank had not included an interest bearing account for their residents trust accounts. *Previously they had not allowed residents to</p> | F 159 | <p>2. The Administrator has educated the Business Office Manager on the requirement for interest bearing accounts.</p> <p>3. The Administrator or designee will audit four trust accounts to ensure those with \$50.00 and greater have their funds in an interest bearing account. Audits will continue for four weeks and then monthly thereafter. Audit will be discussed by the Administrator in monthly Quality Assurance Process Improvement (QAPI) for review and recommendations of continuation/discontinuation of monthly audit.</p> <p>4. March 15, 2016</p> | | |

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| F 159 | Continued From page 2 have accounts in access to \$50.00. | F 159 | | | |
| F 164 SS=D | <p>Review of the resident handbook given to residents at admission revealed "Resident fund accounts may be set up with our office manager and will be placed in an interest bearing account if the amount accrued exceeds a \$50.00 amount."</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> | F 164 | <p>F164</p> <p>1. No immediate corrective action could be taken for affected residents. Nurses were educated on practice at time of survey. All residents are at risk.</p> <p>2. The Director of Nursing (DON) will educate all nurses and medication aides on ensuring privacy when using the Medication Administration Records (MARs). Education will be completed no later than February 25, 2016. Those staff not in attendance will be educated prior to their next shift worked.</p> <p>3. The DON or designee will audit four random medication passes per week for four weeks to ensure the MAR is not left open and unattended. After four weeks, audits will be conducted monthly. Audit will be discussed by the DON in monthly QAPI for review and recommendations of continuation or discontinuation of monthly audit.</p> <p>4. March 15, 2016</p> | 3/19/16 | |

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| F 164 | Continued From page 3 This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on observation, interview, and policy review, the provider failed to ensure the confidentiality of the residents' medication administration records (MAR) had been maintained during four of four medication administrations by one of three staff (registered nurse [RN] A) passing medications. Findings include: 1. Observation on 1/26/16 from 5:30 p.m. thorough 6:00 p.m. in the alternative dining room revealed: *At 5:35 p.m. and at 5:52 p.m. the MAR was left open on two of two medication carts while RN A walked away to deliver medication to a resident. *At 5:45 p.m. and at 5:50 p.m. the MAR was left open on one of two medication carts while RN A walked away to deliver medication to a resident. *During the above times the MAR had been visible for anyone to read. *Residents, staff members, and visitors had been walking in the area of those carts during the above times. Interview on 1/26/16 at 5:55 p.m. with RN A regarding the MAR being left open on the above times revealed no explanation was given for that practice. Interview on 1/27/16 at 3:50 p.m. with the director of nursing revealed it was her expectation the information of the MAR be kept private. The MAR binder should have been closed when the staff walked away from the medication cart. | F 164 | | | |

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| F 164 | Continued From page 4 Review of the provider's undated Use and Disclosure of Health Information policy revealed: *"Facility respects the importance of its residents' personal privacy, and understands the sensitive nature of its residents' health information." *"It is Facility's policy not to use or disclose a resident's health information except as permitted by law, and to adopt safeguards to protect the confidentiality of its residents' health information." | F 164 | | |
| F 176 SS=D | 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Surveyor: 32335 Based on observation, record review, interview, and policy review, the provider failed to thoroughly assess one of one sampled resident (7) to self-administer a nebulizer (breathing) treatment. Findings include: 1. Observation on 1/26/16 at 9:05 a.m. of resident 7 revealed she had been laying in bed with her eyes closed. A nebulizer mask was on her face and, the machine was running. Review of resident 7's undated care plan revealed: *She had been admitted into the hospital on 1/22/16 for cough and congestion. | F 176 | F176 1. No immediate correction could be taken for Resident #7. Resident 7 has been assessed for self-administration of medications. All residents are at risk <i>*and have been assessed for self-administration.</i> 2. The DON will educate all nurses and <i>DR/SDD/TEL</i> medication aides on the Self-Administration of Medication Policy no later than February 25, 2016. Those who are not in attendance during education meeting will receive education prior to their working their next scheduled shift. 3. The DON or designee will audit 4 random medication passes per week to ensure medications are not left with residents who do not have a self-administration of medication assessment <i>*and ← MD order.</i> This audit will occur weekly for 4 weeks and then monthly thereafter. Audit will be brought to the monthly QAPI meeting by the DON for review/recommendations for continuation or discontinuation of monthly audit. 4. March 15, 2016 | <i>3/15/16</i> |

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| F 176 | <p>Continued From page 5</p> <p>*She returned to the facility on 1/24/16 with a diagnosis of pneumonia.</p> <p>*The interventions listed included:</p> <ul style="list-style-type: none"> -Medications as ordered. -Nebulizer as ordered. -May self-administer with mask. -Encourage fluids. -Ambulate short distances with assistance. -Encourage to cough and deep breath. -Monitor vital signs and for signs of congestion. Report to primary care physician if needed. -Monitor for proper usage and report changes. -Set-up by nurse or medication aide following nebulizer policies. <p>Review of resident 7's 11/24/15 Minimum Data Set assessment revealed her Brief Interview for Mental Status score was a 2. A score of 0 to 7 indicated severe cognitive impairment.</p> <p>Review of the 1/25/16 self-administration medication review for resident 7 revealed she had been "deemed appropriate to self medicate [with] nebulizers per mask by IDHCT [interdisciplinary health care team] after appropriate set up by med [medication] nurse/MTA following infection control procedures." There had been no mention of her cognitive impairment.</p> <p>Surveyor: 35625 Observation on 1/26/16 at 2:15 p.m. with licensed practical nurse (LPN) H regarding resident 7's nebulizer treatment revealed:</p> <ul style="list-style-type: none"> *The mask was placed on the resident's face. *Step-by-step details were given to the resident about the nebulizer treatment including the need to keep the mask in place. *The resident did not verbalize understanding of the information. | F 176 | | | |

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| F 176 | Continued From page 6 *At the conclusion of the medication delivery LPN H removed the mask as the resident had fallen asleep. Surveyor: 32335 Interview on 1/27/16 at 2:00 p.m. with the director of nursing revealed she felt it was okay for resident 7 to self-administer the nebulizer treatment. She stated the resident would not take off the mask. She agreed her cognitive ability was impaired. She stated the nurse would set a timer to return to shut off the machine. Review of the provider's March 2015 Nebulizer Administration policy revealed the nurse should have: *Instructed the resident to take deep breaths, pause briefly, then exhale normally, and to repeat the pattern throughout the treatment. *Remained with the resident for the treatment unless the resident had been assessed and authorized to self-administer. *Encouraged the resident to cough and expectorate (spit out phlegm) as needed. *Administered therapy until medication was gone (mist had stopped) or until the designated time of treatment had been reached. | F 176 | | | |
| F 241 SS=D | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: | F 241 | F241 1. Proper fitting clothing were obtained for Resident 6 at the time of survey. No immediate correction could be taken for residents 7, 10, 16, and 17 who did not get their meal at the same time. All residents are at risk. | 3/15/16 | |

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| F 241 | <p>Continued From page 7 Surveyor: 33265</p> <p>A. Based on observation and interview, the provider failed to ensure 1 of 13 sampled residents (6) had proper fitting clothes and was fully dressed. Findings include:</p> <p>1. Observation on 1/26/16 at 1:48 p.m. in resident 6's room during a repositioning in the wheelchair revealed the two certified nursing assistants (CNA) I and J: *Used a lift to raise resident 6 up out of wheelchair. *Left the top of the resident's sweat pants below his buttocks when he was raised up in the lift. *Straightened the incontinent pad in the wheel chair. *Lowered the resident back into the wheelchair. *Had not pulled the sweat pants up to fit around the resident's waist. *Had not checked to be sure no skin was visible.</p> <p>Observation on 1/27/16 at 9:30 a.m. in resident 6's room during care revealed CNAs K and L: *Rolled the resident onto his right side. *Completed his care. *Left sweat pants down under his buttocks area. *Rolled the resident back onto his back.</p> <p>Interview on 1/27/16 at 1:50 p.m. with CNA K regarding resident 6 revealed she: *Tried to get the sweat pants with the slits in them, so they would fit the resident. *Had seen others use too small of sweat pants and leave the sweat pants down under the resident's buttocks. *Thought some left the sweat pants down, so it was easier to keep the resident clean.</p> <p>Interview on 1/27/16 at 3:55 p.m. with the director</p> | F 241 | <p>2. The Administrator will educate all staff on dignity, including ensuring all residents have proper fitting clothing (no skin showing) and that tablemates are served at the same time so that they may eat together. Education will occur no later than February 25, 2016. Those staff not in attendance will be educated prior to their next shift worked.</p> <p>3. The Administrator or designee will conduct walking rounds within the facility 4 times a week at various times and four meal times per week to ensure dignity is maintained and residents have proper fitting clothing and tables are served at the same time at meals. This audit will occur weekly for 4 weeks and then monthly thereafter. Audit will be brought to the monthly QAPI meeting by the Administrator for review and recommendations of continuation or discontinuation of the monthly audit.</p> <p>4. March 15, 2016</p> | |

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| F 241 | <p>Continued From page 8 of nursing (DON) regarding resident 6 revealed she:</p> <ul style="list-style-type: none"> *Was not aware the sweat pants were not being pulled up to fit around the resident's waist. *Was sure they had pants with slits that fit the resident. *Agreed it was a dignity issue, the resident should be wearing clothes that fit, so he was able to be fully dressed. <p>Surveyor: 32335 B. Based on observation, interview, and policy review, the provider failed to serve a supper meal in a timely manner to four of four residents (7, 10, 16, and 17) sitting at the same table in the alternative dining room. Findings include:</p> <ol style="list-style-type: none"> 1. Observation on 1/26/16 from 5:00 p.m. through 5:50 p.m. in the alternative dining room revealed: <ul style="list-style-type: none"> *Residents 7, 10, 16, and 17 were all sitting at one table. *At 5:10 p.m. resident 17 had been served her food. <ul style="list-style-type: none"> -She had assistance from staff at lunch, but there was no staff assisting her for the supper meal. *At 5:16 p.m. resident 7 had been served her food. <ul style="list-style-type: none"> -She was on the restorative dining program and required assistance, but there had not been any staff available to assist her. *At 5:22 p.m. resident 10 had been served. *At 5:25 p.m. resident 16 was served her meal. <p>Interview on 1/26/16 at 5:51 p.m. with an unidentified certified nursing assistant (CNA) revealed:</p> <ul style="list-style-type: none"> *The trays had been delivered in a silver tall container. | F 241 | | |

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| F 241 | Continued From page 9 *There were four CNAs who were in the dining room passing trays. *There were no dietary staff assisting them. *There was no organization to the trays in the silver container. *They had to serve the trays before they could assist the residents. Interview on 1/27/16 at 2:00 p.m. with the director of nursing (DON) revealed she would have expected all residents at one table to be served at the same time. Review of the provider's January 2014 Quality of Life - Dignity policy revealed each resident should have been cared for in a manner that promoted and enhanced quality of life, dignity, respect, and individuality. | F 241 | | |
| F 246 SS=D | 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, and record review, the provider failed to ensure one of one resident (6) had a wheelchair that fit and supported his body. Findings include: | F 246 | F246 1. Resident 6 was assessed by Physical Therapy for wheelchair positioning at the time of survey. All residents who utilize wheelchairs are at risk. <i>*and have been assessed.</i> 2. The DON will educate all staff on <i>OH/SDRCHIEL</i> ensuring resident positioning in wheelchairs is maintained and to report any deviations (residents leaning, slumping, slouching, constant self-repositioning, complaints of discomfort, etc). The education will occur no later than February 25 2016. Staff not in attendance will be educated prior to their next scheduled shift. | 3/15/16 |

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| F 246 | <p>Continued From page 10</p> <p>1. Observation on 1/26/16 at 11:00 a.m. of resident 6 in his wheelchair revealed he: *Was slouched in the wheelchair at an almost straight line with head and back bent backwards over the backrest of the wheelchair and feet elevated. *Was having a difficult time eating his food. *Had part of his skin on his lower abdomen showing. *Ate with his right hand while his left arm hung at the side of the wheelchair. *Had half length wheelchair arm rests, not full length arm rests.</p> <p>Observation on 1/26/16 from 12:35 p.m. to 1:45 p.m. of resident 6 in his wheelchair revealed he: *Was in the same slouched position at a slant. *Continued to have difficulty eating while in that position. *Was asked by licensed practical nurse (LPN) H if he was comfortable, and he responded "no."</p> <p>Observation and interview on 1/26/16 from 1:45 p.m. to 2:00 p.m. of resident 6 revealed: *He was transported back to his room. *His seat belt was then unbuckled. *He was raised out of his wheelchair by certified nursing assistants (CNA) I and J using a lift. *Pyramid shaped side supports were on each side of the wheelchair backrest. Straps secured up and around the wheelchair backrest held the side supports in place. *A cushion was in the seat of the wheelchair. *He was lowered back into the wheelchair. *His seat belt was refastened. *He stated he was six feet five inches tall. *He was returned to the dining room to eat his lunch. *He was back in the same slouched position at a</p> | F 246 | <p>3. DON or designee will audit 4 random residents in wheelchairs each week to ensure resident is positioned properly. This audit will occur weekly for 4 weeks and then monthly thereafter. Audit will be brought to the monthly QAPI meeting by the DON for review and recommendations of continuation or discontinuation of monthly audit.</p> <p>4. March 15, 2016</p> | | |

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| F 246 | <p>Continued From page 11 slant even after the above repositioning.</p> <p>Interview on 1/26/16 at 4:30 p.m. with the director of nursing (DON) regarding resident 6 revealed: *She had not noticed the resident being in a slouched position. *She would contact the physical therapist (PT). *There was no policy on positioning in a wheelchair.</p> <p>Observation on 1/27/16 at 7:45 a.m. of resident 6 in his room revealed: *He was in his bed with his eyes closed. *His wheelchair was in his room by the doorway. *The straps used to hold the side supports in place in the wheelchair seat went over the wheelchair backrest and pulled the backrest from a height of thirteen inches down to eleven and one-half inches. *The inner width of the wheelchair was reduced from twenty-two inches to eleven inches with the side supports in the back corners.</p> <p>Observation and interview on 1/27/16 at 8:10 a.m. with resident 6 revealed he was in his bed and he had no idea where his wheelchair was as it was not in his room.</p> <p>Observation and interview at 1/27/16 at 8:35 a.m. with CNA L revealed: *He was returning resident 6's wheelchair to his room. *Physical therapist (PT) M had requested the wheelchair be brought down to the physical therapy department.</p> <p>Observation and interview on 1/27/16 at 8:40 a.m. with PT M in the physical therapy department regarding resident 6's wheelchair</p> | F 246 | | | |

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| F 246 | <p>Continued From page 12</p> <p>revealed he:</p> <ul style="list-style-type: none"> *Had requested the resident's wheelchair to review. *Believed the resident fit in the chair. *Had observed the resident in the wheelchair on 1/25/16 and had noted no issues. *Agreed to look at the resident's positioning in the wheelchair with the present side supports and leg rests after the resident was placed in his wheelchair. <p>Interview on 1/27/16 at 11:08 a.m. with PT M regarding resident 6 revealed:</p> <ul style="list-style-type: none"> *He agreed the resident's wheelchair fit needed to be re-evaluated. *He was going to do the re-evaluation tomorrow. *He agreed the backrest had not reached the mid-scapular region (shoulder blade) on the resident. *He had changed one foot rest this morning and would look at support for the left arm. <p>Interview on 1/27/16 at 3:55 p.m. with the DON revealed she:</p> <ul style="list-style-type: none"> *Was aware of the PT's plan to re-evaluate resident 6's positioning and fit in his present wheelchair. *Believed they had a system in place to identify the repositioning needs of residents. <p>Review of resident 6's complete medical record revealed:</p> <ul style="list-style-type: none"> *He had had a stroke that left him with decreased ability to use his left arm and leg. *Was six feet five inches tall. *Had a physical therapy evaluation on 8/24/15 when staff reported: -He was "sliding out of his chair due to inability to flex his knees." | F 246 | | |

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| F 246 | Continued From page 13 -"Patient [resident] was sitting in WC [wheelchair] with knees full extended and elevated causing sacral sitting and slouching during meals." -He was sent to restorative nursing for "stretching program to aid in seated resting position." | F 246 | | | |
| F 248 SS=D | 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, record review, interview, and policy review, the provider failed to ensure 2 of 13 sampled residents (5 and 7) received activity programming based on their assessed recreational interests and needs. Findings include: 1. Random observations and interview of resident 5 on 1/26/16 from 8:30 a.m. through 6:00 p.m. revealed she: *Spent all day in her room sitting in a chair facing the door. *Had a TV in her room that never was turned on. -The chair she sat in did not face the TV and required her to turn her head to see it. -Liked to watch TV. *Had a book next to her in her chair but did not read. *Had her eyes closed a lot but woke up when spoken to. | F 248 | F248 <i>DR/SDDOTTEL</i> *5 1. Residents <input type="checkbox"/> and 7 are receiving activity programming based on their assessed recreational interests and needs. All residents are at risk. <i>*and have been assessed.</i> <i>DR/SDDOTTEL</i> 2. The Administrator will educate the Activity Coordinator and Activity Aides on ensuring program activities are based on their assessed interests and needs/abilities and that care plan is reflective of this. All staff will be educated on meaningful activities. Education will occur no later than February 25, 2016. Those not in attendance will be educated prior to their next scheduled shift. 3. The Administrator or designee will audit four resident's activities at random times and places to ensure activities are of their interest and ability and care plan is up to date. Audits will continue for four weeks and then monthly thereafter. Audit will be discussed by the Administrator in monthly QAPI for review and recommendations of continuation or discontinuation of monthly audit. 4. March 15, 2016 | 3/15/16 | |

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| F 248 | <p>Continued From page 14</p> <p>*Liked visitors and encouraged this surveyor to visit her more.</p> <p>*Had four cats when she was at home and liked cats. The facility cat spent a lot of time in her room with her roommate. She had not interacted with the cat, because the cat went right over to her roommate.</p> <p>Review of resident 5's 12/1/15 admission activity assessment revealed she:</p> <p>*Loved to read and do crossword puzzles.</p> <p>*Enjoyed all types of music.</p> <p>*Liked to write cards and notes.</p> <p>*Was active in her faith that was important to her.</p> <p>*Liked visitors.</p> <p>*Enjoyed feeling needed.</p> <p>Review of resident 5's 12/10/15 care plan revealed:</p> <p>***Activities she pursued independently including relaxing in her room in her chair, reading the newspaper and lots of books of all kinds. She also enjoyed watching tv."</p> <p>*Staff were to encourage her to come to activities.</p> <p>Review of resident 5's participation records revealed:</p> <p>*In November following her 11/23/15 admission she attended one musical activity.</p> <p>*In December 2015 she attended one to two musical programs per week</p> <p>*In January she refused everything she was invited to.</p> <p>*The record of individual programs with her only reflected staff invited her to activities, and she declined the offer.</p> <p>-There was no indication they had tried to involve her in activities that had meaning to her in her room, such as reading, devotions, pastoral visits,</p> | F 248 | | |

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| F 248 | <p>Continued From page 15</p> <p>crossword puzzles, or just visiting with her. *There was no documentation since admission that she had been encouraged to attend any of the church services.</p> <p>Interview on 1/27/16 at 9:00 a.m. with the activity coordinator regarding resident 5 revealed she: *Used to come out to activities, but she had not been doing that anymore. *She refused and could sometimes get upset with her staff when they approached her about coming out. *She confirmed they had not done individual programming with her in her room, other than ask her to come to activities. *They had made sure she had books in her room but were unsure if she had read them. *She confirmed she was pretty isolated in her room and was sad about being here. *Thought the resident would like the cat in her room, but she knew the cat was pretty attached to her roommate. *Agreed the way the resident sat in her chair was not agreeable to watching TV, but thought that was the resident's preference.</p> <p>Surveyor: 32335 2. Observation on 1/26/16 from 11:10 a.m. through 12:30 p.m. of resident 7 revealed she: *Had been in the activity room. *Was pushed up to the table where they were playing bingo. *Had cards in front of her. *Was the eighth person down from the activity assistant. *Had not turned over a card once during the time of the activity. *Was staring away from the table and looking</p> | F 248 | | |

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| F 248 | <p>Continued From page 16 around the room.</p> <p>Observation on 1/26/16 at 3:00 p.m. of resident 7 revealed she was sitting in the activity room listening to the music.</p> <p>Review of resident 7's 11/24/15 Minimum Data Set (MDS) assessment revealed: *Her Brief Interview for Mental Status score was a 2. A score of 0 to 7 indicated severe cognitive impairment. *Religion was very important to her. *Reading, music, and doing her favorite things was somewhat important to her. *The news, being outside, or being in groups was not very important to her.</p> <p>Review of resident 7's undated care plan revealed staff were to provide one-to-one attention/assistance to help plan her daily activities.</p> <p>Interview on 1/27/16 at 2:00 p.m. with the DON revealed she was unsure if resident 7 was supposed to get one-to-one activities. She would not have been able to flip over the cards during the bingo game based on her cognitive ability. She really liked to visit. She had a counselor from an outside agency, but they had recently stopped coming. She really enjoyed talking with that counselor.</p> <p>Interview on 1/27/16 with the activity director revealed resident 7 was not on a one-to-one program. She observed group activities but did not participate. She did like to visit and talk with staff. She agreed one-to-one individualized programming would fit her cognitive level.</p> | F 248 | | |

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| F 248 | Continued From page 17 3. Review of the provider's September 2013 Providing Meaningful Activities policy revealed: *"Each resident will be assessed upon admission and no less than quarterly or with a significant change in condition to determine the most desirable and appropriate activities for that resident. *Special attention will be made for resident activities when the resident is isolated due to medical condition or those who may tend to isolate by choice. The plan for these residents will be 1:1 [one-to-one] visits no less than weekly and items for independent activities of their choice will be provided if desired." **Changes to activity programs offered will be discussed at the resident care conference to assure resident continues to be satisfied with their program. | F 248 | | |
| F 250 SS=D | 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, record review, interview, and job description review, the provider failed to ensure medically related social services was provided to one of seven sampled residents (5) who exhibited signs of depression. Findings include: | F 250 | F250 1. Resident 5 has had a social service assessment. All residents are at risk. 2. The Administrator has in-serviced the Social Service Designee on ensuring documentation addresses adjustment to the facility and any changes of condition. 3. The DON or designee will audit four random residents each week to ensure adjustment to the facility is addressed in social service notes and care plan and that any changes of condition that affect mood or behavior are documented. Audits will continue for four weeks and then monthly thereafter. Audit will be discussed by the DON in monthly QAPI for review and recommendations of continuation or discontinuation of monthly audit.*and have been assessed. Dh/SDDOTTEL 4. March 15, 2016 | 3/15/16 |

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| F 250 | <p>Continued From page 18</p> <p>1. Random observations and interview of resident 5 on 1/26/16 from 8:30 a.m. through 6:00 p.m. revealed she:</p> <ul style="list-style-type: none"> *Spent all day in her room sitting in a chair facing the door. *Had her eyes closed quite often. *Had a TV in her room that never was turned on. -The chair she sat in did not face the TV and required her to turn her head to see it. *Had her eyes closed a lot but woke up when spoken to. *Immediately stated in the interview "I'm homesick" and repeated that several times along with saying she wanted to be home. -She understood why she needed to be in the nursing home, but still wanted to be home. *Had no appetite and was not hungry. *Had delayed response to questions. *At meals she did not interact with her tablemates, and appeared uninterested in those around her by looking toward the window. <p>Review of resident 5's entire medical record revealed:</p> <ul style="list-style-type: none"> *She had been admitted on 11/23/15. *Since admission she had lost ten pounds and had not been eating well. *When she was first admitted she went to some activities, but she was not interested in going to anything anymore. *On 1/21/16 she was started on Remeron (medication for depression and to help with appetite). <p>Review of resident 5's 11/30/15 admission Minimum Data Set (MDS) assessment revealed she felt down (depressed).</p> <p>Review of resident 5's 12/10/15 care plan had a</p> | F 250 | | |

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| F 250 | <p>Continued From page 19</p> <p>goal "To be comfortable and accepted in my living environment" but had no specific approaches to assist in that goal.</p> <p>Review of resident 5's social services progress notes from admission on 11/23/15 through 1/26/16 revealed there was nothing documented that addressed her adjustment to the nursing home. They had not addressed her acceptance of the need for placement.</p> <p>Interview on 1/27/16 at 8:30 a.m. with the social services designee (SSD) regarding resident 5 revealed:</p> <ul style="list-style-type: none"> *The social history that had been completed at the time of admission had not been completed very thoroughly. *Since her admission they had noted she was more withdrawn and appeared depressed. *If an MDS had been completed on her today she would have assessed her with the following mood issues: <ul style="list-style-type: none"> -Having little interest or pleasure in doing things. -Feeling down. -Poor appetite. *She had become more quiet and isolated since she had bronchitis shortly after admission. *She confirmed the resident was having a difficult time accepting the nursing home placement. *She had not spent a lot of time visiting with this resident, and had not established the relationship with her that she should have. *She confirmed the resident could have benefited from additional visits. *She was unaware the resident said she was homesick but knew she wanted to go home. *They had talked about making a referral for a mental health evaluation, but that had not been followed through at this point. | F 250 | | |

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| F 250 | Continued From page 20 *The SSD had a social work consultant, but they had never discussed resident 5. Review of the provider's April 2012 social service director job description revealed: *Duties and Responsibilities: "Assist resident in achieving and maintaining their maximum psychosocial functioning and independence." *Duties: Assist resident in dealing with feelings about grief, depression, disability, death, dying, or other emotional, mental, environmental, or physical limitations. *Develop relationship with resident and family and provide or arrange for provision of needed counseling services. *Observe, record, and notify staff of changes in attitude, behavior or personality especially depression, anxiety, withdrawal and uncontrolled aggression. *Find options which best meet the physical and emotional needs of the resident." | F 250 | | | |
| 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 | F 280 | F280 1. Residents 3 and 5 have had their care plan updated. All residents are at risk *and have been assessed. DV/SDDO/H/EL 2. The DON and Interdisciplinary Team have reviewed the Care Plan policy and reviewed the cited deficiency. The DON or designee will educate all staff on care plans and ensuring they are kept accurate and up to date with each resident's individual needs by February 25, 2016. Those not in attendance will be educated prior to their next scheduled shift. | 3/19/16 | |

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| F 280 | <p>Continued From page 21 the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, observation, interview, and policy review, the provider failed to ensure 2 of thirteen sampled residents' (3 and 5) care plans were revised as changes in needs occurred. Findings include:</p> <p>1. Review of resident 5's entire medical record revealed: *She had been admitted on 11/23/15. *Since admission she had lost ten pounds and had not been eating well. *When she was first admitted she came to some activities, but she was not interested in coming to anything anymore. *On 1/21/16 she was started on Remeron (medication for depression and to help with appetite).</p> <p>Random observations and interview of resident 5 on 1/26/16 from 8:30 a.m. through 6:00 p.m. revealed she: *Spent all day in her room sitting in a chair, facing the door. *Had a TV in her room that never was turned on. -The chair she sat in did not face the TV and required her to turn her head to see it. *Stated in the interview "I'm homesick" and repeated that several times along with saying she</p> | F 280 | <p>3. DON or designee will audit 4 care plans per week to ensure that the care plan reflects the care and services provided to the resident. This audit will be done weekly for 4 weeks and then monthly thereafter. Audit will be brought to QAPI by the DON for review and recommendations of continuation or discontinuation.</p> <p>4. March 15, 2016</p> | |

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| F 280 | <p>Continued From page 22 wanted to be home. *Had no appetite and was not hungry. *She was drinking an Equate nutritional supplement, and she was seen eating a muffin and a cookie. *Ate very little during the noon and evening meal on 1/26/15. *Ate two plates of pancakes for breakfast on 1/27/15 and said she loved pancakes.</p> <p>Review of resident 5's 11/30/15 admission Minimum Data Set (MDS) assessment revealed: *Her mood was she felt down (depressed). *She enjoyed books, newspapers, getting outside, and religious programs. *Her current weight was 95 pounds.</p> <p>Interview on 1/27/16 at 8:30 a.m. with the social services designee (SSD) regarding resident 5 revealed: *Since her admission they had noted she was more withdrawn and appeared depressed. *Her mood issues at this time included: -Having little interest or pleasure in doing things. -Feeling down. -Poor appetite. *She confirmed the resident was having a difficult time accepting nursing home placement. *They had talked about making a referral for a mental health evaluation, but that had not been followed through at this point.</p> <p>Interview on 1/27/16 at 9:00 a.m. with the activity coordinator regarding resident 5 revealed she: *Used to come out to activities, but she had not been doing that anymore. *She refused and sometimes got upset with her staff when they approached her about coming out.</p> | F 280 | | |

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| F 280 | <p>Continued From page 23</p> <p>*She confirmed they had not done individual programming with her in her room, other than ask her to come to activities.</p> <p>*They had made sure she had books in her room but were unsure if she had read them.</p> <p>*She confirmed she was pretty isolated in her room and was sad about being here.</p> <p>*She liked to walk.</p> <p>Review of resident 5's weight records revealed she weighed ninety-eight pounds (lb) at admission on 11/23/15. Her most recent recorded weight on 1/18/16 was eighty-eight lb, a ten pound weight loss.</p> <p>Random review of resident 5's December 2015 and January 2016 food intake record revealed she ate between 25 - 100% at meals.</p> <p>Review of resident 5's 1/11/16 nutritional assessment revealed: *She received a Hormel (brand of nutritional drink) supplement twice a day, but the dietitian had recommended she receive it three times a day. *They should provide additional calories by offering whole milk at meals.</p> <p>Review of resident 5's 12/10/15 care plan revealed: *It did not address: -The mood changes she exhibited, and that she was showing signs of depression. -She was not participating in group activities, and she would have benefited from individual programming. -She had lost weight and continued to lose weight. -She liked pancakes.</p> | F 280 | | |

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| F 280 | <p>Continued From page 24</p> <p>-She should have had whole milk at meals and other add-ins to food to increase caloric intake. -She liked to walk. -She was on an antidepressant.</p> <p>Surveyor: 32331 2. Observation on 1/26/16 at 12:30 p.m. at the noon meal and at 5:35 p.m. at the evening meal of resident 3 revealed: *She had received three glasses of thickened liquids at each meal. *She had not received a nose cup (a formed cup with a cut-out rim) to use for those liquids.</p> <p>Review of the provider's undated resident 3's diet card had listed special items that had included a nose cup with her meals.</p> <p>Observation and interview on 1/26/16 at 5:50 p.m. with certified nursing assistant (CNA) C revealed: *She was assisting resident 3 with eating. *She was spooning her nutritional supplement to her. *She stated the resident preferred a spoon over the use of a nose cup for her liquids.</p> <p>Interview on 1/27/16 at 1:45 p.m. with the dietary manager regarding resident 3 revealed she had been preferring a spoon over the use of a nose cup for her liquids.</p> <p>Review of resident 3's revised 12/9/15 care plan revealed: *Staff were to have ensured her assistive devices were available to use at every meal. *Those assistive devices had included a nose cup for liquids.</p> | F 280 | | |

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| F 280 | <p>Continued From page 25</p> <p>Review of the provider's 1/27/16 Weight Summary Report revealed resident 3's current weight for the week of 1/20/16 was 103 lb.</p> <p>Review of resident 3's revised 12/9/15 care plan revealed: *She had a goal to maintain nutritional status by maintaining weight. *Interventions had included: -Monitor her weight. -Current weight was documented at 107 lb. *The above weight was 4 lb less than the weight that had been documented on her current care plan.</p> <p>3. Interview on 1/27/16 at 1:45 p.m. with the dietary manager regarding updating care plans revealed she had thought it was nursing's responsibility to have updated the care plans.</p> <p>Interview on 1/27/16 at 3:15 p.m. with the social services designee revealed: *Each team member of the care plan team was responsible for updating the care plan. *Any updates between quarterly care plan updates were to have been done by the department responsible for that portion of the care plan.</p> <p>Interview on 1/27/16 at 4:15 p.m. with the director of nursing revealed: *Each department was responsible for updating the care plans. *Resident 3's care plan needed to have been current.</p> <p>Review of the provider's undated care plan policy revealed: "The care plan must be updated as</p> | F 280 | | |

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| F 280 | Continued From page 26 there are changes in the resident's condition. Changes may be health related, mood and behavior related, ADL [activities of daily living] functioning related, activities related, dietary related medication related, etc." | F 280 | | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 36413 A. Based on interview, policy review and record review, the provider failed to: *Ensure professional standards were followed in reviewing and reporting laboratory (lab) test results for one of one sampled resident (2). *Ensure appropriate documentation following treatments for one of one sampled residents (2). Findings include: 1. Review of resident 2's complete medical record revealed: *On 12/28/15 the residents certified nurse practitioner (CNP) ordered: -Keflex (medication for infection) 500 milligrams (mg) three times daily for one week for his hip ulcer (a sore caused by pressure). -A culture (lab test to determine type of infection) of his hip. *Lab reports on 1/1/16 revealed: -Positive for methicillin resistant staphylococcus aureus (MRSA) (a bacteria resistant to many antibiotics). -The recommended antibiotics on the lab report | F 281 | F281 1. Resident 2's physician has been contacted regarding lab results. As explained to surveyor by DON, Doxycycline used with same efficacy as Tetracycline. Also provided CNP's rationalization to surveyor, including better dosing compliance and cost effectiveness as reason to use. No new orders were received. Resident 2 is receiving prescribed treatment with positive effect and such is recorded on the Treatment Administration Record (TAR). Resident 4 is being weighed per physician orders. All residents are at risk. 2. The DON to in-service nursing staff no later than February 25, 2016 on the following: ensuring that labs are reviewed and the physician is contacted if ordered medication is not recommended after culture; signing the TAR when treatments are completed; and ensuring residents are weighed upon admission. Those not in attendance will be educated prior to their next scheduled shift. | 3/15/16 |

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| F 281 | <p>Continued From page 27 for that infection included tetracycline, Vancomycin, or Linezolid. *On 1/4/16 the CNP ordered Doxycycline for ten days for the infection in his right hip. *On 1/20/16 the resident was seen by his primary physician, but there was no documentation he had addressed the results of the 1/1/16 labs. *On 1/26/16 the consultant pharmacist completed a medication review and made no recommendation regarding the antibiotic for that specific infection.</p> <p>Phone interview on 1/27/16 at 2:08 p.m. with pharmacist D regarding resident 2 revealed: *The resident's consulting pharmacist was not available. *He confirmed the antibiotic that was being used to treat the infection would not have been the appropriate course of treatment according to the lab results.</p> <p>Interview on 1/27/16 at 2:00 p.m. with licensed practical nurse (LPN) F revealed she would have expected the charge nurse to call the physician when lab work recommended a change of antibiotic treatment.</p> <p>Interview on 1/27/16 at 2:10 p.m. with registered nurse (RN) E revealed her expectations would have been the charge nurse would have called the physician if lab results recommended a different antibiotic.</p> <p>Interview on 1/27/16 at 9:30 a.m. with the director of nursing (DON) revealed her expectations would have been the nurse receiving those lab results would have called the physician's office with the results. She agreed she would have questioned why that antibiotic had been ordered.</p> | F 281 | <p>3. The DON or designee to review four lab cultures each week to ensure any ordered medication is appropriate for the lab result, and if not, the MD was notified for medication change; Audit for TARS each week to ensure treatments are signed off after they are provided; and audit every new admission each week to ensure a weight is obtained upon admission. Audits will continue for four weeks and then monthly thereafter. Audits will be brought to QAPI by the DON for review and recommendations of continuation or discontinuation of audit.</p> <p>4. March 15, 2016</p> | |

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| F 281 | <p>Continued From page 28</p> <p>Review of provider's April 2013 Skin Management Policy revealed "Medical provider will assess and document ulcer response to current treatment each resident routine visit and more often as needed."</p> <p>2. Review of resident 2's physician's order revealed an order to cover with non-boarded foam and wrap with stretch gauze daily.</p> <p>Review of resident 2's January 2016 Treatment Administration Record (TAR) revealed thirteen of twenty six days had no documentation indicating if the treatment had been completed, refused, or omitted.</p> <p>Review of the provider's April 2014 Wound Dressing policy revealed "Staff would initial TAR after treatment had been done."</p> <p>Interview on 1/27/16 at 1:50 p.m. with LPN F revealed she would have been responsible that treatments were done and initialed on her shift. She agreed there were thirteen times in January when staff had not initialed the TAR.</p> <p>Interview with the DON on 1/27/16 at 2:30 p.m. revealed she would have expected staff to initial the TAR when they had completed any treatments. The charge nurse was responsible to make sure treatments were done and initialed.</p> <p>Surveyor: 35625 B. Based on record review, interview, and policy review, the provider failed to ensure an accurate weight was obtained on admission for 1 of 18 sampled residents (4). Findings include:</p> | F 281 | | | |

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| F 281 | <p>Continued From page 29</p> <p>1. Review of resident 4's electronic medical record revealed: *On 11/27/15 her recorded weight was 128.0 pounds (lb). *On 12/11/15 her recorded weight was 128.0 lb. *On 12/25/15 her recorded weight was 114.5 lb. *On 1/1/16 her recorded weight was 110.0 lb.</p> <p>Review of resident's 4's paper medical record revealed: *No weight was obtained the week of December 1 through 5, 2015, as the resident had been hospitalized during that time. *A weight of 128 lb was recorded with the word hospital in parentheses. *For December 13 through 19, 2015, a weight of 114 lb was obtained. In parentheses was "x2" indicating the resident had been weighed twice. *For December 20 through 26, 2015, a weight of 114.5 lb was recorded. *For December 27 through 31, 2015 a weight of 110 lb was recorded.</p> <p>Interview on 1/27/16 at 3:50 p.m. with the DON regarding resident 4's weights revealed: *The first two weights in the electronic medical record were taken from the hospital documentation. *Her expectation was a resident would be weighed on admission and at least weekly thereafter.</p> <p>Review of the provider's April 2013 Weight policy revealed the resident was to be weighed on admission, the return from the hospital, and weekly on the bath day to monitor and ensure the weight remained stable.</p> | F 281 | | |

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| F 283 F 283 SS=D | Continued From page 30 483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Surveyor: 36413 Based on record review and interview, the provider failed to ensure a discharge summary was completed for one of two sampled residents (14) who was discharged. Findings include: 1. Review of resident 14's complete medical record revealed a discharge summary had not been completed. The resident had been discharged on 11/23/15. Interview on 1/27/16 at 3:00 p.m. with the director of nursing revealed there was not a discharge summary in his record. She said there had been one completed, but they were unable to find it. | F 283 F 283 | F283 1. A discharge summary has been completed for resident 14. All residents who discharge are at risk. 2. The DON will in-service medical records personnel no later than February 25, 2016 on ensuring closed charts on discharged residents contain a discharge summary for those residents with an anticipated discharge. Those not in attendance will be educated prior to their next scheduled shift. 3. The DON or designee to audit all discharges each week to determine if a discharge summary is required and that it is completed. Audits will continue for four weeks and monthly thereafter. Audits will be brought to QAPI by the DON for review and recommendations of continuation or discontinuation of the audit. 4. March 15, 2016 | 3/15/16 |
| F 311 SS=D | 483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. | F 311 | F311 1. Residents 3 and 7 are receiving restorative nursing services. All residents needing assistance are at risk. *and have been assessed. DH/SDDO/H/EL | 3/15/16 |

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| F 311 | <p>Continued From page 31</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335</p> <p>A. Based on observation, record review, interview, and policy review, the provider failed to follow a restorative program for one of two sampled residents (7). Findings include:</p> <p>1. Observation in the alternative dining room on 1/26/16 from 12:30 p.m. through 1:45 p.m. of resident 7 revealed she did not have staff assisting her with her meal. A staff member stopped by and prompted her to eat a bite, and she did. That staff member walked away and did not return. She was able to pick up the spoon and eat a few bites of her ground meat. Her beverages had not been touched other than two sips from her water to take her medications. She was looking around throughout the meal.</p> <p>Observation in the alternative dining room on 1/26/16 from 5:00 p.m. through 5:45 p.m. of resident 7 revealed staff had not assisted her with her meal. She had eaten the ground meat, some potatoes, picked up her dessert bar, and had taken a few bites. She was distracted throughout the meal and had not drank any of her beverages.</p> <p>Review of resident 7's 11/24/15 Minimum Data Set (MDS) assessment revealed her Brief Interview for Mental Status score was a 2. A score of 0 to 7 indicated severe cognitive impairment.</p> <p>Review of resident 7's undated care plan revealed a focus area for nutrition. One intervention was "Staff of 1 provides verbal cues and assistance to load utensils with bites of food</p> | F 311 | <p>2. The DON will in-service nursing staff no later than February 25, 2016 on the importance of providing the nursing ordered restorative services prescribed in the plan of care. Those not in attendance will be educated prior to their next scheduled shift.</p> <p>3. The DON or designee will audit four residents a week receiving restorative services to ensure services have been provided and documented. Audits will continue for four weeks and then monthly thereafter. The DON will bring results of audits to the monthly QAPI meeting for review and recommendation on continuing or discontinuing the audit.</p> <p>4. March 15, 2016</p> | |

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| F 311 | <p>Continued From page 32 for [resident name] to complete eating process on her own."</p> <p>Interview on 1/27/16 at 1:30 p.m. with the restorative care coordinator and the speech therapist regarding resident 7 revealed: *The speech therapist determined who was on the restorative dining program. *The resident was on the restorative dining program. *She was to have a staff member sit with her, fill the spoon, and hand it to her to eat. *She provided the information to the director of nursing (DON) who was responsible to implement it.</p> <p>Review of the provider's 1/14/14 Restorative Nursing Program policy revealed: *"Restorative nursing includes, but is not limited to: skill practice in walking, dressing, grooming, eating, swallowing, transferring, amputation care, splint care, communication, PROM/AROM [passive range of motion/active range of motion], scheduled toileting, bladder training, or bed mobility." *The program concept was to have actively focused on achieving and maintaining optimal physical, mental, and psychosocial functioning. *Each resident who participated in the program would have an individual program with individual goals.</p> <p>Surveyor: 32331 B. Based on interview, record review, and policy review, the provider failed to ensure scheduled services were provided for one of four sampled residents (3) on a restorative nursing program. Findings include:</p> | F 311 | | |

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| F 311 | <p>Continued From page 33</p> <p>1. Review of resident 3's medical record revealed: *Her diagnoses had included arthritis. *She had a past history of an open area on her thumb and on the third and fourth fingers on her left hand. -Those areas had recently healed. *The goal of the restorative nursing program was to have prevented further contractures (a shortening of a muscle) of her hand.</p> <p>Observation on 1/26/16 at 12:30 p.m. of resident 3 revealed resident had a splint on her left hand.</p> <p>Review of resident 3's revised 12/9/15 care plan revealed she: *Had a goal to participate in a restorative nursing program. *Was on a maintenance therapy program.</p> <p>Review of resident 3's 12/1/15 Minimum Data Set (MDS) quarterly assessment, section C, revealed: *She had a Brief Interview for Mental Status (testing of thought processes) score of none. *A score of none indicated severe impairment or loss.</p> <p>Review of the provider's untitled December 2015 and January 2016 restorative log and progress notes regarding resident 3 revealed: *She had a goal to prevent further contractures of her hand. *She was scheduled for five times per week each month. *Her program had consisted of: -Passive range of motion (PROM) to her lower and upper extremities (limb of the body). -PVC (a type of synthetic plastic form) splint used</p> | F 311 | | |

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| F 311 | <p>Continued From page 34 for her hand.</p> <p>*She was to have received fifteen minutes of restorative therapy each week.</p> <p>*From 12/1/15 through 12/31/15 she had received therapy a total of:</p> <p>-Week one: three times. -Week two: none -Week three: two times. -Week four: two times. -Week five: four times.</p> <p>*She had been scheduled for a total of five times per week or twenty times.</p> <p>*She had received therapy a total of eleven times.</p> <p>*From 1/1/16 through 1/26/16 she had received therapy a total of:</p> <p>-Week one: five times. -Week two: five times. -Week three: three times. -Week four through 1/26/16: two times.</p> <p>*On week three she had been scheduled five times, and she had received therapy a total of three times.</p> <p>Interview on 1/27/16 at 2:20 p.m. and at 2:35 p.m. with the restorative care coordinator revealed:</p> <p>*She was responsible for the restorative nursing program.</p> <p>*She had two full-time employees that worked in the restorative program.</p> <p>*Resident 3 was scheduled for a restorative therapy program five times per week.</p> <p>*She agreed resident 3 was not always receiving her scheduled restorative therapy each week.</p> <p>Interview on 1/27/16 at 4:15 p.m. with the director of nursing regarding resident 3's restorative nursing therapy program revealed:</p> <p>*She had a recent history of an open area on her hand.</p> | F 311 | | |

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| F 311 | Continued From page 35 *It had been important for her to have received the therapy as part of her maintenance plan on that hand. *She had needed to receive the restorative therapy as scheduled. Review of the provider's January 2010 Restorative Nursing Program policy revealed: *The program concept was to have actively focused on achieving and maintaining optimal physical, mental, and psychosocial functioning. *Each resident who participated in the program would have an individual program with individual goals. *Restorative nursing had included PROM and splint care. | F 311 | | |
| F 314 SS=D | 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 pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: | F 314 | F314 1. Resident 4 is receiving skin care per physician orders. All residents are at risk. 2. The DON will educate nurses that a physician must be notified and a new order is needed when changing skin care treatments. Education will occur no later than February 25, 2016. Those not in attendance will be educated prior to their first shift worked. <i>*and have been assessed. DH/SDD/HJL</i> | 3/15/16 |

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| F 314 | <p>Continued From page 36 Surveyor: 35625 Based on observation, record review, and interview, the provider failed to ensure the physician was notified of changes and orders were obtained for changes in treatment for one of four sampled residents (4) with skin breakdown. Findings include:</p> <p>1. Observation on 1/27/16 at 8:45 a.m. with certified nursing assistant/medication aide G involving resident 4's skin treatment revealed: *An eraser-size red and open area was present on her right buttock. *The wound was cleansed and a layer of zinc oxide cream (to prevent and treat skin irritation) was applied. *No dressing or covering was used.</p> <p>Review of resident 4's medical record revealed: *A 12/1/15 admission Minimum Data Set (MDS) assessment revealed: -She was at risk for developing pressure ulcers. -She had no unhealed pressure, venous, or arterial ulcers. *A 1/20/16 physician's order to change the dressing daily through cleansing and then applying hydrogel (a water-based ointment) and optifoam (a dressing used in the treatment of pressure ulcers).</p> <p>*Review of the January 2016 treatment administration record (TAR) for resident 4 revealed: -The dressing change with the hydrogel and optifoam was completed from January 21 to 24, 2016. -A treatment to apply zinc oxide and monitor twice a day was started on the evening of 1/22/16.</p> | F 314 | <p>3. The DON or designee will audit four residents with orders for skin care to ensure the physician is notified and new orders are obtained with any skin care regime change. Audits will be weekly for four weeks and monthly thereafter. The DON will bring results of audits to the monthly QAPI meeting for review and recommendation on continuing or discontinuing the audit.</p> <p>4. March 15, 2016</p> | |

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| F 314 | <p>Continued From page 37</p> <p>*Review of the weekly wound assessment flow sheet for resident 4 revealed on:</p> <ul style="list-style-type: none"> -12/28/15 a stage two 0.8 centimeter (cm) wound was found, and zinc oxide was applied. -1/6/16 a stage two 0.4 cm wound was observed, and zinc oxide cream was applied. -1/11/16 a stage two 0.3 by 0.2 cm wound was observed, and zinc oxide cream was applied. -1/13/16 it was marked as healed. -1/17/16 a stage two 0.4 by 0.3 cm wound was observed, and zinc oxide cream was applied. -1/22/16 a stage two was marked as healed with a notation that zinc oxide cream was to be applied twice a day. <p>*Review of the medical record for resident 4 revealed no documentation for the following items:</p> <ul style="list-style-type: none"> -Initial notification of the skin concern to the physician. -Physician notification the ulceration had healed and reopened. -Physician notification the wound had healed on 1/22/16. -An order to discontinue the daily dressing change using hydrogel and optifoam. <p>Interview on 1/27/16 at 3:50 p.m. with the director of nursing (DON) revealed:</p> <ul style="list-style-type: none"> *Zinc oxide was used as a protective cream. *An order to discontinue the hydrogel and optifoam should have been obtained. *She acknowledged if an order or notification was done than it would be in the chart. *No further information was given regarding treatment of resident 4's wound. <p>Policies concerning wound care were requested from the DON, and none were received by the</p> | F 314 | | |

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| F 314 | Continued From page 38 end of the survey. | F 314 | | |
| F 325 SS=D | <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure one of four sampled residents (5) with weight loss received necessary care to prevent further weight loss. Findings include:</p> <p>1. Review of resident 5's following weight records revealed: *11/23/15, at admission she weighed 98 pounds (lb). *12/21/15, she weighed 92.5 lb. *1/18/16, she weighed 88 lb; a 10 pound weight loss since admission.</p> <p>Review of resident 5's consulting dietitian/registered dietitian (RD) assessments revealed: *11/24/15, "Resident reported her appetite was</p> | F 325 | <p>F325</p> <p>1. Resident 5 is receiving her prescribed diet and supplements. All residents are at risk. <i>*and have been assessed. DK/SDOTT/EL</i></p> <p>2. The DON will in-service nursing and dietary staff on importance of providing the ordered diet and supplements as recommended by the Registered Dietician and notification of the physician should weight loss occur. In-service will occur no later than February 25, 2016. Those not in attendance will receive education prior to their first shift worked.</p> <p>3. The DON or designee will audit four random residents each week to ensure they are receiving prescribed diet and any weight loss is reported to the physician. Audits will continue for four weeks and then monthly thereafter. The DON will bring results of audits to the monthly QAPI meeting for review and recommendation on continuing or discontinuing the audit.</p> <p>4. March 15, 2016</p> | 3/15/16 |

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| F 325 | <p>Continued From page 39</p> <p>good. Her weight was on the lower end of the normal range but her weight had been stable. She was at risk for weight loss and skin breakdown given her lower intake at meals. She recommended 1.4 ounce (oz) Hormel (nutritional supplement). She recommended that speech therapy evaluate because the resident coughed when she ate."</p> <p>*December 2015, There was not a monthly RD assessment.</p> <p>*1/11/16, "Current weight 89.5 lb. Recommended the resident receive Hormel supplement three times a day [tid], receive whole milk with meals."</p> <p>Review of resident 5's January 2016 medication administration record revealed she received the Hormel supplement two times a day.</p> <p>Random observations with an interview of resident 5 on 1/26/16 revealed:</p> <p>*At meals she ate very little at the noon and supper meal. She seemed distracted or uninterested in eating and was looking around the dining room.</p> <p>*She did not receive any milk at her meals.</p> <p>*There was no additional gravy put on her meat dishes.</p> <p>*She had an Equate supplement in her room that she said her family had brought her.</p> <p>Interview on 1/27/16 at 6:00 p.m. with the dietary manager regarding resident 5 revealed:</p> <p>*The resident had lost weight since admission.</p> <p>*The resident had not received the whole milk at the above meals that had been recommended.</p> <p>*Nursing was supposed to follow-up with the RD's recommendation to increase the Hormel supplement, but she was not sure if that had been done. She did not know if the resident had</p> | F 325 | | |

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| F 325 | <p>Continued From page 40</p> <p>received that.</p> <p>*She was unaware where the resident was getting the Equate supplement from her family, but that was not the supplement they had stocked.</p> <p>-She was not receiving another supplement such as Ensure.</p> <p>-It would have been the provider's responsibility to supply a supplement if that was what the resident needed.</p> <p>*The resident had been evaluated by the speech therapist (ST), because she coughed when she ate. She thought the resident should have been eating in the assisted dining room, but the ST did not agree with that. She thought the ST thought it was more of a behavior that she did eat well.</p> <p>-The resident loved pancakes, and on Wednesdays she received pancakes at breakfast.</p> <p>Review of resident 5's 12/10/15 care plan revealed:</p> <p>*The focus was her ability to feed herself without assistance.</p> <p>"Monitor weights and intakes.</p> <p>-Provide with a regular diet with regular textures.</p> <p>-Provide Hormel 4 ounces twice a day. I like coffee."</p> <p>*The care plan had not addressed:</p> <p>-The weight loss.</p> <p>-The whole milk at meals.</p> <p>-The recommendations of additional means to increase calories based on the dietitian's recommendations.</p> <p>-Interventions to address her mood that impacted her appetite.</p> <p>-That she loved pancakes and would readily eat them.</p> | F 325 | | |

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| F 325 | Continued From page 41 Interview on 1/27/16 at 11:45 a.m. with the ST regarding resident 5 revealed: *She had evaluated the resident but had discontinued the therapy, because the resident would not follow her recommendations. *She felt the resident showed signs of depression. Review of resident 5's entire medical record revealed there was no documentation the physician had been notified of the resident's weight loss until 1/20/16. At that time the physician had recommended Remeron (an antidepressant with appetite stimulating effects) and to continue with the Ensure shakes. Review of the provider's January 2006 Nutritional Risk policy revealed: **The facility will ensure that each resident achieves and/or maintains acceptable parameters of nutrition and hydration status unless the resident's clinical condition deems this is not possible. *Residents identified to be at nutrition or hydration risk will receive a comprehensive nutrition and hydration risk will receive a comprehensive nutritional assessment and monthly follow-up by a dietitian or designee until no longer determined to be at nutrition or hydration risk." | F 325 | | | |
| F 371 SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions | F 371 | F371 1. The facility will obtain a bid for kitchen floor replacement/repair no later than March 15, 2016 and such work will commence as soon as contractor is able. The fans in the walk-in refrigerator were cleaned and the shelving units in the dish machine area have been replaced with cleanable surfaces. All residents are at risk. | 3/15/16 | |

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| F 371 | Continued From page 42 This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, record review, and policy review, the provider failed to ensure sanitary conditions were maintained in the kitchen for the following: *Three of four floor areas (food preparation, bakers, and dishmachine) had uncleanable surfaces with moderate amounts of cracked, scarred, stained, and no finish on the tiles. *Two of two fans in the walk-in refrigerator were not clean. *Six of six shelving units in the dishmachine area had uncleanable surfaces. Findings include: 1. Observation on 1/26/16 in the kitchen from 9:10 a.m. through 9:35 a.m. revealed: *The floors in the food preparation, bakers, and dishmachine areas had a moderate amount of cracked, scarred, stained, and no finish on the twelve inch by twelve inch tiles. *The floor had a significant amount of debris built up along the baseboards. *The floor in front of the walk-in refrigerator's threshold had an approximately three and one-half feet by one and one-half inch wide crevice (opening) filled with a moderate accumulation of grease with dust. -That floor was no longer a cleanable surface. *Two of two fans in the walk-in refrigerator contained a moderate accumulation of grease with white and gray lint on them. | F 371 | 2. The Dietary Manager and RD, in collaboration with the Administrator and Maintenance Supervisor have reviewed the policies and procedures about maintaining sanitary conditions in the kitchen and have reviewed findings in this citation. The Dietician will in-service dietary staff no later than February 25, 2016 on kitchen sanitation requirements and cleaning schedules. Those not in attendance will be in-serviced prior to their first shift worked. 3. The Administrator or designee will conduct a weekly audit on kitchen sanitation for four weeks and then monthly. The Administrator will bring results of audits to the monthly QAPI meeting for review and recommendation on continuing or discontinuing the audit. 4. March 16, 2016 | |

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| F 371 | <p>Continued From page 43</p> <p>-Those fans were blowing directly over the food stored there.</p> <p>*The above refrigerator was used for storage of residents' food.</p> <p>*Six shelving units in the dishmachine area contained clean dishes that had a moderate amount of loose laminate with unfinished plywood on the sides.</p> <p>-Those shelving units were no longer cleanable surfaces.</p> <p>*The above shelves were used for the storage of residents' clean dishes.</p> <p>Interview on 1/26/16 at 12:45 p.m. with the dietary manager regarding the above areas in the kitchen revealed:</p> <p>*Dietary staff were responsible for cleaning the floors.</p> <p>*Maintenance staff were responsible for the repair or replacements of the floors.</p> <p>*Maintenance staff were responsible for cleaning the fans in the walk-in refrigerator.</p> <p>-She had been unsure of the last time those fans had been cleaned.</p> <p>*Maintenance staff were responsible for repair or replacement of the shelves in the dishmachine area.</p> <p>Interview on 1/26/16 at 1:45 p.m. with the administrator and the dietary manager regarding the above areas in the kitchen revealed they agreed:</p> <p>*The floor was no longer a cleanable surface.</p> <p>-The floor in front of the walk-in refrigerator had a crevice filled with debris, and it needed to be cleaned out and filled in.</p> <p>*The fans in the walk-in refrigerator needed to have been cleaned.</p> <p>*The shelving units in the dishmachine area</p> | F 371 | | |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 01/27/2016 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE COMMUNITY | | | STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028 | | |
| (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 371 | <p>Continued From page 44 needed to have been repaired or replaced.</p> <p>Interview on 1/27/16 at 8:40 a.m. with the dietary manager and maintenance assistant B regarding the above areas in the kitchen revealed: *Maintenance assistant B stated maintenance was not responsible for cleaning the floors in the dietary department. -The dietary department was responsible for cleaning the floors. -The maintenance department was responsible for repair or replacement of the floors as needed. -There was no schedule for any floor work by the maintenance department. *They both agreed the floor was no longer a cleanable surface *Maintenance assistant B stated maintenance was responsible for cleaning the fans in the walk-in refrigerator. -Those fans were to have been cleaned each week. *The shelving units in the dishmachine area had multiple areas with loose laminate and unfinished woods on the sides of those shelves. *Maintenance assistant B agreed those shelves needed to have been repaired or replaced. *Maintenance assistant B stated the dietary department was to have informed maintenance of any repair or replacement needs in the kitchen.</p> <p>Interview on 1/27/16 at 2:00 p.m. with the dietary manager revealed the provider had no specific policies in the kitchen for cleaning the floors, the walk-in refrigerator fans, or the storage of clean dishes.</p> <p>Review of the provider's undated Dietary Cleaning Schedule revealed: *The floor was to have been mopped daily by</p> | F 371 | | | |

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| NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE COMMUNITY | | | STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028 | | |
| (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 371 | Continued From page 45 staff scheduled for the: -Evening pots and pans position. -Evening dishwasher position. *The shelves were to have been wiped down by staff scheduled for the evening pots and pans position. Review of the provider's 12/25/15 Friday Jobs for the maintenance department revealed: *Fans in the kitchen area were to have been cleaned each Friday. *Those fans had been last cleaned on 12/25/15. *The fans in the walk-in refrigerator had not been cleaned for over one month. Review of the provider's revised 2008 Sanitization policy revealed: *The food service area was to have been maintained in a clean and sanitary manner. *All shelves and equipment were to have been kept clean and maintained in good repair. *Kitchen surfaces not in contact with food should have been cleaned on a regular schedule and frequently enough to have prevented accumulation of grime. *The dietary manager was responsible for scheduling staff for regular cleaning of the kitchen. | F 371 | | | |
| F 441 SS=E | 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 | F 441 | F441 1. Infection control data for November and December is on file. All residents are at risk. | 3/15/16 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 01/27/2016 |
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| NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE COMMUNITY | | | STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028 | | |
| (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 46</p> <p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</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: 32335 Based on observation, interview, record review, and policy review the provider failed to implement and promote consistent adherence to infection control practices by having a functioning infection control program with appropriate oversight. Findings include:</p> | F 441 | <p>2. The Administrator, DON and interdisciplinary team reviewed the infection control policies, as well as the cited deficiency. The infection control nurse will receive education on infection control program requirements from the Director of Clinical Services no later than February 25, 2016. Additionally, staff will be educated by the DON on their role and responsibility for ensuring infection prevention and control no later than February 25, 2016.</p> <p>3. The DON or designee will audit the infection control data collected on a weekly basis, as well as the monthly summary. Audits will be weekly for 4 weeks and then monthly thereafter. Results of audit will be discussed by DON at monthly QAPI meeting for recommendation on continuation or discontinuation of audit.</p> <p>4. March 15, 2015</p> | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 01/27/2016 |
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| NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE COMMUNITY | | | STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028 | |
| (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 | Continued From page 47 1. Interview and record review on 1/27/16 at 3:15 p.m. with the infection control nurse revealed: *She had no specialized training or additional training for infection control. *She could not locate the infection control data for November or December 2015. *She was not aware of nor involved in any training on infection control for new employees. -She thought that was done by the person in charge of the nurse aide training program. *There was no documentation of monitoring or auditing of infection control practices. Review of the provider's undated Infection Control Policy and Procedures revealed: *A staff member was to have gone through each department on a routine basis to monitor infection prevention and control. -Those reports were to be reviewed at the infection control/quality assurance meetings (held at least quarterly). *They should have provided on-going evaluation of the performance of each individual in relation to infection prevention and control. This surveyor had asked to see the infection control information presented to the quality assurance committee, and it had not been provided by the end of the survey. | F 441 | | |

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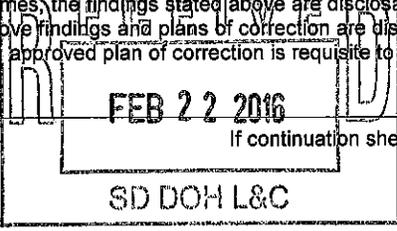
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 01/27/2016 |
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| NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE COMMUNITY | STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028 |
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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 1/27/16. The original 1967 Riverview Manor (building 01) was found not 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 and the Fire Safety Evaluation System (FSES) dated 1/27/16 upon correction of the deficiency identified below.</p> <p>Please mark an "F" in the completion date column for the deficiency identified as meeting the FSES to indicate the provider's commitment to continued compliance with the fire safety standards.</p> | K 000 | | |
| K 020 SS=C | <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and record review, the provider failed to maintain the one hour fire resistive rating of vertical openings for two randomly observed areas. The front exit stair enclosure was separated by wire glass vision panels. The door from the stair enclosure to the lower level was not equipped with latching hardware. Findings include:</p> | K 020 | | F 3/15/16 |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE <i>Administrator</i> | (X6) DATE <i>2/19/16</i> |
|--|-----------------------------------|---------------------------------|

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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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | | (X3) DATE SURVEY COMPLETED 01/27/2016 |
|---|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE COMMUNITY | | | STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028 | | |
| (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 020 | Continued From page 1 1. Observation at 10:30 a.m. on 1/27/16 revealed the north exit stair enclosure used large wire glass vision panels as the vertical separation. Further observation revealed the wire glass door leading from the stair enclosure to the lower level lobby was not equipped with latching hardware. Review of previous survey data confirmed that condition had existed since the building was constructed. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct the deficiency identified in K000. | K 020 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 1989 ADDITION B. WING _____ | (X3) DATE SURVEY COMPLETED 01/27/2016 |
| NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE COMMUNITY | | | STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028 | |
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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 1/27/16. The 1989 addition to Riverview Manor (building 02) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p> | K 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Administrator

3/19/16

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.

FEB 22 2016
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10620 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 01/27/2016 |
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| NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE COMMUNITY | STREET ADDRESS, CITY, STATE, ZIP CODE 611 E 2ND AVE FLANDREAU, SD 57028 |
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|--------------------|---|---------------|--|--------------------|
| S 000 | Compliance/Noncompliance Statement Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 1/26/16 through 1/27/16. Riverview Healthcare Community was found not in compliance with the following requirement: S169. | S 000 | | |
| S 169 | 44:73:02:18(5-7) Occupant Protection The facility shall take at least the following precautions: (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters shall 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. Any other exterior doors shall be locked or alarmed. The alarm shall be audible at a designated staff station and may not automatically silence when the door is closed; (7) A portable space heater and portable halogen lamp, household-type electric blanket or household-type heating pad may not be used in a facility; This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 16385 Based on observation, interview, and policy review, the provider failed to maintain the electrically activated audible alarm at one of one first floor door entrance. Findings include: 1. Observation on 1/26/16 at 9:00 a.m. revealed the first floor entrance door was equipped with an | S 169 | <p>S169</p> <ol style="list-style-type: none"> 1. The facility will request a bid from a contractor for keypad installation on first floor door no later than March 15, 2016 and such work will commence as soon as contractor is able to complete. 2. The Administrator will in-service facility staff on need to have doors alarmed at exits for resident safety. 3. The Administrator or designee will audit a random door each week to ensure they alarm when opened. Audits will continue for four weeks and then monthly thereafter. The Administrator will bring results of audits to the monthly QAPI meeting for review and recommendation on continuing or discontinuing the audit. 4. March 15, 2016 | 3/15/16 |

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

TITLE

(X6) DATE

[Signature]

Administrator

2/19/16

South Dakota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10620 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 01/27/2016 |
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| NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE COMMUNITY | STREET ADDRESS, CITY, STATE, ZIP CODE 611 E 2ND AVE FLANDREAU, SD 57028 |
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|--------------------|---|---------------|---|--------------------|
| S 169 | <p>Continued From page 1</p> <p>audible alarm. The alarm was not activated at the time of the observation. The first floor entrance was within sight distance of the nurses station when staff were present.</p> <p>The first floor entrance door was observed not activated and not monitored on: *1/26/16 at 9:00 a.m. *1/26/16 at 1:00 p.m. *1/26/16 at 4:55 p.m. *1/27/16 at 7:25 a.m. *1/27/16 at 11:45 a.m.</p> <p>Observation of the door alarm panel on 1/27/16 at 8:00 a.m. revealed the first floor entrance alarm button had been in the off position.</p> <p>Interview on 1/27/16 at 11:30 a.m. with the administrator confirmed the first floor entrance door alarm button had been in the off position during the day hours.</p> <p>Review of the provider's 03-08 "RVM Alarm Systems" policy revealed "Exit Door Alarm (Potential - Wandering Residents) Located South Wall, both floors, nurses desk - red light will blink to show which door affected and alarm sounds. Requires prompt response."</p> | S 169 | | |
| S 000 | <p>Compliance/Noncompliance Statement</p> <p>Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 1/26/16 through 1/27/16. Riverview Healthcare Community was found in compliance.</p> | S 000 | | |