

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

**ORIGINAL**

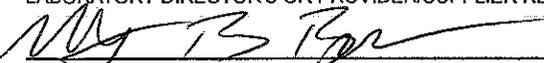
PRINTED: 04/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>04/09/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SOUTHRIDGE HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS  Surveyor: 29354 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities was conducted from 4/8/14 through 4/9/14. Areas surveyed included quality of life, quality of care, nursing services, dietary services, pharmacy service, dignity, and respect. Southridge Health Care Center was found not in compliance with the following requirements: F241, F250, F279, F281, F325, F327, F425, and F514.	F 000	Addendums noted with an asterisk per 5/19/14 telephone to facility administrator. DK/SD/DH/MF	
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: Surveyor: 29354 Based on record review, interview, and policy review, the provider failed to ensure dignity had been maintained for one of three sampled residents (2) who had not received a weekly bath or shower. Findings include:  1. Review of resident 2's medical record revealed: *An admission date of 1/3/14. *Diagnosis of right below knee amputation. *The 1/10/14 Minimum Data Set (MDS) revealed he: -Needed extensive assistance of two people with dressing.	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 5-2-14
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000 INITIAL COMMENTS

F 000

Surveyor: 29354

A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities was conducted from 4/8/14 through 4/9/14. Areas surveyed included quality of life, quality of care, nursing services, dietary services, pharmacy service, dignity, and respect. Southridge Health Care Center was found not in compliance with the following requirements: F241, F250, F279, F281, F325, F327, F425, and F514.

F 241 483.15(a) DIGNITY AND RESPECT OF SS=D INDIVIDUALITY

F 241

5/6/14

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:

Surveyor: 29354

Based on record review, interview, and policy review, the provider failed to ensure dignity had been maintained for one of three sampled residents (2) who had not received a weekly bath or shower. Findings include:

1. Review of resident 2's medical record revealed:

- \*An admission date of 1/3/14.
- \*Diagnosis of right below knee amputation.
- \*The 1/10/14 Minimum Data Set (MOS) revealed he:
  - Needed extensive assistance of two people with dressing.

Staff will offer resident (2) and other residents a shower at least weekly as residents prefer. Staff will assist resident (2) and other resident's with ADLs as appropriate. Showers/baths will be documented in bath book and care tracker after completion. Resident refusals will be documented as ADL assistance/activity will be documented in care tracker book to first page.

All staff that provides baths will be responsible to document every shower or bath in the bath book after completed.

The Director of Nursing (DON) and the Administrator will review the policy and procedure for quality of life ensuring dignity and respect for resident (2) and all other residents.

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

TITLE

(X6) DATE

*[Signature]*

Administrator

5-2-14

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

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F 241 : Continued From page 1

- Needed extensive assistance of one person with personal hygiene and bathing.
- Used a Hoyer lift (a mechanical lift used for transfers) for transfers with two people.
- \*The 1/3/14 care plan revealed he took a shower.
- \*The 1/14/14 care plan revealed he needed assistance with his care and mobility (getting around).
- \*There was no documentation on the undated March 2014 and undated April 2014 daily bath flow sheet that he had received a bath or shower.
- \*The electronic medical record indicated he had received seven showers in fourteen weeks.

i Interview on 4/8/14 at 9:15 a.m. with the resident i revealed he:

- ! \*Had received five showers since admission.
- \*Usually had taken a shower on Friday evenings.
- \*Would have taken more showers if they would have helped him.

Interview on 4/8/14 at 3:15 p.m. with certified nurse assistant (CNA) A revealed:

- \*She had assisted residents with showers.
- \*She confirmed resident 2 had not received his shower on 4/4/14 due to other residents had required assistance with activities of daily living. It had gotten late, and resident 2 had not wanted to take a shower that late at night. The nurse had been informed to let the next day shift know to give resident 2 a shower.
- \*They had not been "short staffed" on 4/4/14.

Interview on 4/8/14 at 3:50 p.m. with the director of nursing regarding resident 2 revealed:

- \*They used the daily bath sheet and care tracker for bathing documentation.
- \*There was no documentation on the daily bath sheet the resident had received a shower.

F 241

Education of the policy for quality of life – dignity for all staff will be completed by DON and/or Administrator by May 1, 2014.

*\* DON or designee will audit resident 2 and four random residents on both documentation weekly times for weeks and report results to QAPI monthly until 100% of compliant and deemed acceptable by QAPI team.*

*DK/SDDH/MF*



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F 250 ; Continued From page 3

- \*Diagnoses of depression, end stage renal disease, and dialysis.
- \*A 1/13/14 fax to the physician stated "Res (resident) states to social services that he is depressed. On Wellbutrin SR (antidepressant ; medications) 100 milligrams {mg} orally bid (twice a day). Can this be increased?" Physician response on 1/14/14 was to increase the dosage to 150 mg BID.
- \*The 1/13/14 Care Area Assessment ; Documentation completed by social services designee 8 revealed the resident stated he had little interest or pleasure in doing things. The ; resident had not felt like doing anything and was depressed.
- \*The 1/21/14 social services progress notes stated he showed mild depression symptoms.
- \*There was no further documentation on the resident's depression.
- Interview on 4/8/14 at 4:40 p.m. with the director of nursing confirmed:
  - \*There were no mood and behavior sheets for resident 2, because he was on an antidepressant.
  - \*They only documented mood and behavior sheets for residents who were on antipsychotic medications.
- Interview on 4/8/14 at 5:00 p.m. with social services designee B regarding resident 2 revealed she:
  - \*Was a licensed social worker in another state and was waiting for her license in South Dakota.
  - \*Had documented a quarterly assessment on the resident.
  - \*Agreed she should have been more involved with his feelings of depression.
  - \*Agreed there was no follow-up documentation regarding the increase in the antidepressant.

F 250 Antidepressant's weekly X 12 and report results to QAPI monthly until 100% of compliant and deemed acceptable by QAPI team.

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F 250	Continued From page 4  Review of the provider's May 2013 Social Worker job description revealed: • **The role of the Social Worker in a long term care facility is to enable each individual to function at the highest possible level of social and emotional wellness. • *Provides psychosocial assessments of patients/residents and families to identify emotional, social, and environmental strengths and problems related to their diagnosis, illness, treatment, and/or life situation. • *Document assessment, plan, interactions, and interventions. • *Provide education to patients/residents and families around issues related to adaptation to the patient/resident's diagnosis, illness, treatment, and/or life situation."	F 250	
F 279 ; 483.20(d), 483.20(k)(1) DEVELOP SS=D	COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279	5/6/14  A comprehensive care plan will be developed, edited and communicated to appropriate staff along with C.N.A packet care plans regarding diet/diet changes, fluid restrictions as applicable for resident (2) and all other residents. Pressure ulcer prevention/care will be updated on resident (2) care plan and all other residents at risk of having pressure ulcers.  Charge nurses will update care plan with ulcer new order/interventions. Skin team will document on weekly rounds of resident (2) and all residents with pressure ulcers and update care plan as needed.

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F 279 Continued From page 5  
due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

; This REQUIREMENT is not met as evidenced by:  
Surveyor: 29354  
Based on record review, interview, and policy review, the provider failed to ensure care plans had been individualized, accurate, and updated to reflect the current status for one of three sampled residents (2). Findings include:

- 1. Review of resident 2's medical record revealed:
  - \*A 1/3/14 physician's order for a renal, constant carbohydrate diet with 1200 cc (cubic centimeter) fluid restriction.
  - \*A 2/17/14 physician's order for a renal diet, NDD3 (consists of food of nearly regular texture), diet texture, 1200 cc fluid restriction.
  - \*A 3/25/14 physician's order for a renal, consistent carbohydrate, NDD3 diet with 1200 ml (milliliter) fluid restriction.
  - \*Review of the 1/3/14 care plan revealed the diet order: CHO (consistent carbohydrate) with 1200 cc fluid/day.
  - \*Review of the updated 4/7/14 pocket care plan utilized by the certified nursing assistants revealed renal diet with 1200 fluid restriction.
  - \*Review of the 2/20/14 at 10:00 a.m. interdisciplinary notes revealed a superficial open area on the coccyx (buttock) measuring 1.5 by 0.5.
  - \*Weekly pressure ulcer (localized injury to the skin and/or underlying tissue that occurs over a bony prominence) record for: -2/20/14 stage two, 4.5 by 1.5 pressure ulcer to

F 279 Staff will be educated regarding care plan, updates, pressure ulcer/prevention, fluid and diet restrictions and collaborative departments on or before May 1, 2014.

DON or designee will audit resident (2) care plan and four other care plans with diet restrictions, fluid restrictions and/or pressure ulcers weekly X 12 and report results to QAPI monthly. Audits will continue until 100% compliant and deemed acceptable by QAPI team.

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F 279 , Continued From page 6

F 279

- inside fold of coccyx.
- -2/27/14 stage one, 3.0 by 0.8 pressure ulcer continued.
- -3/6/14 area was healed.
- \*There was no documentation on the 1/3/14 care plan for the above pressure ulcer.

Interview on 4/8/14 at 2:45 p.m. with the registered dietitian (RD) agreed the care plan had not reflected resident 2's current dietary order.

- Interview on 4/8/14 at 3:50 p.m. with the director of nursing revealed:
- \*She agreed the care plan had not reflected resident 2's current dietary order or recent pressure ulcer.
- \*The care plan should have been updated with changes in the resident's diet and pressure ulcer.

Interview on 4/9/14 at 8:50 a.m. with registered nurse, Minimum Data Set (MOS) case manager C revealed:

- \*There was no indications of a pressure ulcer or interventions on resident 2's care plan.
- \*The skin team usually had let her know in the past about pressure ulcers.

- Review of the provider's January 2009 Care Plans-Comprehensive policy revealed the facility would develop a "Comprehensive care plan for each resident that included measurable objectives and time tables to meet the resident's medical, nursing, and psychological needs. Care plans were revised as changes in the resident's condition dictated."

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET SS=D PROFESSIONAL STANDARDS

F 281

5/6/14

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F 281	<p>Continued From page 7</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, record review, interview, and policy review, the provider failed to ensure professional standards of practice for: *Physician's order was followed for one of one sampled resident (2) who received insulin. *Physician had been notified of medication not given to one of one sampled resident (2) who received insulin. *Communication between the nursing department and dietary services for one of one sampled resident (2) on a fluid restriction. *Monitoring pre and post dialysis for one of three sampled residents (2) who received dialysis. *Proper hand hygiene during randomly observed medication administration for one of three observed nurses (C).</p> <p>Findings include:</p> <p>1. Review of resident 2's medical record revealed: *He had a diagnoses of diabetes mellitus and end stage renal disease. *He received dialysis three times a week outside of the facility. *He had a physician's order for Novolog insulin to be given everyday at noon. *Medication administration records (MAR) for January 3, 2014 through April 7, 2014 revealed he had not received the noon insulin: -Eleven times in January. -Twelve times in February. -Eleven times in March.</p>	F 281	<p>Resident (2) had a change in physician orders (April 17, 2014) to cancel noon insulin order.</p> <p>Nursing staff will contact by phone/in-person the DON and primary care physician with any missed doses of any medications including insulin for clarification.</p> <p>DON or designee will audit MAR on resident (2) and four random insulin residents weekly X 12 and will report to QAPI monthly until 100% compliant and deemed acceptable by QAPI team.</p> <p>Nursing and Dietary Manager will better communicate fluid restriction amounts. Approximately 60% of fluid intake is given by Dietary department and documented on care tracker and approximately 40% of fluid intake is given by nursing staff and documented on MAR, fluid intake percentages may be altered per resident preference. Resident (2) to be educated as stated in facility policy of fluid restriction guidelines, by nursing staff at time of order.</p> <p>Dietary manager or designee will audit resident (2) care plan and four other care plans with fluid restrictions weekly X 12 and report results to QAPI monthly until 100% compliant and deemed acceptable by QAPI team.</p> <p>DON or designee will educate on documenting</p>

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F 281	<p>Continued From page 8</p> <ul style="list-style-type: none"> <li>-Two times in April.</li> <li>*There was no documentation on the dialysis communication forms that indicated he had received insulin while at dialysis.</li> </ul> <p>Interview on 4/8/14, at 11:00 a.m. with the primary physician regarding resident 2 revealed he had been unaware the resident had not received the noon insulin on dialysis days.</p> <p>: Interview on 4/8/14 at 2:15 p.m. with registered nurse E revealed:</p> <ul style="list-style-type: none"> <li>*They had not given resident 2 his insulin on dialysis days, because he left at 10:00 a.m.</li> <li>*She was not sure if the dialysis unit had given the resident insulin on those days.</li> </ul> <p>Interview on 4/9/14 at 8:30 a.m. with the director of nursing regarding resident 2 revealed her expectations would have been for the nurses to contact the primary physician about the noon dose of insulin not being given.</p> <p>Review of the provider's 10/23/13 Medication Therapy and Administration policy revealed:</p> <ul style="list-style-type: none"> <li>*Medications would be administered in a safe and timely manner as prescribed.</li> <li>*Medications would be administered according to established schedules.</li> <li>*All medication orders would be supported by appropriate care processes and practices.</li> <li>*Medications would be administered in accordance with the orders, including any required time frame.</li> </ul> <p>2. Review of resident 2's medical record revealed no documentation informing the physician the noon insulin had not been given eleven times in January, twelve times in February, eleven times</p>	F 281	<p>removing pressure dressings after dialysis on TAR on or before May 1, 2014. Daily B/P and pulse is to be completed by nursing staff and recorded on TAR.</p> <p>DON or designee will audit TAR on resident (2) and up to four dialysis patients weekly X 12 and report results to QAPI until 100% compliant and deemed acceptable by QAPI team.</p> <p>DON or designee will audit proper hand washing hygiene X 12 weeks then monthly X 3 months. DON or designee will educate nursing staff on hand washing policy and Administer medication policy on or before May 1, 2014.</p>

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F 281	<p>Continued From page 9 in March, and two times in April.</p> <ul style="list-style-type: none"> <li>· Interview on 4/8/14 at 11:00 a.m. with the primary physician regarding resident 2 revealed he had not been informed the resident had not received the noon insulin on dialysis days.</li> <li>· Interview on 4/8/14 at 2:15 p.m. with registered nurse E revealed they had not notified resident 2's primary physician he had not received the noon insulin on dialysis' days.</li> <li>· Interview on 4/9/14 at 8:30 a.m. with the director of nursing regarding resident 2 revealed her expectations would have been for the nurses to contact the primary physician about the noon dose of insulin not being given.</li> <li>· Review of the provider's 10/23/13 Medication Therapy and Administration policy revealed the physician would identify situations where medications should be tapered, discontinued, or changed to another medication.</li> <li>· 3. Review of resident 2's medical record revealed: <ul style="list-style-type: none"> <li>*He had been admitted on 1/3/14 with physician's orders for 1200 cc fluid restriction per day. The 3/25/14 physician's orders continued with the 1200 cc fluid restriction per day.</li> <li>*The electronic medical record intake/output by week chart with supplements revealed he had taken in per week: <ul style="list-style-type: none"> <li>· -8680 cc fluids for week of 3/9/13.</li> <li>· -7540 cc fluids for week of 3/16/14.</li> <li>· -10235 cc fluids for week of 3/23/14.</li> <li>· -8280 cc fluids for week of 3/30/14.</li> <li>· -2950 cc fluids for week of 4/6/14.</li> </ul> </li> <li>*There was no documentation for fluid restriction</li> </ul> </li> </ul>	F 281	

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F 281	Continued From page 10 <ul style="list-style-type: none"> <li>· on the 1/13/14 Care Area Assessment completed by the registered dietitian (RD).</li> <li>· *The 1/14/14 dialysis plan of care revealed to maintain fluid restrictions.</li> <li>· *There was no documentation in the interdisciplinary notes about resident education for fluid restriction.</li> </ul> <p>Observation and interview on 4/8/14 at 9:15 a.m. in resident 2's room revealed a large glass with water in it. Interview at that time with resident 2 revealed he filled the glass up with water when ever he wanted.</p> <p>Interview on 4/8/14 at 2:00 p.m. with the certified dietary manager (COM) revealed:</p> <ul style="list-style-type: none"> <li>· *She thought resident 2 was on a 1500 cc fluid restriction per day.</li> <li>· *She changed her mind after the surveyor reviewed the physician's order for 1200 cc fluid restriction per day saying they must have lowered the amount.</li> <li>· *The surveyor reviewed the order for 1200 cc fluid restriction per day being the same since admission.</li> <li>· *Dietary had not informed nursing how much fluid dietary provided for the resident each day.</li> </ul> <p>Interview on 4/8/14 at 2:15 p.m. with registered nurses E and F revealed:</p> <ul style="list-style-type: none"> <li>· *They knew he was on a 1200 cc fluid restriction but had been unaware how much nursing was allotted to give him since dietary would inform them.</li> <li>· *Dietary had not let them know how much fluid to give.</li> <li>· *They usually recorded the amount of fluid on the medication administration record (MAR).</li> <li>· *There was no documentation of daily fluid intake</li> </ul>	F 281	

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

PRINTED: 04/21/2014  
FORM APPROVED  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/09/2014
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NAME OF PROVIDER OR SUPPLIER  SOUTHRIDGE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105
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F 281 - Continued From page 11 F 281

on the January 3, 2014 through April 8, 2014  
MAR.

Interview on 4/8/14 at 2:45 p.m. with the RD  
, revealed:

- \*There was an intake sheet on the back of the resident 2's door that staff documented intake on.
- \*Dietary tried to give him 70 percent (%) of his total restricted fluids per day.
- \*She agreed the CAA nutritional status assessment had not addressed fluid restriction.

Observation on 4/8/14 at 3:10 p.m. in resident 2's room revealed no intake sheet on the back of his door.

Interview on 4/9/14 at 8:30 a.m. with the director of nursing revealed her expectations would be for:

- \*Dietary and nursing to do a better job of communicating between each other.
- \*The staff to have documented resident 2's intake.

Review of the provider's 8/11/09 Hydration policy revealed "Any resident on a fluid restriction will be placed on I(intake) and O (output) recording sheets."

4. Review of resident 2's dialysis care plan revealed:

- \*Assess/monitor VS (vital signs - temperature, pulse, respirations) and condition.
- \*Assess/monitor access site (shunt used for dialysis) QD (every day).
- \*Arm access care: Remove tape and gauze six hours after dialysis. Remove Band-Aid 24 hours (next day) after dialysis.
- \*Medication administration record (MAR) from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/09/2014
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NAME OF PROVIDER OR SUPPLIER  SOUTHRIDGE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105
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F 281 , Continued From page 12

F 281

- January 3, 2014 through April 8, 2014 revealed:
  - Remove pressure dressing to access site Tuesday, Thursday, and Saturday. There was no documentation one time in February and four times in March of having been done.
  - Daily blood pressure and pulse had not been documented two times in February, three times in March, and one time in April.

- Interview on 4/9/14 at 8:30 a.m. with the director of nursing revealed:
  - \*If there was no documentation then the areas had not been done.
  - \*The MAR should have been initialed when the treatments and vitals signs had been completed.

- Review of the provider's 10/28/13 Outpatient Dialysis policy revealed:
  - \*\*Nursing staff will monitor the resident prior to and post hemodialyses.
  - \*A resident assessment will be documented prior to being transported to outpatient dialysis and immediately after.
  - \*It is important to take care of the access to prevent complications."

- 5. Observation on 4/9/14 at 7:55 a.m. in the east dining room revealed: *\*D MB 5-2-14*
  - \*Licensed practical nurse *C* had prepared medications. She took the medication cup and a glass of water in her right hand. Then:
    - With her left hand she took a Kleenex from the top of the med cart.
    - Wiped up a spill on the floor with the Kleenex.
    - Disposed of the Kleenex in the garbage can.
    - Without performing hand hygiene went to a residents' table to administer the medication.

- Interview on 4/9/14 at 8:30 a.m. with the director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(Xi) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/09/2014
NAME OF PROVIDER OR SUPPLIER  SOUTHRIDGE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105	
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F 281 Continued From page 13 F 281

of nursing revealed her expectations would have been for LPN to perform hand hygiene after wiping the spill up from the floor and before continuing with the medication administration. *MB 5-2-14*

Review of the provider's undated Hand Washing/Hand Sanitizer policy revealed hand washing and/or hand sanitizing to reduce the transmission of organism and prevent the spread of infection.

Review of the provider's January 2014 Hand Hygiene policy revealed "Hand hygiene is done before and after having direct contact with residents. After having contact with potentially contaminated surfaces and objects in all locations. Handling of medications including between residents during medication pass and as needed."

F 325 483.25(j) MAINTAIN NUTRITION STATUS F 325  
SS=D UNLESS UNAVOIDABLE

Based on a resident's comprehensive assessment, the facility must ensure that a resident -  
(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  
(2) Receives a therapeutic diet when there is a nutritional problem.

This REQUIREMENT is not met as evidenced by:  
Surveyor: 29354

*\* to resident in and DK/SDOH/ME* 5/6/14

Sack lunches and or early/late meals will be offered to any resident out of facility during meal times depending on resident preference.

Dietary manager will create documentation sheets for listing residents away during mealtime and will post the list of residents gone at meals in kitchen area to document sack lunches given.

Dietary Manager or designee will document when sack lunch is sent and contents of lunch. They will also document upon return contents of sack lunch.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/09/2014
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NAME OF PROVIDER OR SUPPLIER  SOUTHRIDGE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 325 Continued From page 14

Based on record review, interview, and policy review, the provider failed to ensure the nutrition needs were met for one of one resident (2) who:

- \*Was on a therapeutic diet, received insulin, and had dialysis three times a week.
- \*Was on a fluid restriction.
- \*Had a pressure ulcer.

Findings include:

- : 1. Review of resident 2's medical record revealed:
  - \*He had diagnoses of insulin dependent diabetes and end stage renal dialysis.
  - \*He received insulin three times a day.
  - \*Was on a renal, consistent carbohydrate diet, NDD3 (consists of food of nearly regular texture) with 1200 cc fluid restriction per day.
- ' Interview on 4/8/14 at 9:15 a.m. with resident 2 revealed:
  - \*He went to dialysis three times a week. He was usually gone over the noon hour, and he had not had dinner on those days.
  - \*They started sending a sack lunch with him on dialysis days a few days ago.
  - \*Somedays he was "pretty hungry" when he returned from dialysis.
- : Interview on 4/8/14 at 2:00 p.m. with the certified dietary manager (COM) revealed:
  - \*They always sent sack lunches along with the dialysis residents.
  - \*Resident 2 had refused sack lunches in the past and would throw the food into the garbage.
  - \*There was no documentation in resident 2's chart regarding his refusal of sack lunches.
- Interview on 4/8/14 at 2:15 p.m. with dietary cook G regarding resident 2 revealed:

F 325

Documentation is to be done and followed up by dietary manger when sack lunches are refused.

Nursing staff is to notify dietary department of residents who will be out of facility during meal times.

Dietary Manager or designee will audit sack lunch document for missing documentation weekly X 12 and report results to QAPI monthly until 100% of compliant and deemed acceptable by QAPI team.

DON will educate nursing staff on proper notification of acquired PU's on or before May 1, 2014. Nursing staff will notify RD on any acquired PU's.

DON or designee will audit skin assessment sheet for proper notification on resident (2) and up to four random residents' weekly X 12 and report results to QAPI until 100% compliant and deemed acceptable by QAPI team.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/09/2014
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE

F 325 Continued From page 15

F 325

\*No one had informed her to send a sack lunch with resident 2 on dialysis days until recently.  
: \*They would hold his lunch for him until he returned from dialysis. A lot of the times the resident had refused the lunch.

Interview on 4/9/14 at 8:30 a.m. with the director of nursing (DON) revealed:  
: \*She had been unaware a sack lunch had not been sent with resident 2 on dialysis days.  
: \*She would expect a sack lunch to have been sent with resident 2 on dialysis days.

Review of the provider's April 2011 Diets policy revealed:  
: \*Nursing staff are responsible for informing the dietary department of the dietary needs/concerns/requests of the resident."  
: \*If a resident is leaving the facility and will not be present for a meal, the charge nurse needs to notify the dietary department of this, in writing, being sure to include which meals will be missed."

2. Review of resident 2's medical record revealed he was on a 200 cc fluid restriction.  
Refer to F281, finding 3.

3. Review of resident 2's medical record revealed:  
: \*He had acquired a stage two pressure ulcer in the facility on 2/20/14.  
: \*There was no documentation on the 2/24/14 interdisciplinary notes by the registered dietitian (RD) regarding the pressure ulcer.

Interview on 4/8/14 at 2:45 p.m. with the RD revealed she had not been informed of resident 2's pressure ulcer.

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

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FORM APPROVED  
OMS NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  SOUTHRIDGE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 325 Continued From page 16

Review of the provider's undated Pressure Ulcer Care Plan criteria interventions were to notify the dietitian regarding a pressure ulcer.

F 327 : 483.250) SUFFICIENT FLUID TO MAINTAIN SS=D HYDRATION

The facility must provide each resident with sufficient fluid intake to maintain proper hydration ; and health.

This REQUIREMENT is not met as evidenced by:

- Surveyor: 29354
- Based on record review, interview, and policy review, the provider failed to monitor and document fluid intake for one of one sampled resident (2) on a fluid restriction. Findings include:

- Review of resident 2's medical record revealed he was on 1200 cc fluid restriction.
- Refer to F281, finding 3.

F 425 483.60(a),(b) PHARMACEUTICAL SVC - SS=D ACCURATE PROCEDURES, RPH

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet :

F 325 :

F 327

Nursing and Dietary Manager will better communicate fluid restriction amounts. Approximately 60% of fluid intake is given by Dietary department and documented on care tracker and approximately 40% of fluid intake is given by nursing staff and documented on MAR, fluid intake percentages may be altered per resident preference.

Resident (2) to be educated as stated in facility policy of fluid restriction guidelines, by nursing staff at time of order.

Dietary manager or designee will audit resident (2) care plan and four other care plans with fluid restrictions weekly X 12 and report results to QAPI monthly until 100% compliant *and MB 5-2-14*

F 425

5/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/09/2014
NAME OF PROVIDER OR SUPPLIER  SOUTHRIDGE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105	
(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 425 Continued From page 17  
the needs of each resident.

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced by:

Surveyor: 29354

Based on record review, interview, and policy review, the provider failed to ensure medications were accessible, and administered for one of three sampled residents (2). Findings include:

- 1. Review of resident 2's medical record revealed:
  - \*A 1/3/14 admission date.
  - \*Diagnoses of depression, end stage renal disease, and diabetes.
  - \*Medication administration record (MAR) for January 3, 2014 through April 7, 2014 revealed he had not received the noon insulin:
    - Eleven times in January.
    - Twelve times in February.
    - Eleven times in March.
    - Two times in April.
  - \*MAR for January 3, 2014 through April 7, 2014 revealed he had not received Bupropion (antidepressant medication):
    - Eleven times in January.
    - Seven times in February.
    - Eight times in April.

Interview on 4/8/14 at 11:00 a.m. with the primary physician regarding resident 2 revealed:

F 425 Resident (2) had a change in physician orders (April 17, 2014) to cancel noon insulin order.

Nursing staff to notify Residents Physician anytime a Resident will be out of facility and there will be missed medications. Bupropion dose was increased and resident receives meds through VA Pharmacy, which needs to be ordered 7 -21 days prior to need for medication to come.

Nursing Staff to document the reason medications are not given. If medications are not available from VA pharmacy the nursing staff is to notify alternative pharmacy, and notify Physician.

DON or designee will develop policy and procedure relevant to medication availability from pharmacy by May 1, 2014.

DON or designee will audit availability of medications for resident (2) and up to 2 residents receiving medications from the pharmacy weekly X 12 and report results to QAPI monthly until 100% compliant and deemed acceptable by QAPI team.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/09/2014
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(X4) 1D 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 425 Continued From page 18

F 425

\*He had been unaware the resident had not received the noon insulin on dialysis days.  
 \*His expectations would have been:  
 : -For the insulin to have been given .  
 . -To have been informed of the above.

· Interview on 4/8/14 at 2:15 p.m. with registered nurse E revealed:  
 \*They had not given resident 2 his insulin on dialysis days, because he left at 10:00 a.m.  
 \*She was not sure if the dialysis unit had given the resident insulin on dialysis days.

Interview on 4/9/14 at 8:05 a.m. with licensed practical nurse D revealed:  
 \*The antidepressant had not been given.  
 \*There was a problem with obtaining medications from the pharmacy, because it was the VA (Veterans Administration) pharmacy.  
 : \*Resident 2's wife wanted the medications sent to her house first

: Interview on 4/9/14 at 8:30 a.m. with the director of nursing regarding resident 2 revealed her expectations would have been for:  
 \*The nurses to contact the primary physician about the noon dose of insulin not being given.  
 \*Medications were to be available at all times for each resident.

Review of the provider's 10/28/13 Medication Therapy and Administration policy revealed:  
 \*\*"Medication shall be administered in a safe and timely manner, and as prescribed.  
 \*All medication orders will be supported by appropriate care processes and practices.  
 \*Medications must be administered in accordance with the orders, including any required time frame."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/09/2014
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NAME OF PROVIDER OR SUPPLIER  SOUTHRIDGE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105
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(X4) 1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 425 ; Continued From page 19

Surveyor requested but there was no policy relevant to medication availability from pharmacy.

F 425

F 514 ' 483.75(1)(1) RES  
SS=D RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:  
Surveyor: 29354  
; Based on record review, interview, and policy review, the provider failed to maintain clinical records that had accurate documentation for one of three sampled residents (2). Findings include:

1. Review of resident 2's medical record revealed the January 3, 2014 through April 7, 2014 Medication Administration Record (MAR) had multiple areas that had incomplete documentation.

Interview on 4/9/14 at 8:05 a.m. with licensed

F 514

5/6/14

Resident (2) medication MAR has missed documentation as to why medications were not given.

Nursing staff is expected to circle the medication MAR initials if medication is not given and document on the back of the MAR the reason not given.

\*  
DON or designee will audit medication MAR's for missed documentation for resident (2) and four random residents weekly x 12 and report results to QAPI monthly until 100% compliant and deemed acceptable by QAPI team.

*DON or designee will educate staff on MAR documentation on or before 05/16/14. DK/SD/DH/MF*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/09/2014
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NAME OF PROVIDER OR SUPPLIER  SOUTHRIDGE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105
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F 514 ' Continued From page 20  
practical nurse D revealed:  
\*There were multiple medications (meds) on the MAR not initialed as having been given, initialed areas with a circle drawn around it, and no documentation on the response sheet as to why the medication was not given.  
' \*She usually documented on the back of the MAR why the medication had not been given.  
' \*If the medication on the MAR had been circled that indicated the med was not given or not available.  
' \*She confirmed she had not documented on the MAR each time she had not given a med or the med was unavailable.

Interview on 4/9/14 at 8:15 a.m. with the director of nursing revealed:  
\*The nursing staff needed more education on documentation.  
\*If a medication had not been signed off by the person administering the med she considered it not given.

Review of the provider's 11/8/12 Documentation policy revealed it was to "Provide a readable, accurate, and detailed description of the condition of the resident, the cares received, responses from resident and action taken."

: Review of the provider's 10/28/13 Medication Therapy and Administration policy revealed:  
' \*If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose.  
' \*The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before

F 514

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

PRINTED: 04/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/09/2014
NAME OF PROVIDER OR SUPPLIER  SOUTHRIDGE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105	
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			(X5) COMPLETION DATE

F 514 : Continued From page 21  
: administering the next dose."

F 514