

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/10/2014
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NAME OF PROVIDER OR SUPPLIER DOW RUMMEL VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1321 W DOW RUMMEL ST SIOUX FALLS, SD 57104
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F 000	<p><i>Handwritten: Addendums noted with an asterisk per 10/23/14 telephone to facility administrator (skodochime)</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 26180</p> <p>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/8/14 through 9/10/14. Areas surveyed included abuse and neglect. Dow Rummel Village was found not in compliance with the following requirement: F226.</p>	F 000	Preparation, submission and implementation of the Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	
F 226 SS=E	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on record review, investigation, staff training, interview, and policy review, the provider failed to implement procedures to protect residents from abuse by: *Investigating two of two allegations (accusation against someone without proof) by sampled residents (2, and 3) of mistreatment by staff. *Investigate and report to the South Dakota Department of Health (SD DOH) two of two resident allegations of mistreatment (4 and 5) against a staff member (A) within 24 hours for the initial report, and five working days the final report as required by state regulations. *Providing initial orientation on abuse prevention to any new employee upon being hired. Findings include:</p>	F 226	<p>Dow Rummel Village (DRV) does not agree with the findings of this survey report and feel the comments and remarks captured on this report were not accurate. Staff comments were used out of context in this report. We feel DRV has a cohesive management team and strives for excellence in all we do. The services we provide residents are top notch and this survey report will not break down the integrity and professionalism of our team.</p> <p>F226 DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>All residents have the potential to be affected by our abuse and neglect reporting policies. A revised policy and procedure was developed using guidance from several reference publications and through review with our leadership team.</p>	10/2/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rebecca [Signature]</i>	TITLE <i>Administrator</i>	(X6) DATE <i>10-14-14</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 180 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 226	<p>Continued From page 1</p> <p>1a. Interview on 9/9/14 at 1:17 p.m. with resident 2 revealed: *He had been admitted to the facility four years ago. *He was alert and oriented to person, place, and time of day. *His wife had lived in the independent living section of the facility. The staff assisted him in the evening to go visit with her. *He was a diabetic (uncontrolled blood sugar levels in the blood), and required the staff to check his blood sugar level in the mornings. The night charge nurse assisted him with that. *He had a concern with male night nurse D who used to work for the facility and had recently been "fired." The male nurse used to be in the military and had been quite "obnoxious or militant with his approach." *One morning the male charge nurse had woke him up to check his blood sugar level. After he had said good morning to me, I (resident 2) stated "Go to hell." "I had been joking, but he obviously had not liked my comment." "He (charge nurse) made me repeat my statement several times." "Finally the male charge nurse said "You know, I can see to it you can't see your wife in the evenings anymore." *He had reported the above conversation to the staff at his next care conference meeting. *The staff at the care conference meeting had not checked back with him after he had reported the above conversation.</p> <p>Interview on 9/9/14 at 1:30 p.m. with the licensed social worker (LSW) regarding the above incident with resident 2 revealed: *She had been aware of the above incident with the resident and nurse D.</p>	F 226	<p>A revised policy and procedure was developed through a team collaboration and use of reference publications. All nursing facility staff received mandatory training on the new policy on September 30, 2014. All new hires will receive abuse and neglect training within 30 days of hire using our Relias online training vendor. All DRV associates campus wide will receive Abuse and Neglect training by October 31st. All staff will receive Abuse and Neglect training yearly through the Relias online training vendor with reminders going to staff emails. The revised policy and procedure directly references the initial reporting form to the Department of Health, the Ombudsman, law enforcement, and family members, as well as gives nursing associates the investigational grid tools to begin an investigation. We addressed that all staff are mandatory reporters and emphasized the importance of promptly reporting to any member of the facility leadership team any incident or suspected incident of neglect and/or abuse. Signs were updated in the break rooms to reflect this. All staff annually and at initial hire will be required to read and sign they have read and understand the Abuse and Neglect Reporting policy.</p> <p><i>*to ensure incidents such as those events involving residents 2, 3, 4 & 5 are reported & investigated within the appropriate time frames. OS/SDDH/MF</i></p>	
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F 226	<p>Continued From page 2</p> <p>*The DON had handled the above situation. *She had not been aware if there had been an investigation done on the above allegation/concern from the resident.</p> <p>Interview on 9/10/14 at 9:40 a.m. with the DON regarding the above interview revealed: *She had been aware of the above incident 2 years ago. *She had visited with resident 2, and he had complained on RN D's gruff approach. *RN D had been in the military, and his approach was more aggressive or gruff. The provider had done coaching with him on his approach and demeanor with improvement observed. *She had agreed that was not an acceptable comment from RN D to resident 2. *At the time of the allegation she had not considered that a type of abuse, and no investigation had been completed or reported to the SD DOH.</p> <p>b. Interview on 9/9/14 at 9:20 a.m. with an anonymous staff member revealed: *She had been a direct care giver for resident 3. *Resident 3 had been confused and would yell out frequently to "help me." *RN D had no patience for her and would yell at the resident to "shut-up" in front of other residents. *About a year ago resident 3 had been yelling out frequently, and she had taken the resident to her bathroom. RN D had followed them into the resident's bathroom and stated "I'm going to take you outside and throw you in a snowbank if you don't shut-up." It had been blizzarding outside that day. *She had reported the above incident to the DON. The DON informed her "No one ever complains</p>	F 226	<p>All reports of abuse and neglect [REDACTED]</p> <p>[REDACTED] reviewed at monthly CQI meetings for a period of 6 months and then the CQI team will recommend continued action. Investigational grids used for falls, injuries of unknown origin, missing property, etc..., will be reviewed as needed with the leadership team(may include Admin, DON, Director of Social Services, and possible nursing associate designees) applying QAPI principles to determine time, frequency, staff working, and other investigational questions referenced in the revised Abuse and Neglect Reporting policy.</p> <p><i>* will be reviewed by the Administrator or designee within 24 hours. CS/SDDH/MF</i></p> <p>1a. Resident 2's remembrance of conversation was not consistent with RN D's recall of conversation. A Coaching Opportunity was done on 1/17/2013 with RN D.</p> <p>Per facility Abuse Policy, if verbal or mental abuse has been determined to be unintentional but inappropriate, refer associate for counseling.</p> <p><i>* Those reports will be submitted to the Dept of Health going forward & will be CS/SDDH/MF</i></p>	
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F 226	<p>Continued From page 3 of RN D, everyone likes him." *After the above incident with RN D "She had stopped reporting things to the DON." *She had stopped reporting any concerns to the charge nurses as they "Blow it off." *Since the above situation and her attempt to inform the DON she no longer was comfortable reporting any type of abusive situations.</p> <p>Interview on 9/9/14 at 9:45 a.m. with certified nursing assistant B revealed: *She had been aware of the above incident with resident 3. *She had confirmed resident 3 was confused and would yell out frequently. "RN D had been verbally abusive to her. He would yell at her "You need to stop that, no one can hear you." *She had stated "RN D was intimidating, rude, and was not nice to the residents." *She had not voiced any of her concerns regarding RN D to the DON.</p> <p>Interview on 9/10/14 at 9:50 a.m. with the DON regarding the above conversation with the anonymous staff person revealed: *She had not been aware of the above incident and conversation with resident 3. *The staff had been required to write down any concerns of that nature, and there were none. *She had agreed that was not an acceptable comment from RN D to resident 3.</p> <p>No investigational report had been located on the above concern and situations with resident 3 and RN D.</p> <p>c. Review of the provider's 9/9/14 Director of Nursing Services job description revealed: **"Must be able to provide leadership to resident</p>	F 226	<p>b. Anonymous staff member revealing her concern for resident 3 did not report incident to Director of Nursing (DON). DON did not have any knowledge of this incident. Resident 3 does not wake up until 7:00 – 7:30 am. RN D's shift ends at 6:15 – 6:30 am. Anonymous staff member reports, it had been blizzarding outside that day, which means this incident possibly occurred 6-9 months ago.</p> <p>This anonymous staff member voluntarily left her position with Dow Rummel since the survey.</p> <p>Resident 3 continues to call out "Help me" and nursing has partnered with Home Care Services for 1:1 companionship.</p>		

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F 226	<p>Continued From page 4</p> <p>care functions such as: training, supervision, and protection of residents' rights." ***Be alert and active in supporting facility's commitment to safe practices and respect for resident's rights." ***Evaluate the deliver of the Health Care Center's and Memory Care Center's nursing services and maintain standards that are in full compliance with regulatory requirements." ***Work effectively with physicians, department heads, and shift supervisors, and consultants to assure the consistent delivery of quality resident care."</p> <p>Interview on 9/10/14 at 11:45 a.m. with the administrator revealed she: *Had not been fully aware of all of the situations above until today. *Had not been aware of resident 2's concerns regarding RN D. *Would have expected the care team to bring any of those concerns to her attention. *Would have expected any of the direct care givers to report their concerns to the charge nurses. If those concerns had not been addressed they should have then reported to the DON and the resident care specialist.</p> <p>Review of the provider's undated Executive Director Health Care Services job description revealed: ***Oversee management and supervisory responsibilities for all licensed facility operations and services." ***Provide leadership and guidance to ensure the sustained safety, soundness, and planned growth for the organization." ***Strong personal commitment to a high standard of quality, leadership, and service in deliver of</p>	F 226			

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F 226	<p>Continued From page 5 long term care services." **Foster a strong, cohesive team environment that builds confidence, strong morale, and effective working relationships among all departments and staff."</p> <p>Surveyor: 26180 2. Review of an investigation received by the SD DOH revealed: *The undated cover letter stated the initial complaint was on employee A, and involved residents 4 and 5. -The accusation was failure to provide care and resident abuse or neglect. *The date and time of the event was 6/9/14. *The date of the Initial and Final 5-working day investigation reports were 7/22/14. -That was six weeks after the initial accusation. *The investigation form instructed them to fax the investigation to the SD DOH complaint coordinator at 1-866-539-3866.</p> <p>Further review of the 5-day investigation report of the above investigation revealed: *On 6/23/14 certified nursing assistant (CNA) A assisted CNA B with a bath for resident 4 who was difficult to bathe due to behaviors. -At that time CNA A told CNA B she had given a shower to that same resident on 6/9/14. When the resident had exhibited difficult behaviors she wiped her face with a cold washcloth. -CNA B reported that conversation to the resident care supervisor (RSC) on 6/24/14. *That investigation further revealed: -On 6/18/14 CNA A had mentored CNA C. It was not until 6/27/14 that CNA C had reported to the RCS that during her preceptorship CNA A had not performed morning care for residents.</p>	F 226	<p>2. Incident with Employee A occurred on 6/9/14 with resident 4. Employee A did not share incident with another staff member, Employee B, until 6/23/14. Employee B reported to Resident Care Supervisor on 6/24/14. Within the same week resident 5 and Employee C reported to Resident Care Supervisor the cares not completed by Employee A. Employee A was terminated on 6/30/14. Notification of termination was faxed to SD DOH – OLC, for Employee A’s failure to comply with CNA certification.</p>		

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F 226	<p>Continued From page 6</p> <p>-On 6/24/14 resident 5 reported to the RSC CNA A had never offered to perform perineal and catheter care for her, -That resident had completed that care without CNA's assistance. *CNA was terminated on 6/30/14.</p> <p>Interview on 9/10/14 with the director of nursing (DON) revealed: *She had faxed the final report to the SD DOH on 7/1/14. *It was not until 7/14/14 that she received a telephone call from a high school in Sioux Falls saying they had received this fax in error. The DON instructed them to shred the document. *She had sent the investigation to the same fax number she had always sent it to that was a Sioux Falls number. She did not know who was receiving those reports. -When she had accidentally sent the report to the high school it was because she had accidentally dialed the wrong number. *She was unaware of the 1-866 fax number. *On 7/22/14 during the investigation she had sought clarification from the complaint coordinator office with the SD DOH regarding the investigation on this particular event. -Because of the timing of the unfolding of the investigation she had not understood that she still needed to submit an initial report to SD DOH. *She confirmed the timing of the reports had not occurred as was required.</p> <p>3. Interview on 9/9/14 at 11:05 a.m. with the human resource (HR) director revealed he: *Had been in that position for two years and was responsible for the initial orientation process for all new employees. *Covered the areas that were required by the</p>	F 226		

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F 226	<p>Continued From page 7</p> <p>state including resident's rights with new employees.</p> <p>-The abuse prevention policy was not part of his initial orientation.</p> <p>-He assumed that training was covered in the specific department orientation.</p> <p>*Directed new staff to their departments for further orientation after he was done.</p> <p>*Could not say whether each department covered the abuse prevention policy with new employees.</p> <p>Interview on 9/10/14 at 8:30 a.m. with the resident care supervisor (RCS) revealed she:</p> <p>*Supervised all of the certified nursing assistants.</p> <p>*Was not responsible for training on the abuse prevention plan.</p> <p>*Thought that was part of the training during the initial orientation in HR.</p> <p>*Was not sure how that initial training on abuse was accomplished.</p> <p>*Knew they covered abuse annually in September in their staff inservices.</p> <p>*Confirmed that if new staff started after September they could potentially not have received specific abuse training until their annual inservice in the following September.</p> <p>Interview on 9/10/14 at 10:00 a.m. with the director of nurses (DON) revealed:</p> <p>*The formal training on abuse was done annually in the fall.</p> <p>*When new staff were mentored (trained) on the floor they also received training at the time of an incident such as a fall or missing resident regarding the investigation tool.</p> <p>*They needed to improve their training on the abuse policy and process.</p> <p>Review of the provider's August 2014 Abuse</p>	F 226	<p>All new hires will receive abuse and neglect training within 30 days of hire using our Relias online training vendor.</p> <p>All DRV associates campus wide will receive Abuse and Neglect training by October 31st. All staff will receive Abuse and Neglect training yearly through the Relias online training vendor with reminders going to staff emails. The Human Resources Director will oversee its direction.</p>	

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F 226	<p>Continued From page 8</p> <p>Prohibition policy revealed: **Alleged violations involving any mistreatment, neglect, abuse including injuries of unknown source and misappropriation of resident property will be reported immediately to the facility administrator, charge nurse, DNS [director of nursing service] and/or SW [social worker] as well as to any other officials in accordance with State law (including the State survey and certification agency). *The facility will have evidence that all alleged violations re thoroughly investigated and will prevent further potential abuse while the investigation is in progress. *Results of all investigations will be reported to the Administrator or designee and to other officials in accordance with State law (including the State survey and certification agency) within 5 working days of the incident. *Training: Upon hire and annually all employees will receive education related to abuse prohibition practices such as: -Interventions to deal with aggressive and/or catastrophic reactions of residents. -Reporting knowledge relating to suspected or witnessed abuse without fear of reprisal. -Recognizing signs and limitations regarding burnout, frustration and stress. -Definitions of abuse, neglect and misappropriation of resident property." **Prevention: -Education. -Supervision: Supervisors are responsible for monitoring compliance to procedures and directing associates to follow the Care plan. Supervisory staff must also monitor for inappropriate behaviors, such as using derogatory language, rough handling, etc as well as associate reactions to stressful situations and</p>	F 226	<p>A revised policy and procedure was developed using guidance from several reference publications and through review with our leadership team.</p> <p>The revised policy and procedure directly references the initial reporting form to the Department of Health, the Ombudsman, law enforcement, and family members, as well as gives nursing associates the investigational grid tools to begin an investigation. We addressed that all staff are mandatory reporters and emphasized the importance of promptly reporting to any member of the facility leadership team any incident or suspected incident of neglect and/or abuse. Signs were updated in the break rooms to reflect this. All staff annually and at initial hire will be required to read and sign they have read and understand the Abuse and Neglect Reporting policy. The Human Resources Director will be responsible for signatures through the Relias online training vendor. If there are handwritten signatures, they will be scanned into electronic employee files.</p>	
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F 226	Continued From page 9 the potential for burnout reactions and react accordingly. *The following are to be reported: suspicious bruising or bruising of unknown origin, any injuries of unknown origin, fractures, resident or family concerns of abuse, neglect mistreatment or reports of missing property or money, witnessed abuse, etc."	F 226			