

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 09/11/2014
--	--	--	---

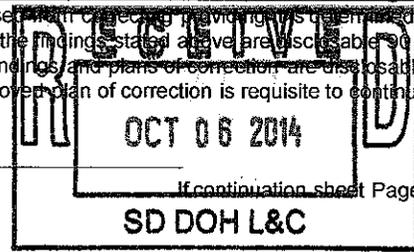
NAME OF PROVIDER OR SUPPLIER SOUTHRIDGE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105
---	--

(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 000	INITIAL COMMENTS Surveyor: 22452 complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/2/14 through 9/11/14. Areas surveyed included: staffing, abuse and neglect, and resident care issues. Southridge Health Care Center was found not in compliance with the following requirements: F221, F222, F225, F241, F248, F278, F279, F281, F309, F325, F333, F353, F356, F368, F371, F490, and F493.	F 000		
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 A Based on observation, record review, interview, and policy review, the provider failed to accurately assess one of one resident (1) who used a seat belt in his wheelchair (w/c) for positioning, and was unable to release the seat belt independently. Findings include: 1. Review of resident 1's medical record revealed: *He had been admitted on 7/3/14. *There was no physician's order for the use of the seat belt. *There was no assessment to indicate the use of the seat belt.	F 221	1. The chair or bed equipment for Residents 1 and 4 were assessed for appropriateness related to their medical symptoms using the Physical Restraint Assessment form and the clinical records were reviewed. The residents were determined not to have any negative outcomes related to the use of the chair or bed equipment. The clinical records for all residents who use equipment on their chair and/or bed were reviewed to ensure the equipment was properly	10/10/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 10-5-14
---	------------------------	----------------------

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is demonstrated 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.



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

PRINTED: 09/25/2014
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 09/11/2014
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 221	<p>Continued From page 1</p> <p>Review of resident 1's 7/15/14 Interdisciplinary Progress Notes revealed: *Minimum Data Set (MDS) coordinator G had documented: -He had his own w/c with a seat belt. -He was unable to release the seat belt. -That seat belt was considered a restraint.</p> <p>Review of resident 1's 7/17/14 Occupational Therapy (OT) Plan of Care revealed: *He was at risk for falling out of his w/c. *He was unable to use his seat belt independently. *He had been using a seat belt to keep him positioned appropriately. *He had not been allowed to use the seat belt as he could not manage it himself. *Therapy was to have come up with an alternate method to keep him safely positioned in his w/c.</p> <p>Review of resident 1's admission MDS assessment on 7/10/14 revealed: *Restraints were coded zero (none) for all areas in section P under physical restraints. *Those areas used in the chair or out of the bed had included: -Trunk restraint. -Limb restraint. -Chair prevents rising. -Other.</p> <p>Interview on 9/8/14 at 1:45 p.m. with OT H regarding resident 1 revealed: *On 7/17/14 he had a seat belt. *He had been unable to independently release the seat belt when it was buckled. *That would have been a restraint as he was unable to independently release the seat belt.</p>	F 221	<p>assessed for appropriateness related to the medical symptoms.</p> <p>2. All side rails will be removed and replaced with transfer rails upon receipt of them as soon as received; order was placed on 10/3/14. A Physical Restraint Assessment form was developed to ensure a systematic assessment of the chair or bed equipment is completed to include the resident's medical symptom(s), cognitive and physical function, observation of the resident to determine the effect the equipment has on the resident's function, whether the resident can easily and voluntarily remove the equipment, and a determination of whether the equipment meets the definition of a physical restraint. The Restorative Nurse was designated to coordinate the assessment of chair and bed equipment with input from the therapy department. The Restorative Nurse will report on residents who have a new or revised need for chair or bed equipment during the daily (M-F) clinical stand-up meeting with the interdisciplinary team (IDT). The IDT was educated regarding the revised form and the physical restraint assessment process.</p>		

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 09/11/2014
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 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	<p>Continued From page 2</p> <p>*She had recommended on her evaluation form to use the tilt mechanism in his w/c to allow improved positioning.</p> <p>*She was unsure when the seat belt buckle had been discontinued.</p> <p>*There had been no assessment completed for the use of the seat belt.</p> <p>Interview on 9/9/14 at 9:10 a.m. with MDS coordinator G regarding resident 1's seat belt use revealed:</p> <p>*The seat belt had been considered a restraint.</p> <p>*That seat belt had been on him during the initial MDS assessment period.</p> <p>*It should have been coded on the 7/10/14 admission MDS assessment under:</p> <ul style="list-style-type: none"> -Trunk restraint. -Chair prevents rising. <p>*He would have been unable to release the seat belt when it was buckled.</p> <p>*She agreed the provider had not accurately assessed him for the seat belt.</p> <p>Interview on 9/10/14 at 8:15 a.m. with the director of nursing regarding resident 1's seat belt use revealed she confirmed:</p> <p>*There had been no assessment completed for the seat belt.</p> <p>*There was no physician's order for the use of the seat belt.</p> <p>Observation on 9/10/14 at 9:45 a.m. of resident 1's w/c revealed an unbuckled seat belt attached to both sides of the inside of the w/c.</p> <p>Review of the provider's 6/11/14 Use of Restraints policy revealed:</p> <p>**Restraints shall only be used for the safety and well-being of the resident(s) and only after other</p>	<p>F 221</p> <p>3. At monthly QAPI meetings, the Director of Nursing or designee will report on the IDT clinical stand-up review of all residents with physical restraint assessments to verify accuracy and appropriateness of the equipment used, and decisions will be determined for further performance improvement action based on the result of the report. The reports on physical restraint assessment process will occur until the QAPI committee determines otherwise.</p>	

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

PRINTED: 09/25/2014
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 09/11/2014
--	--	--	---

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 221	<p>Continued From page 3</p> <p>alternatives have been tried unsuccessfully.</p> <p>*Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls.</p> <p>*The definition of a restraint is based on the functional status of the resident and not the device.</p> <p>*If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition, and this restricts his/her typical ability to change position or place, that device is considered a restraint.</p> <p>*Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including:</p> <ul style="list-style-type: none"> -Placing a resident in a chair that prevents the resident from rising. <p>*Restraints may only be used if/when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention and a restraint is required to:</p> <ul style="list-style-type: none"> -Treat the medical symptom. -Protect the resident's safety. -Help the resident attain the highest level of his/her physical or psychological well-being. <p>*Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints.</p> <p>*The assessment shall be used to determine possible underlying causes of the problematic medial symptoms and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms.</p> <p>*Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative.</p>	F 221		
-------	---	-------	--	--

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 09/11/2014
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 221	<p>Continued From page 4</p> <p>Surveyor: 32332</p> <p>B. Based on observation, interview, and policy review, the provider failed to follow their Comprehensive Mobility Assessment recommendations for the use of side rails/transfer bars for one of two sampled residents (4) who used side rails. Findings include:</p> <p>1. Random observations from 9/2/14 through 9/10/14 of resident 10's bed revealed two half side rails (transfer bars) attached to each side at the head of the bed.</p> <p>Review of resident 4's medical record revealed: *A 6/10/14 Comprehensive Mobility Assessment indicated: -She used one transfer bar on her right side in bed to turn in bed. -She used a body pillow to her left side in bed. -There was a physician's order for the use of the transfer bar. -There was signed consent by her power of attorney for the use of the transfer bar. -Use of the transfer bar had been added to the care plan. *The 7/17/14 care plan indicated she had bilateral (on both sides of the bed) transfer bars to aid with bed mobility.</p> <p>Interview on 9/10/14 at 10:00 a.m. with MOS Coordinator B revealed: *She had completed the side rail/transfer bar assessment on 6/10/14. *That assessment was called the Comprehensive Mobility Assessment. *It was to have been used to write the care plan. *She had been aware the assessment had not matched information on the care plan. *She would have used the care plan information</p>	F 221	

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 09/11/2014
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 221	Continued From page 5 to care for the resident rather than the assessment. *The assessment had not been accurate. Review of the provider's 6/11/14 Use of Restraints policy revealed: *Prior to placing a resident in restraints there shall be a pre-restraining assessment and review to determine the need for restraints. *The assessment shall be used to determine possible underlying causes of the problematic medial symptoms and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that might improve the symptoms. *Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative.	F 221		
F 222 SS=G	483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 30170 Based on record review and interview, the provider failed to ensure an anti-anxiety medication was administered to one of one sampled resident (5) for the appropriate indications. Findings include: 1. Review of resident 5's complete medical record revealed: *He had been admitted on 10/7/13.	F 222	1. The clinical record and drug regimen for Resident 5 was reviewed. There was a brief sedation effect that had resolved and no ongoing harm was identified. The care plan was updated with specific indications for use of the psychoactive medications and non-pharmacological interventions. The clinical records, drug regimen, and care plan for all residents who are prescribed psychoactive medications were reviewed for appropriate dosage and indications for use, and non-pharmacological interventions.	10/10/14

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 09/11/2014
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)
F 222	<p>Continued From page 6</p> <p>*His diagnoses included: -Dementia (loss of memory). -Anxiety state. -Right hip fracture on 3/8/14 related to a fall. *Admitted to Hospice services on 8/28/14 related to his dementia. *On 8/28/14 he had a physician's order for Ativan (anti-anxiety medication) 2 milligrams (mg)/milliliter (ml) administer 0.25 ml (one-half mg) to 0.5 ml (1 mg) sublingually (under the tongue) every four hours as needed for anxiety.</p> <p>Review of resident 5's Antipsychotic Monitoring Tool sheet revealed: *On 8/28/14 at 8:00 p.m. he had been given 1 ml of Ativan sublingually for displaying "agitation with cares." *On 8/29/14 at 2:00 a.m. he had been given another 1 ml of Ativan for displaying "agitation with cares." *Ativan 1 ml was equivalent to 2 mg of Ativan, which would mean the resident had received twice the physician's ordered dose.</p> <p>Interview on 9/3/14 at 4:00 p.m. with the director of nursing (DON) regarding the above record review revealed: *She had been unaware there was an incorrect dose of Ativan administered to resident 5. *She agreed the resident had been given twice the physician ordered dose of Ativan. *The resident could have been severely injured with that incorrect dose of Ativan.</p> <p>Interview on 9/4/14 at 10:30 a.m. with the DON regarding licensed practical nurse (LPN) D that had been involved in administering the incorrect dose of Ativan to resident 5 revealed: *She had spoken to LPN D on the phone</p>	F 222	<p>2. All licensed nursing staff were educated regarding checking for dosage instructions, appropriateness and assessment of the need for psychoactive medication, and care plan development and implementation of non-pharmacological interventions.</p> <p>3. Pharmacy consultant will continue to do drug regimen reviews monthly. At monthly QAPI meetings, the Director of Nursing or designee will report on an audit of the Medication Administration Record, the behavior monitoring documentation, and the Pharmacist's Drug Regimen Review for all residents who have prescribed psychoactive medications to verify appropriateness and accuracy of the administration of the medications. These audits will occur weekly for 90 days, and then bimonthly for 90 days. When the QAPI committee determines otherwise, frequency of audits may be changed. Based on findings of the review, performance improvement actions will be implemented.</p>

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 09/11/2014	
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 222	<p>Continued From page 7 regarding the medication error. *LPN D had stated she had not been feeling well that night. *That had been LPN D's reason for the medication error.</p> <p>Anonymous interview on 9/10/14 at 3:00 p.m. regarding resident 5 revealed: *The next day after he had received the Ativan he was hard to arouse. *He had gone all day without eating, because he had been too sleepy. *He had slept most of the next day after he had received the Ativan.</p> <p>Telephone interview on 9/11/14 at 11:30 a.m. with LPN D and the business manager A revealed: *She was aware a medication error had occurred with resident 5's Ativan. *She stated she had not been feeling well that night, and that was the reason she had administered the incorrect dose of Ativan. *Resident 5 was swinging and attempted to hit her and another co-worker as they were attending to him. She administered the Ativan to stop him from hitting at them.</p> <p>Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing 8th Ed., St. Louis, Mo., 2013, p. 582, revealed: *"Administering medications to patients requires knowledge and a set of skills that are unique to a nurse. You first assess that the medication ordered is the correct medication. *A medication error can cause or lead to inappropriate medication use or patient harm. Medication errors include inaccurate prescribing, administering the wrong medication, giving the medication using the wrong route or time interval,</p>	F 222		

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 09/11/2014
NAME OF PROVIDER OR SUPPLIER SOUTHRIDGE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105	
(X4) 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 222	Continued From page 8 and administering extra doses or failing to administer a medication. Preventing medication errors is essential. Because nurses play an essential role in preparing and administering medications, they need to be vigilant in preventing errors. Medication errors are related to practice patterns, health care product design, or procedures and systems such as product labeling and distribution."	F 222		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - {4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	1. Reference checks were completed for employees L, CC, DD, EE, FF, GG, HH, and II. Review of the court documents for Employee L revealed the charge did not restrict her from employment. Employee files were reviewed for all employees hired and still working since June 2014 and were determined to have reference checks completed. 2. The Administrator or human resources representative will complete reference checks and investigate past convictions identified on through criminal background checks before an employee is hired. The employment application form was revised on 9/17/14 to include professional references, current/past employer, and permission to contact.	10/10/14

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 09/11/2014	
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 225	<p>Continued From page 9</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 30170 Based on record review, interview, and policy review, the provider failed to thoroughly investigate one of one newly hired nursing staff (D) who had allegations of simple assault against another person. Findings include:</p> <p>1. Review of employee D's file revealed: *The person was hired on 7/30/14. *The criminal background check revealed: -Simple assault attempt to cause bodily injury. -Simple assault recklessly causes bodily injury. -Simple assault attempt to put another in fear of bodily harm. -Simple assault intentionally cause bodily injury. *There had been no reference checks completed by the provider.</p> <p>Interview on 9/10/14 at 11:30 a.m. with the administrator, business manager A, and the director of nursing regarding the above concerns revealed: *The administrator was unaware the employee had convictions pending for simple assault. *Business manager A had hired the individual without thoroughly investigating the results of the</p>	F 225	<p>3. The human resources representative will randomly audit two employee files for completion of reference checks and investigation into negative findings on the criminal background checks weekly for 90 days and then monthly for 90 days. Issues will be reported to the Administrator. The Administrator will provide a report during the monthly QAPI meeting. When the QAPI committee determines otherwise, frequency of audits may be changed. Based on findings of the report, performance improvement actions will be implemented.</p>	

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 09/11/2014
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 225	Continued From page 10 background check. She had not completed reference checks, because she did not have the time to do a thorough investigation. *The DON had been unaware of the situation. *All agreed the matter should have been taken care of prior to employment by the provider. Review of the provider's June 2014 Abuse and Neglect policy revealed: *The provider would protect the residents using a variety of techniques which would include but were not limited to: *Screening of potential hires: -"Prospective applicants to our facility will provide a list of references prior to employment -The interviewing supervisor is required to verify a minimum of two of the applicant's references, specifically the most recent employers, by either phone call or in writing. -If the applicant is a licensed nurse or certified nursing assistant, the Board of Nursing will be contacted concerning any findings of abuse, neglect, or mistreatment of patients/residents or misappropriation of their property. -A criminal background check will be completed on all potential employees when offered employment"	F 225			
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	1. Interview of Resident 6 determined there was no negative outcome related to timeliness of call light response. Residents who have had delayed call light response times greater than 10 minutes will be identified from a call light system audit for the past 30 days. Those	10/10/14	

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 09/11/2014
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 241	Continued From page 11 Surveyor: 32335 A. Based on observation, record review, interview, and policy review, the provider failed to answer call lights in a timely manner for one of one random resident (6). Findings include: Surveyor: 33265 1. Interview on 9/6/14 at 11:45 a.m. with resident 6 revealed: *She required two staff to assist her in transferring using the Hoyer lift. **"Only had one CNA [certified nursing assistant] on last night." "I need two people to help me." "Had to wait forever to go the the bathroom." Interview on 9/17/14 at 7:59 p.m. with resident 6 revealed: *She had put her call light on at 6:30 p.m. following the evening meal for the assistance of one person to place a bedpan under her. *She finished and put her call light on at 6:40 p.m. to be taken off the bedpan. *She received assistance to get off the bedpan at 7:55 p.m. *She was in pain and was told there was a red area on her buttocks where the bedpan had been. Surveyor: 32335 2. Review of the provider's call light data collection report from 8/26/14 through 9/8/14 revealed: *There was no data from 9/2/14 through 9/8/14. *The data collection system had stopped working for those dates. *They were not aware the system had stopped working until surveyors had requested the data on 9/8/14. *The data for the situations mentioned above was	F 241	residents will be interviewed to determine if there were any negative outcomes. 2. All staff will be educated on the use of the call light system and will be instructed that all staff must answer lights, identify the resident need, and either respond or summon the appropriate assistance. 3. At monthly QAPI meetings, the Administrator or designee will review call light response times weekly for 90 days, then bimonthly for 90 days, and then monthly ongoing to identify any response times in excess of 10 minutes to identify patterns of occurrence, investigate further to determine the contributing factors for the delay(s), and determine if there is a need for changes to staffing patterns. When the QAPI committee determines otherwise, frequency of audits may be changed or discontinued.	

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 09/11/2014
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 241	Continued From page 12 not available due to the system not working. *The report indicated that all the call lights tracked had been activated in the bedroom. *There were no call lights on the report that had been activated from a bathroom. 3. Interview and record review on 9/9/14 at 3:15 p.m. with the administrator and the director of nursing (DON) revealed: *They had no specific timeframe for when a call light should have been answered. *They stated it "depends on what is going on in the facility." *The call light data report tracked the date, time, room number, location, staff response time, and how long the light had been green before being turned off. *Staff were to hit the button and turn the light to green when they were in assisting the resident. *Non-nursing staff had been instructed to check on the residents with call lights activated, should not turn the light to green. *The call light report had N/A (not applicable) multiple times throughout the report for how long staff were in the room assisting the resident. *They figured staff were turning the light off when entering the room instead of changing it to green. *The DON was not aware of how the call light system worked regarding turning the light to green and had not received any training on the call lights. *No follow-up education had been provided to staff regarding how to use the call light system. *The administrator ran the report once a month to review the average time for answering the call lights. *He did not utilize the reports unless there was a concern or complaint. *The reports were not reviewed for quality	F 241		

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 09/11/2014
NAME OF PROVIDER OR SUPPLIER SOUTHRIDGE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105	
(X4) 10 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 241	Continued From page 13 assurance. *On 9/1/14 in room 322 the call light had been activated for two hours and twenty-three minutes. When asked if that was too long for a call light to be activated without staff response they both stated "it would depend on what is going on in the facility." Neither the administrator nor the DON would agree that it was too long. A call light policy had been requested by this surveyor but it had not been provided by the time of the survey exit. Review of the provider's April 2013 Quality of Life - Dignity policy revealed "staff shall promote dignity and assist residents as needed by promptly responding to the resident's request for toileting assistance."	F 241		
F 248 SS=D	483.15(1)(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: 32332 Based on observation, interview, record review, and policy review, the provider failed to: *Ensure an effective activity program for one of one sampled resident (4) on isolation precautions (keeping resident in room to prevent spread of infections). Findings include:	F248	1. Review of the clinical record for Resident 4 was reviewed on 9/22/14 and was determined to have no negative outcome related to lack of activities. Clinical records for residents in isolation and those who do not attend group activities were reviewed. 2. The Activity Director will participate in the daily (M-F) clinical stand-up meeting with the interdisciplinary team (IDT) so that she is aware of all changes of condition, including residents on isolation, in order to individualize activities for those residents accordingly. For those residents who are not able or choose not to participate in daily group activities, the Activity	10/10/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ 8. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
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 248	<p>Continued From page 14</p> <p>1. Review of resident 4's medical record revealed: *She was placed on isolation precautions on 7/28/14 due to an infection. *She was not allowed out of her room. *Her 7/17/14 activity care plan revealed: -"I am weak and do not want to participate in groups." -"I want you to visit me twice weekly for sensory stimulation [activity that engages the five senses]." -"Visit me, lotion my arms, read to me, play music."</p> <p>Review of the provider's one-to-one program schedule revealed resident 4 was to have received one-to-one visits weekly on Monday by the activity staff.</p> <p>Random observations of resident 4 throughout the survey from 9/2/14 through 9/10/14 revealed: *No activity visits had been witnessed. *Resident 4 had music playing in her room on only one occasion.</p> <p>Interview on 9/4/14 at 8:20 a.m. with activity aide C regarding resident 4 revealed: *She tried to visit the resident two to three times/weekly. *She had documented all visits on the care tracker (computerized documentation). *The resident was to have been visited more before she came down with an infection. "But then we needed to gown and glove and we weren't sure what to do."</p> <p>Interview on 9/4/14 at 8:35 a.m. with the activity coordinator revealed:</p>	F 248	<p>Director will plan a program of daily individualized activities. The CNA care cards will include the daily individualized activities. The CNAs and activity staff will collaborate to ensure those daily activities occur and are documented on participation records.</p> <p>3. The Activity Director or designee will audit the participation records for five residents per week for twelve weeks, and then five residents per month. The reports on activity participation will continue until the QAPI committee determines otherwise.</p>

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 09/11/2014
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 248	Continued From page 15 *Resident 4 had been receiving more one-to-one activity before her infection. She was on hospice, and the hospice aide came five times/week. *She had agreed the hospice aide was to have been performing personal care rather than doing an activity. *She had agreed all hospice visits were to have been supplemental to activity the resident received from the provider. *She had agreed residents who were isolated from others should have received more activity visits. Review of the provider's 10/28/13 Activity Programs and Services policy revealed residents on a "full room visit program" were to have received, at a minimum, three room visits per week.	F 248		
F 278 ssE	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is	F 278	1. Review of clinical record for Resident 1 determined there was no negative outcome related to inaccurate assessment. All residents could be at risk for negative outcomes related to inaccurate assessments. 2. MDS Case Managers were educated regarding timely and accurate monthly nursing summaries, assessment of potential physical restraints with the use of chair and bed equipment, and accurate coding of the self-performance of resident activities of daily living.	10/10/14

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 09/11/2014
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)
F 278	<p>Continued From page 16</p> <p>subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, record review, and policy review, the provider failed to ensure an accurate assessment for one of one sampled resident (1) who had been using a seatbelt. Findings include:</p> <p>1. Review of resident 1's medical record revealed: *He had been admitted on 7/3/14. *There was no physician's order for the use of the seat belt. *There was no assessment to indicate the use of the seat belt.</p> <p>Review of resident 1's 7/15/14 Interdisciplinary Progress Notes revealed: *Minimum Data Set (MDS) coordinator G had documented: -He had his own wheelchair with a seat belt. -He was unable to release the seat belt. -That seat belt was considered a restraint.</p> <p>Review of resident 1's admission MDS assessment on 7/10/14 revealed:</p>	F 278	<p>One MDS Case Manager was designated as the coordinator of the MDS and care planning process.</p> <p>3. All changes of condition, including new or revised needs, will be reported during the daily (M-F) clinical stand-up meeting with the interdisciplinary team (IDT). Prior to the clinical stand-up meeting, the MDS Case Managers will review current assessment documentation to ensure the changes of condition have been documented and assessed. The MDS Case Managers will report to the Director of Nursing if documentation or assessment was lacking. The MDS Coordinator will report monthly at the QAPI meeting on effectiveness of the MDS and care planning process. These reports will occur until the QAPI committee determines otherwise.</p>

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

PRINTED: 09/25/2014
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 09/11/2014
--	--	--	---

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 278	<p>Continued From page 17</p> <p>*Restraints were coded zero (none) for all areas in section P under physical restraints.</p> <p>*Those areas used in the chair or out of the bed had included:</p> <ul style="list-style-type: none"> -Trunk restraint. -Limb restraint. -Chair prevented rising. -Other. <p>Interview on 9/9/14 at 9:10 a.m. with MOS coordinator G regarding resident 1's seat belt use revealed:</p> <p>*The seat belt had been considered a restraint.</p> <p>*That seat belt had been on him during the initial MOS assessment period.</p> <p>*It should have been coded on the 7/10/14 admission MOS assessment under:</p> <ul style="list-style-type: none"> -Trunk restraint. -Chair prevented rising. <p>*He would have been unable to release the seat belt when it was buckled.</p> <p>*She agreed the provider had not accurately assessed him for the seat belt.</p> <p>*She agreed he had not been accurately coded on the 7/10/14 admission MOS assessment for a physical restraint.</p> <p>Review of provider's 10/28/13 resident assessments MOS policy revealed all personnel who complete any portion of the MOS must sign and certify the accuracy of that portion of the assessment.</p>	F 278		
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p>	F 279		

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

PRINTED: 09/25/2014
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 09/11/2014
NAME OF PROVIDER OR SUPPLIER SOUTHRIDGE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105		
(X4) 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 279	<p>Continued From page 18</p> <p>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</p> <p>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 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on record review, care plan review, and policy review, the provider failed to update and revise resident (1) care plan. Findings include:</p> <p>1. Review of resident 1's medical record revealed he: *Was admitted on 7/3/14. *Had diagnosis had included diabetes. *Had needed extensive assistance by staff with his care. *Had been on a tube feeding (nourishment provided through a tube into the stomach) since admission. *Had lost 4.6 pounds or 3.6 percent of his weight the first month after admission. *He had a physician's order on 7/3/14 for "Weight Weekly."</p>	F 279	<p>1. The care plan for Resident 1 was reviewed and revised. Review of the clinical records determined there was no negative outcome related to the inaccurate care plans. All care plans over the next 90 days will be reviewed and revised for accuracy.</p> <p>2. MDS Case Managers and licensed nurses were educated about the care planning process, in particular with changes of condition and new orders. Licensed nurses are designated with the responsibility of keeping the care plan, including the paper/electronic and CNA care cards, up to date. One MDS Case Manager was designated as the coordinator of the MDS and care planning process.</p> <p>3. All changes of condition, including new or revised needs, will be reported during the daily (M-F) clinical stand-up meeting with the interdisciplinary team (IDT). Following the IDT, the MDS Case Managers will randomly audit a minimum of three care plans for those residents identified with changes of condition during the stand-up meeting to ensure the care plans and CNA care cards were updated. Any updates that have not occurred will be reported to the Director of Nursing who will provide corrective education, as needed.</p>	10/10/14	

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

PRINTED: 09/25/2014
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 09/11/2014
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 279	Continued From page 19 Review of resident 1's 7/22/14 care plan revealed: **"I want to maintain my weight." **"Monitor my weights." *There was no documentation in his care plan regarding the weight loss. Interview on 9/9/14 at 10:35 a.m. with the consultant registered dietitian regarding resident 1 revealed she: *Had been aware of his weight loss. *Knew his weekly weights had not been consistently obtained. *Expected h"1s care plan to have been updated regarding his weight loss. Review of the provider's 6/5/14 Comprehensive Care Plans policy revealed: **"An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident." **"Care plan goals and objectives are derived from information contained in the resident's comprehensive assessment and: -Are resident oriented. -Are behaviorally stated. -Are measurable. -Contain timetables to meet the resident's needs."	F 279	The MDS Coordinator will report monthly at the QAPI meeting on effectiveness of the MDS and care planning process. Based on report, further education and/or corrective action will be planned and carried out. These reports will occur until the QAPI committee determines otherwise.	
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.	F 281	1. The clinical record was reviewed for Resident 1 to identify the nurse who received the physician order for "weight weekly," and the care plan and CNA care card was reviewed and updated. The nurse	10/10/14

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 09/11/2014	
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 281	<p>Continued From page 20</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331</p> <p>Based on record review, interview, and policy review, the provider failed to follow physicians' orders for weight monitoring for one of two residents (1) on a tube feeding. Findings include:</p> <p>1. Review of resident 1's medical record revealed he: *Was admitted on 7/3/14. *Had been on a tube feeding since admission. *He had a physician's order on 7/3/14 for "Weight Weekly."</p> <p>Review of resident 1's weight sheet from the first week in July 2014 through the first week in September 2014 revealed *The weekly weights were not completed for: -July 2014 week two and week four. -August 2014 week three and week four.</p> <p>Interview on 9/9/14 at 10:35 a.m. with the consultant registered dietitian regarding resident 1's weights revealed: *He had a physician's order for weekly weights. *Weekly weights had not been consistently obtained. *She would have expected the weights to have been obtained as ordered.</p> <p>Surveyor: 32332 Interview on 9/10/14 at 8:35 a.m. with certified nurse assistant (CNA) I revealed when asked how weights were to have been obtained stated: *Monthly weights were to have been obtained on all residents on the first seven days of each month. *Weekly weights were to have been obtained on</p>	F 281	<p>was identified and counseled by the Director of Nursing. The Director of Nursing had a conversation with the pharmacy supplier to clarify the process for filling medication orders. All residents could be at risk for failure to carry out physician orders.</p> <p>2. A. Ongoing education will be developed for licensed staff regarding professional standards of practice related to nursing processes.</p> <p>B. All new physician orders received the day before will be reported during the daily (M-F) clinical stand-up meeting with the interdisciplinary team (IDT). Following the IDT, the MDS Case Managers will randomly audit the records for all of the residents affected by new physician orders to ensure the orders were carried out, and care plans/CNA care cards were updated, as needed. If any orders are identified as not carried out, the MDS Case Manager will report this to the Director of Nursing who will counsel the staff person involved and/or provide corrective education, as needed.</p> <p>C. Weekly weights will be completed at the time of bathing, the CNAs will report the weight to the licensed</p>	

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 09/11/2014
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 281	<p>Continued From page 21</p> <p>Monday or Tuesday so they would have been available for staff meetings.</p> <p>*No one had been responsible for obtaining the weights, "Just whoever does it, does it."</p> <p>*The bath aide was never responsible for obtaining weights.</p> <p>Interview on 9/10/14 at 8:40 a.m. with nurse aide L revealed:</p> <p>*The nurses had been primarily responsible for obtaining residents' weights.</p> <p>*If the nurses had been too busy the nurse aides would obtain them.</p> <p>Interview on 9/10/14 at 8:45 a.m. with registered nurse (RN) J and medication technician (med tech)/CNA K revealed:</p> <p>*The CNA was responsible for obtaining resident weights.</p> <p>*Monthly weights were to have been obtained the first ten days of each month.</p> <p>*The nurses and med techs were not responsible for obtaining weights.</p> <p>*CNAs obtained weekly weights on Mondays.</p> <p>*There was no set time for obtaining the weights; the staff were to obtain the weights whenever they got the chance. It did not matter what time of day it had been done.</p> <p>Surveyor: 32331</p> <p>Interview on 9/10/14 at 8:15 a.m. with the director of nursing regarding resident 1's weights revealed:</p> <p>*His weight had not been completed weekly.</p> <p>*She would have expected the weekly weights to have been obtained as physician ordered.</p> <p>Review of the provider's revised 12/11/12 Weight and Height policy revealed:</p>	F 281	<p>nurse who will document the weight on the Vitals record. All nursing staff were educated on the weekly weight and documentation process, assignments, and completion of the weekly weight documentation.</p> <p>3. The Director of Nursing will report monthly, on a continuous basis, at the QAPI meeting on progress of professional standards being met and action plans will be developed for further education and/or correction.</p>		

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

PRINTED: 09/25/2014
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 _____ 8. WING	(X3) DATE SURVEY COMPLETED C 09/11/2014
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 281	Continued From page 22 *All new admissions would have had their weights taken weekly for one month. *Then monthly thereafter, unless otherwise indicated, during the resident's stay.	F 281		
F 309 SS=G	Surveyor: 32332 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, interview, and policy, the provider failed to assess, monitor, and document pain management and end-of-life care for one of one sampled hospice (terminal) residents (2). Findings include: 1. Review of resident 2's medical record revealed: *A 8/7/14 admission date from an acute care hospital. *Diagnosis of malignant neoplasm (tumor) of the lung. *He expired (passed away) on 8/22/14. Review of resident 2's 8/7/14 physician's orders revealed:	F 309		

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

PRINTED: 09/25/2014
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 09/11/2014
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 309	<p>Continued From page 23</p> <p>*Hydrocodone (narcotic pain medication) 5/325 milligrams (mg) one tablet every six hours as needed for pain. (That was discontinued on 8/7/14 by the physician and resumed on 8/12/14).</p> <p>*Acetaminophen 500 mg, two tablets every four hours as needed for mild pain.</p> <p>Review of resident 2's 8/21/14 physician's orders revealed: **"Patient declining, reporting difficulty swallowing, less responsive, and transitioning toward actively dying." **"Okay to discontinue all scheduled medications." **"Roxana! (narcotic pain medication) 0.25 milliliter (ml) to 1.0 ml every one hour as needed (PRN) for shortness of breath (SOB) or pain." **"Lorazepam (antianxiety medication) 1.0 mg one tablet crushed and given buccally (inside side of mouth) every one hour PRN anxiety/restlessness."</p> <p>Review of resident 2's 8/8/14 through 8/22/14 PRN medication record revealed: *Pain monitoring 0 to 10 with 0 being no pain and 10 being worst possible pain. *Non-pharmacological interventions to include: -Food/fluids. -Books on tape. -Toileting. -Massage. Repositioning. -Soft music. -Quiet environment. -Aromatherapy. -Spiritual counseling. -Deep breathing. -Reassurance. -Exercise. -Relaxation.</p>	F 309	<p>1. Observation of Resident 2 and review of his clinical record determined the scalp condition is improving with no further negative outcome; the care plan and CNA care cards were reviewed and revised, as needed. Clinical records for all residents with skin conditions, pain management, and/or end of life care to ensure appropriate nursing assessment, monitoring, care planning, and medical treatment interventions were documented. The care plans for residents receiving hospice services were reviewed to ensure the facility and hospice care plans were collaborative.</p> <p>2. All new physician orders received the day before will be reported during the daily (M-F) clinical stand-up meeting with the interdisciplinary team (IDT). Following the IDT, the MDS Case Managers will randomly audit the records for all residents affected by new physician orders to ensure the orders were carried out, and care plans/CNA care cards were updated, as needed. If any orders are identified as not carried, the MDS Case Manager will report this to the Director of Nursing who will counsel the staff person involved and/or provide corrective education, as needed.</p>	10/10/14	

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

PRINTED: 09/25/2014
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 09/11/2014
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 309	Continued From page 24 -Dim lighting. -Warm compress. -Cold compress. *Acetaminophen had been documented as administered eight times from 8/8/14 through 8/18/14. *Five doses of the acetaminophen had no location for the pain. *Acetaminophen had been documented as administered on 8/8/14 with no location of pain at a pain rating of 8. Food/fluids, repositioning, relaxation, and dim lighting had been documented as non-pharmacological interventions. There was no follow-up documentation to the effectiveness of the acetaminophen or non-pharmacological interventions. *Acetaminophen had been documented as administered on 8/15/14 for chest pain at a pain rating of 6 with no non-pharmacological interventions documented. There was no follow-up documentation to the effectiveness of the acetaminophen. *Acetaminophen had been documented as administered on 8/18/14 for no location of pain, no pain rating, and no non-pharmacological interventions documented. *There was no non-pharmacological interventions documented for the acetaminophen administered on 8/9/14, 8/12/14, 8/13/14, and 8/15/14. *There was no documentation of any pain medication administration after 8/18/14. *The resident never received any hydrocodone, Roxanol, or lorazepam. Review of resident 2's 8/18/14 through 8/22/14 interdisciplinary progress notes revealed: *8/18/14 at 11:50 a.m. by hospice registered nurse (RN)- "Denies pain during visit. States he is	F 309	3. The Director of Nursing will report monthly, on a continuous basis, at the QAPI meeting on progress of standards being met and action plans will be developed for further education and/or correction.		

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

PRINTED: 09/25/2014
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 09/11/2014	
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 309	<p>Continued From page 25 comfortable."</p> <p>*8/21/14 at 5:00 p.m. - "Orders received to discontinue all scheduled medications/PRN medications. New order for Roxanol and lorazepam. Pharmacy made aware by hospice."</p> <p>*8/22/14, "Transferred to room 300 approximately at 9:00 a.m. Summoned to room at 9:55 a.m. No perceivable pulse or blood pressure. Family at bedside. Hospice nurse here at 10:00 a.m. Orders of doctor at 10:08 a.m."</p> <p>*There was no documentation from 8/18/14 through 8/22/14 of his pain control or his condition.</p> <p>Interview on 9/10/14 at 10:00 a.m. with the director of nursing regarding resident 2 revealed:</p> <p>*She had only been at the facility less than three weeks.</p> <p>*She was not going to state what her expectations of PRN follow-up should have been, as the nurses did not know yet what her expectations were.</p> <p>*He was moved to another room an hour before his death by orders of the administrator. The administrator felt since there was such a large number of visitors a larger room would be more appropriate.</p> <p>*When questioned by the surveyor the lack of documentation regarding his condition from 8/18/14 through 8/22/14 her response was "What would you expect?"</p> <p>Review of the provider's 1/20/12 Hospice Program policy revealed:</p> <p>**"When a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency, and resident/family will be developed and shall include directives for managing pain and other uncomfortable</p>	F 309		

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 09/11/2014
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 309	Continued From page 26 symptoms." **"Provision of drugs and medical supplies as needed for palliation (comfort) and management of the terminal illness and related conditions that will be provided by each entity."	F 309		
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS 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: 32331 Based on observation, record review, interview, and policy review, the provider failed to maintain adequate nutritional status for one of two sampled residents (1) on a tube feeding resulting in weight loss. Findings include: 1. Observation on 9/3/14 at 5:05 p.m. of resident 1 in his room revealed: *A 1000 cc (cubic centimeter) ready-to-hang prefilled tube feeding container of Jevity 1.2 (a tube feeding nutrition supplement). *The Jevity 1.2 was infusing on the feeding pump at a flow rate of 80 cc per hour. *The pump digital reading read "183 ml [milliliters]	F 325	1. Observation and clinical record review for Resident 1 was conducted to ensure the feeding pump was working at the appropriate flow rate, the formula bag was dated, and weekly weights were conducted. The consultant Registered Dietitian has completed all assessments for nutritional intervention related to tube feeding. All other residents on tube feeding or at risk for weight loss were changed to weekly weights and other interventions were implemented. Meal cards are consistently used on all trays at all meals. 2. All licensed nurses will be re-educated by the consultant pharmacist on tube feeding policy and procedures, and will also be educated on adequate intake and output regarding residents who receive tube feeding. Dietary and nursing staff were re-educated on the importance of using the meal cards and placing them on the tray to ensure accurate meal plans are followed. A weekly Wound and Weight committee was started to include the MDS Case Managers, Director of Nursing, the certified wound care nurse, and the consultant Registered Dietitian to review all residents at risk for weight loss and/or wound management needs.	10/10/14

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 09/11/2014
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 325	<p>Continued From page 27</p> <p>fed."</p> <p>-That amount of tube feeding would have equaled 183 cc or 6 ounces (oz).</p> <p>*The resident was verbalizing he was "hungry" and "thirsty."</p> <p>Interview on 9/3/14 at 5:07 p.m. with licensed practical nurse F regarding resident 1 revealed:</p> <p>*There had been "issues" with the feeding pump which had been currently beeping.</p> <p>*The physician had ordered his feeding to go until 6:00 p.m. that evening due to problems with the pump.</p> <p>*He complained about being hungry "a lot of the time."</p> <p>*With him "a common thing was thirst."</p> <p>Observation on 9/3/14 at 6:30 p.m. of resident 1 in his room revealed:</p> <p>*That same above container of the tube feeding.</p> <p>*The flow rate on the feeding pump was set at 80 cc per hour.</p> <p>*The feeding pump digital read "295 ml fed."</p> <p>-That amount of tube feeding would have equaled 295 cc or approximately 10 oz.</p> <p>Interview on 9/3/14 at 6:31 p.m. with registered nurse E regarding resident 1's tube feeding revealed:</p> <p>*There had been ongoing problems with the feeding pump not working properly.</p> <p>*The physician had ordered a feeding until 6:00 p.m. that night because of the pump problems.</p> <p>Record review on 9/3/14 of resident 1's medical record revealed he:</p> <p>*Had an admission date of 7/3/14.</p> <p>*Had physician's orders dated 7/3/14 for "NPO [no food by mouth] Diet" "Jevity 1.2 at 80 cc for 11</p>	F 325	<p>3. At monthly QAPI meeting, the Director of Nursing and the Registered Dietitian will provide a collaborative report, on a continuous basis, about effectiveness on the education on the tube feeding policy and procedures, the weekly weight process, and use of the meal cards to ensure outcomes reflect an understanding and implementation of effective practices. Based on report, further education and/or corrective action will be planned and carried out.</p>	

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

PRINTED: 09/25/2014
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 09/11/2014
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 325	<p>Continued From page 28</p> <p>hours start at 0500 [5:00 a.m.] and end at 1600 [4:00 p.m.] 240 cc free water flush four times daily.</p> <p>*Had been on a tube feeding since admission.</p> <p>*Had a diagnosis that had included diabetes.</p> <p>*Had needed extensive assistance with his care.</p> <p>*Had lost a total of 4.7 pounds or 3.7 percent (%) of his weight within the first month of admission.</p> <p>*Had lost a total of 4.6 lb or 3.6% the first month after his admission.</p> <p>*Had lost a total of 3.8 lb or 3.0% the first two months after his admission.</p> <p>*He had a physician's order on 7/3/14 for "Weight Weekly."</p> <p>Review of resident 1's 7/7/14 Nutrition History & Data Collection Form by the consultant registered dietitian (RD) revealed:</p> <p>*No nutritional assessment regarding nutritional adequacy of calories, protein, or fluids.</p> <p>*He had a low albumin (a measurement of protein in the blood) level of 3.4 grams(g)/deciliter (dl). -A normal reference range for albumin would have been 3.5 through 5.0 g/dl.</p> <p>Review of resident 1's 7/11/14 Interdisciplinary Progress Notes by the consultant RD revealed:</p> <p>*His tube feeding was his primary means of nutrition.</p> <p>*No nutritional assessment had been done regarding nutritional adequacy of calories, protein, or fluids.</p> <p>*His feeding was to have provided 100% of his total nutrient needs as well as his water needs.</p> <p>**"His weight is stable."</p> <p>Review of resident 1's 8/24/14 Interdisciplinary Progress Notes by the consultant RD revealed:</p> <p>**"Overall stable for nutrition."</p>	F 325		

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 09/11/2014	
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 325	<p>Continued From page 29</p> <p>*No nutritional assessment had been done regarding nutritional adequacy of calories, protein, or fluids.</p> <p>Review of resident 1's 1/0 (Intake/Output) Chart Detail Report from 8/28/14 through 9/4/14 revealed:</p> <p>*He had an average daily intake of 662 cc.</p> <p>*There was no output on the report form.</p> <p>*That intake was less than half of what he should have received according to his physician's orders for the tube feeding and the water flushes for a total of 1673 cc per twenty-four hours.</p> <p>Interview on 9/4/14 at 8:15 a.m. with the director of nursing regarding resident 1 revealed:</p> <p>*There had been problems with his feeding pump not working properly and "beeping."</p> <p>*A new feeding pump had been obtained on 9/3/14.</p> <p>*She agreed there had not been accurate tracking on how much formula he had received since admission because of the problems with the pump.</p> <p>*There had been poor documentation of the resident's intake of his tube feeding and water.</p> <p>Review of resident 1's 7/22/14 care plan revealed:</p> <p>*"I want to maintain my weight."</p> <p>*"Monitor my weights."</p> <p>*There was no documentation in his care plan regarding the weight loss.</p> <p>Review of resident 1's weight sheet from the first week in July 2014 through the first week in September 2014 revealed</p> <p>*The weekly weights were not completed for: -July, weeks two and four.</p>	F 325		

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 09/11/2014	
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 325	<p>Continued From page 30 -August, weeks three and four.</p> <p>Interview on 9/9/14 at 10:35 a.m. and at 2:30 p.m. with the consultant RD regarding resident 1 revealed:</p> <ul style="list-style-type: none"> *She stated she had been aware of his weight loss. *Weekly weights had not been consistently obtained. *Expected his care plan to have been updated with the weight loss. *His albumin level had been low. *His protein level needed to have been increased in his tube feeding. *Had not included nutritional adequacy of calories, protein, and fluids in her assessments. *His tube feeding pump had not been working properly. *His weight loss reflected an estimated 275 calories less per day than his needs. *Those calories would have maintained his weight and prevented weight loss. *She stated he had not received all the tube feeding as ordered that contributed to the weight loss. <p>Review of the provider's 2/16/14 Clinical Nutrition Services policy revealed the consultant RD was to have been responsible for completing a monthly tube feeding assessment that included nutritional adequacy of calories, protein, and fluids.</p> <p>Review of the provider's 10/5/12 Enteral Nutrition/Hydration policy revealed:</p> <ul style="list-style-type: none"> *Documentation guidelines included: <ul style="list-style-type: none"> -Type and amount of feeding and water administered. -Intake every shift. 	F 325		

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 09/11/2014
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 325	Continued From page 31 -Output recorded every shift. -If feeding was held. -Physician notification as necessary. Review of the provider's undated Documentation Guidelines policy regarding tube feedings revealed there was to have been: *Nutrient used. *Amount and rate. *Number of cc and calories in twenty-four hours. *Weight. Review of the provider's revised 7/16/14 Serving of Food policy revealed nursing was responsible for the feeding of tube-fed residents.	F 325		
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Surveyor: 30170 Based on record review and interview, the provider failed to ensure the correct dosing and administration of Ativan (anti-anxiety) medication administered by one of one licensed practical nurse (LPN) D for one of one sampled resident (5). Findings include: 1. Review of resident 5's August 2014 medication administration record (MAR) and the Antipsychotic Monitoring Tool form revealed: *There was a physician's order for Ativan 2 milligrams (mg) per milliliter (ml) administer 0.25 ml to 0.5 ml po (orally) or SL (sublingual [under	F 333	1. Observation of Resident 5 and review of the clinical record determined there was no further negative outcome related to the significant medication errors. The Licensed Practical Nurse (LPN) K was counseled on appropriately measuring medication. The Medication Administration Records (MARs) for all residents in September 2014 were reviewed for documentation gaps and reconciled with current orders. 2. All licensed staff were educated on ensuring documentation for medication administration is completed and measurement of medications is accurate. The Medical Records Coordinator will review the MARs for documentation gaps	10/10/14

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 09/11/2014
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)
F 333	<p>Continued From page 32</p> <p>the tongue) every four hours as needed (PRN) for anxiety.</p> <p>*On 8/28/14 at 8:00 p.m. LPN D had administered Ativan 1 cc (equivalent to 1 ml) which would have been 2 mg, because the resident had been "agitated with cares." That was an incorrect dose. She had administered twice the prescribed dose.</p> <p>*On 8/29/14 at 2:00 a.m. LPN D had administered another incorrect dose of Ativan. She had administered 1 cc orally for "agitation with cares."</p> <p>Interview on 9/3/14 at 4:00 p.m. with the director of nursing (DON) regarding the above record review revealed:</p> <p>*She had been unaware there was an incorrect dose of Ativan administered to resident 5.</p> <p>*She agreed the resident had been given twice the physician ordered dose of Ativan.</p> <p>*The resident could have been severely injured with that incorrect dose of Ativan.</p> <p>Interview on 9/4/14 at 10:30 a.m. with the DON regarding the LPN D that had been involved in administering the incorrect dose of Ativan to resident 5 revealed:</p> <p>*She had spoken to LPN D on the phone regarding the medication error.</p> <p>*LPN D had stated she had not been feeling well that night.</p> <p>*That had been LPN D's reason for the medication error that occurred on 8/28/14 and 8/29/14.</p> <p>Anonymous interview on 9/10/14 at 3:00 p.m. regarding resident 5 revealed:</p> <p>*The next day after he had received the Ativan he was hard to arouse.</p> <p>*He had gone all day without eating, because he had been too sleepy.</p>	F 333	<p>for all residents for October 2014, and then random audits for 20% of the MARs for 90 days. Identified medication errors will be reported to the Director of Nursing, who will retain medication error records to determine the monthly medication error rate and whether any errors are significant. When system is determined to be in place, the audits will be discontinued. The consultant pharmacist will educate nursing staff on the policy and procedures related to medication administration, reconciliation of controlled substances, and storage of medications.</p> <p>3. At the monthly QAPI meeting, the Director of Nursing will provide a report, on a continuous basis, about the effectiveness of the education based on the medication error rate.</p>

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

PRINTED: 09/25/2014
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 09/11/2014	
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 333	<p>Continued From page 33</p> <p>*He had slept most of the next day after he had received the Ativan.</p> <p>Telephone interview on 9/11/14 at 11:30 a.m. with LPN D and business manager A revealed: *She was aware a medication error had occurred with resident 5's Ativan. *She stated she had not been feeling well that night, and that was the reason she had administered the incorrect dose of Ativan. *Resident 5 was swinging and had attempted to hit her and another co-worker as they were attending to him. She administered the Ativan to stop him from hitting at them.</p> <p>Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, p. 582, revealed: **Administering medications to patients requires knowledge and a set of skills that are unique to a nurse. You first assess that the medication ordered is the correct medication. *A medication error can cause or lead to inappropriate medication use or patient harm. Medication errors include inaccurate prescribing, administering the wrong medication, giving the medication using the wrong route or time interval, and administering extra doses or failing to administer a medication. Preventing medication errors is essential. Because nurses play an essential role in preparing and administering medications, they need to be vigilant in preventing errors. Medication errors are related to practice patterns, health care product design, or procedures and systems such as product labeling and distribution."</p>	F 333		
F 353 SS=J	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS	F 353		

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 09/11/2014
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 353	<p>Continued From page 34</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, and interview, the provider failed to ensure adequate staff on a twenty-four hour period to ensure all the residents' basic needs were met according to their plan of care. Findings include:</p> <p>1. Interview on 9/4/14 at 10:30 a.m. with business manager O regarding staffing revealed she: *Had been doing scheduling for about a month and one-half to two months. *Had been put in the position the end of July 2014 after the human resource staff person who had</p>	F 353	<p>1. The facility participated in a job fair on 9/24/14. Open staff positions continue to be advertised with a starting bonus for CNAs and LPN or RNs starting 9/21/14. Nine CNAs have started since 9/10/14. Contact with temporary staffing agencies continues for both day and night shifts. An hourly pay differential was initiated for staff working on the night shift. A Staff Development Coordinator was hired; start date 10/7/14.</p> <p>2. A recruitment and retention plan will be developed with a staffing committee on or before 10/10/14. The Advancing Excellence consistent assignment and staff satisfaction tools will be utilized with this committee activity. The Director of Nursing will have a face-to-face meeting with the staffing scheduler in the morning about day shift and prior to the night shift to discuss adequacy of staffing and assignments. This will occur Monday – Friday; the weekend staffing will be reviewed on Friday. A checklist of duties for the weekend manager on duty will be developed and the MOD will be expected sign and date that form.</p>	10/10/14	

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 09/11/2014	
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 353	<p>Continued From page 35</p> <p>been doing the scheduling left. She had received minimal training for the position.</p> <p>*Had been trying to cover open nursing shifts with the staff they had.</p> <p>*Had been calling three staffing agencies in conjunction with the administrator to fill open nursing spots with little success</p> <p>*Stated two staffing facilities had not been able to supply them with any staff.</p> <p>*Stated one staffing facility had sent them a certified nursing assistant (CNA) on 8/27/14 and on 9/9/14. They had sent them a licensed practical nurse on 9/7/14 that had been utilized as a CNA.</p> <p>*Knew there were shifts that were not fully covered with nurses and CNAs.</p> <p>*Stated the nurses usually worked twelve hour shifts 6:00 a.m. to 6:30 p.m. or 6:00 p.m. to 6:30 a.m.</p> <p>*Stated the medication technicians (MT)/CNA usually worked the same twelve hour shifts. Some of the MT/CNAs worked eight hour shifts.</p> <p>*Stated the CNAs also usually worked twelve hour shifts. Some CNAs would work eight hour shifts or any amount of hours that would help fill in hours.</p> <p>*Stated the adequate amount of nursing staff for the twenty-four hour period would be as follows:</p> <ul style="list-style-type: none"> -One nurse on each wing from 6:00 a.m. to 6:30 p.m. and from 6:00 p.m. to 6:30 a.m. (Warren wing, east wing, and center wing). -Usually a med tech/CNA would staff the memory care unit instead of a nurse for a twelve hour shift from 6:00 a.m. to 6:30 p.m. and from 6:00 p.m. to 6:30 a.m. -Four CNAs would work the center wing from 6:00 a.m. to 6:30 p.m. twelve hour shifts. -Three CNAs would work the east wing from 6:00 a.m. to 6:30 p.m. twelve hour shifts. 	F 353	<p>The MOD will be responsible to contact the Administrator and Director of Nursing as directed by facility policies related to grievances, incidents/occurrences, and staffing concerns. A competency evaluation plan upon hire and annually will be developed to determine necessary education needs.</p> <p>3. The Administrator will provide a report at the monthly QAPI meeting, on a continuous basis, regarding staffing levels, staffing satisfaction, and staffing turnover. The report will also include progress on the recruitment and retention committee, the MOD process, and well as competency evaluation program.</p>	

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 09/11/2014
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)
F 353	<p>Continued From page 36</p> <ul style="list-style-type: none"> -One CNA would work the Warren wing from 6:00 a.m. to 6:30 p.m. a twelve hour shift. -One CNA would work in the memory care unit from 6:00 a.m. to 6:00 p.m. a twelve hour shift. -Two to three CNAs would work the center wing from 6:00 p.m. to 6:30 a.m. twelve hour shifts. -Two CNAs would work the east wing from 6:00 p.m. to 6:30 a.m. twelve hour shifts. -One CNA would work in the memory care unit from 6:00 p.m. to 6:30 a.m. a twelve hour shift. -One MT/CNA on both the east wing and the center wing from 6:00 a.m. to 6:30 p.m. a twelve hour shift. -One MT/CNA on both the east wing and the center wing from 6:00 p.m. to 6:30 a.m. a twelve hour shift. <p>*If there was not a nurse in the Warren wing from either 6:00 a.m. to 6:30 p.m. or from 6:00 p.m. to 6:30 a.m. they would leave the doors to the unit open, and the nurse from the east or the center wings would cover that area too.</p> <p>Review of the 8/18/14 through 9/7/14 nursing schedules revealed deviations from the above adequate staffing on the following dates:</p> <ul style="list-style-type: none"> *8/18/14, Two CNAs worked 6:00 a.m. to 6:30 p.m. on the center wing instead four CNAs. Two CNAs worked from 6:00 a.m. to 6:30 p.m. on the east wing instead of three. One CNA worked the east wing from 6:00 p.m. to 6:30 a.m. instead of two. *8/19/14, Two nurses worked from 6:00 p.m. to 6:30 a.m. instead of three. *8/22/14, Two nurses worked from 6:00 p.m. to 6:30 a.m. instead of three. *8/23/14, Two nurses worked from 6:00 p.m. to 6:30 a.m. instead of three twelve hour shift nurses. One nurse worked 6:00 p.m. to 10:00 p.m. (short an 8 hour nurse). 	F 353	

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

PRINTED: 09/25/2014
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 09/11/2014
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 353	Continued .From page 37 *8/24/14, Two CNAs worked from 6:00 a.m. to 6:30 p.m. on the center wing instead of four. Two CNAs worked from 6:00 a.m. to 6:30 p.m. on the east wing instead of three. There was not a CNA in the Warren wing from 6:00 a.m. to 6:30 p.m. One CNA worked from 6:00 p.m. to 6:30 a.m. on the center wing instead of two. *8/25/14, Two nurses worked from 6:00 a.m. to 6:30 a.m. instead of three. Two CNAs worked from 6:00 a.m. to 6:00 p.m. on the east wing instead of three. One CNA worked on the center wing from 6:00 p.m. to 6:30 a.m. instead of two. *8/26/14, Two CNAs worked the center wing from 6:00 a.m. to 6:30 p.m. instead of four. Two CNAs worked the east wing from 6:00 a.m. to 6:30 p.m. instead of three. One CNA worked the center wing from 6:00 p.m. to 6:30 a.m. instead of two. *8/27/14, Two nurses worked from 6:00 p.m. to 6:30 a.m. instead of three. Three CNAs worked the center wing from 6:00 a.m. to 6:30 p.m. instead of four. *8/28/14, Two nurses worked from 6:00 p.m. to 6:30 a.m. instead of three. One MT/CNA worked from 6:00 p.m. to 6:30 a.m. instead of two. *8/29/14, Three CNAs worked the center wing from 6:00 a.m. to 6:30 p.m. instead of four. *8/30/14, Three CNAs worked the center wing from 6:00 a.m. to 6:30 p.m. instead of four. *8/31/14, Two CNAs worked the center wing from 6:00 a.m. to 6:30 p.m. instead of four. Two CNAs worked the east wing from 6:00 a.m. to 6:30 p.m. instead of three. Two CNAs worked the east wing from 2:00 p.m. to 9:00 p.m. No CNAs were scheduled after 9:00 p.m. to 6:30 p.m. *9/4/14, Three CNAs worked the center wing from 6:00 a.m. to 6:30 p.m. instead of four. *9/5/14, Two nurses worked from 6:00 p.m. to 6:30 p.m. A licensed practical nurse also worked from 6:00 p.m. to 6:30 a.m. but was in orientation.	F 353		

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

PRINTED: 09/25/2014
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 _____	(JO) DATE SURVEY COMPLETED C 09/11/2014
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 353	<p>Continued From page 38</p> <p>One CNA worked from 2:00 p.m. to 10:00 p.m. Two CNAs worked from 6:00 p.m. to 6:30 a.m. to cover the whole facility.</p> <p>*9/6/14, Two nurses worked from 6:00 p.m. to 6:30 a.m. instead of three. Four CNAs worked from 6:00 p.m. to 6:30 a.m. to cover the facility instead of six.</p> <p>*9/7/14, Two nurses worked from 6:00 p.m. to 6:30 a.m. instead of three.</p> <p>Observation on 9/5/14 from 10:48 a.m. through 11:50 a.m. concerning staffing for the days shift of 6:00 a.m. to 6:00 p.m. revealed:</p> <p>*Had been schedule changes since yesterday afternoon.</p> <p>*On center wing:for forty-six residents -Had had two CNAs scheduled for the two hours between 2:00 p.m. and 4:30 p.m. -Had had one CNA scheduled for the two hour period between 4:30 p.m. and 6:30 p.m. which would include getting residents to dinner and back to room after dinner. -Had pulled the MT/CNA from east wing for 5:00 p.m. to 6:00 p.m. to help.</p> <p>*On the east wing there were thirty-two residents: -A new orient was found with the scheduled MT/CNA.</p> <p>*On Warren wing with five residents: -Had one CNA scheduled for eight hour shift. At time of observation scheduled had changed and this person was staying for a total of eleven hours. -Had one nurse scheduled for a twelve hours shift. No nurse was present at time of observation and no one had been found to fill in for the nurse.</p> <p>Observation on 9/5/14 from 9:00 p.m. through 10:00 p.m. concerning staffing for the night shift</p>	F 353	

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 09/11/2014
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 353	<p>Continued From page 39</p> <p>of 6:00 p.m. to 6:00 a.m. revealed:</p> <p>*On the center wing with forty-six residents:</p> <ul style="list-style-type: none"> -Evening/bedtime snack cart was sitting at nurses station. The food bin with snacks and food had some ice remaining. More than half of the bin was full of food items. -They had pulled another MT/CNA from the east wing to work on center between 6:00 p.m. and 8:00 p.m. -At 9:00 p.m. there were four residents' call lights on and two residents were in wheelchairs against a wall by the nurses station waiting to be assisted to bed. -Had one CNA scheduled for an eight hour shift. This person was present until 10:30 p.m.. - After 10:30 p.m. there would be one nurse and one MT/CNA for 58 residents from 10:30 p.m. to 6:30 a.m. to answer lights, administer medications, meet all resident needs. <p>*On the east wing: to care for thirty-two residents</p> <ul style="list-style-type: none"> -Evening/bedtime snack cart was sitting at nurses station. The food bin with snacks and food had some ice remaining. The food bin looked full of food items. -One CNA had been scheduled from 6:00 p.m. to 8:00 p.m. -They had pulled one MT/CNA from the Warren wing for 6:00 p.m. to 6:30 a.m. --One nurse for 6:00 p.m. to 6:30 a.m. <p>*On the Warren wing there was one nurse for five residents from 6:00 p.m. to the 6:30 a.m. shift.</p> <p>Interview on 9/6/14 at 11:45 a.m. with resident 35 revealed:</p> <ul style="list-style-type: none"> *She required two staff to assist her in transferring using the Hoyer lift. **Only had one CNA on last night." "I need two people to help me." "Had to wait forever to go the the bathroom." 	F 353		

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

PRINTED: 09/25/2014
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 09/11/2014
--	--	--	---

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 353	<p>Continued From page 40</p> <p>Observation on 9/6/14 from 11:18 a.m. through 12:10 p.m. concerning stalling for the days shift of 6:00 a.m. to 6:00 p.m. revealed: *Had been schedule changes since yesterday afternoon. *On east wing to care for thirty-two residents: -One licensed practical nurse (LPN) had been on assignment schedule to come in, but was not scheduled to come in. This was an error</p> <p>ObseIvation and intervew on 9/6/14 from 11:10 p.m. through 12:10 a.m. concerning stalling for the night shift of 6:00 p.m. to 6:00 a.m. revealed: *On the center wing with forty-six residents: -Evening/bedtime snack cart was sitting at nurses station. The food bin with snacks and food had very little ice remaining. More than half of the bin was full of food items. -The scheduled MT/CNA for center had to add the five residents from Warren wing to her patient list. -One CNA remained on the center wing as the second one was pulled to the east wing to assist until people were in bed. -One nurse was present on center wing. *On the east wing with thirty-two residents: -Evening/bedtime snack cart was sitting at nurses station. The food bin with snacks and food had very little ice remaining. More than half of the bin was full of food items. -Four residents were seated in the nurses station, two of these were asleep in their chairs or wheelchairs. The third was yelling for help. The fourth was wheeling back and forth. -One CNA had gone on break at 7:15 p.m. and never returned. The nurse had reported her as missing to the police. The police had checked and found her at home in bed. She did not intend</p>	F 353		
-------	--	-------	--	--

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 09/11/2014
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 353	<p>Continued From page 41 to return to work.</p> <ul style="list-style-type: none"> -A second CNA had not shown up for work, had not called, could not be reached. -One nurse and one CNA remained for the duration of the night shift. -A CNA from center wing was pulled to the east wing to assist until people were in bed. Once all were in bed she would be going home. -The nurse on duty had attempted to call all staff to assist. No one had agreed to come in. She then notified the manager on duty which had been the administrator at 11:55 p.m. She was instructed to call the LPNs and see if one would come in early tomorrow. *On the Warren wing: <ul style="list-style-type: none"> -Double doors to unit open. -All five call lights were on to identify where residents were located. If a resident put call light on these would flash all three colors and in a faster tone to identify need. -No staff was present in the Warren wing. <p>Observation on 9/7/14 from 9:40 a.m. through 10:40 a.m. concerning staffing for the day shift of 6:00 a.m. to 6:00 p.m. revealed: *Front desk receptionist was going through mail. She stated the mail was from Saturday. She had not had time to go through the mail on Saturday.</p> <p>*On the center wing with forty-six residents: -Between 4:30 p.m. and 6:30 p.m. there were one MT/CNA and one nurse on duty. During this time residents would have to get to evening meal and be assisted following the meal.</p> <p>Interview on 9/7/14 at 7:59 p.m. with resident 35 revealed: *She had put her call light on at 6:30 p.m. following the evening meal for the assistance of one person to place a bedpan under her.</p>	F 353		

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

PRINTED: 09/25/2014
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 09/11/2014
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)
F 353	<p>Continued From page 42</p> <p>*She finished and put her call light on at 6:40 p.m. to be taken off the bedpan.</p> <p>*She received assistance to get off the bedpan at 7:55 p.m.</p> <p>*She was in pain and was told there was a red area on her buttocks where the bedpan had been.</p> <p>Observation on 9/7/14 from 7:45 p.m. through 8:45 p.m. concerning staffing for the night shift of 6:00 p.m. to 6:00 a.m. revealed:</p> <p>*On the center wing with forty-six residents:</p> <ul style="list-style-type: none"> -Evening/bedtime snack cart was sitting at nurses station. More than half of the bin was full of food items. -The MT/CNA had been pulled off center wing and sent to Warren wing. -One nurse remained on the center wing. -There were two CNAs until 10 p.m. and a second nurse from 6:00 p.m. to 9:00 p.m. <p>*On the east wing with thirty-two residents:</p> <ul style="list-style-type: none"> -One nurse and one CNA were scheduled for the entire night shift. -One MT/CNA was leaving at 9:00 p.m. -One other CNAs was leaving at 10:30 p.m. -At 8:10 p.m. there were six residents seated in the nurses station area. Four of these were asleep in their chairs or wheelchairs. The fifth one was yelling for help. The sixth one was wheeling back and forth. -At 8:20 p.m. the administrator was wheeling the east wing's evening/bedtime snack cart to the east wing *One nurse from a temporary staffing agency was working the night shift and floating between center and east wings. <p>Observation on 9/5/14 from 10:48 a.m. through 11:50 a.m. concerning staffing for the days shift of</p>	F 353	

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 09/11/2014
--	--	--	---

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 353	<p>Continued From page 43</p> <p>6:00 a.m. to 6:00 p.m. revealed:</p> <ul style="list-style-type: none"> *Had been schedule changes since yesterday afternoon. *On center wing:for forty-six residents -Had had two CNAs scheduled for the two hours between 2:00 p.m. and 4:30 p.m. -Had had one CNA scheduled for the two hour period between 4:30 p.m. and 6:30 p.m. which would include getting residents to dinner and back to room after dinner. -Had pulled the MT/CNA from east wing for 5:00 p.m. to 6:00 p.m. to help. *On the east wing there were thirty-two residents: -A new orient was found with the scheduled MT/CNA. *On Warren wing with five residents: -Had one CNA scheduled for eight hour shift. At time of observation scheduled had changed and this person was staying for a total of eleven hours. -Had one nurse scheduled for a twelve hours shift. No nurse was present at time of observation and no one had been found to fill in for the nurse. <p>Observation on 9/5/14 from 9:00 p.m. through 10:00 p.m. concerning staffing for the night shift of 6:00 p.m. to 6:00 a.m. revealed:</p> <ul style="list-style-type: none"> *On the center wing with forty-six residents: -Evening/bedtime snack cart was sitting at nurses station. The food bin with snacks and food had some ice remaining. More than half of the bin was full of food items. -They had pulled another MT/CNA from the east wing to work on center between 6:00 p.m. and 8:00 p.m. -At 9:00 p.m. there were four residents' call lights on and two residents were in wheelchairs against a wall by the nurses station waiting to be assisted 	F 353		

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 09/11/2014
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 353	Continued From page 44 to bed. -Had one CNA scheduled for an eight hour shift. This person was present until 10:30 p.m.. - After 10:30 p.m. there would be one nurse and one MT/CNA for 58 residents from 10:30 p.m. to 6:30 a.m. to answer lights, administer medications, meet all resident needs. *On the east wing: to care for thirty-two residents -Evening/bedtime snack cart was sitting at nurses station. The food bin with snacks and food had some ice remaining. The food bin looked full of food items. -One CNA had been scheduled from 6:00 p.m. to 8:00 p.m. -They had pulled one MT/CNA from the Warren wing for 6:00 p.m. to 6:30 a.m. --One nurse for 6:00 p.m. to 6:30 a.m. *On the Warren wing there was one nurse for five residents from 6:00 p.m. to the 6:30 a.m. shift. Interview on 9/6/14 at 11:45 a.m. with resident 35 revealed: *She required two staff to assist her in transferring using the Hoyer lift. **"Only had one CNA on last night." "I need two people to help me." "Had to wait forever to go the the bathroom." Observation on 9/6/14 from 11:18 a.m. through 1210 p.m. concerning staffing for the days shift of 6:00 a.m. to 6:00 p.m. revealed: *Had been schedule changes since yesterday afternoon. *On east wing to care for thirty-two residents: -One licensed practical nurse (LPN) had been on assignment schedule to come in, but was not scheduled to come in. This was an error. Observation and interview on 9/6/14 from 11:10	F 353		

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 09/11/2014	
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 353	Continued From page 45 p.m. through 12:10 a.m. concerning staffing for the night shift of 6:00 p.m. to 6:00 a.m. revealed: *On the center wing with forty-six residents: -Evening/bedtime snack cart was sitting at nurses station. The food bin with snacks and food had very little ice remaining. More than half of the bin was full of food items. -The scheduled MT/CNA for center had to add the five residents from Warren wing to her patient list. -One CNA remained on the center wing as the second one was pulled to the east wing to assist until people were in bed. -One nurse was present on center wing. *On the east wing with thirty-two residents: -Evening/bedtime snack cart was sitting at nurses station. The food bin With snacks and food had very little ice remaining. More than half of the bin was full of food items. -Four residents were seated in the nurses station, two of these were asleep in their chairs or wheelchairs. The third was yelling for help. The fourth was wheeling back and forth. -One CNA had gone on break at 7:15 p.m. and never returned. The nurse had reported her as missing to the police. The police had checked and found her at home in bed. She did not intend to return to work. -A second CNA had not shown up for work, had not called, could not be reached. -One nurse and one CNA remained for the duration of the night shift. -A CNA from center wing was pulled to the east wing to assist until people were in bed. Once all were in bed she would be going home. -The nurse on duty had attempted to call all staff to assist. No one had agreed to come in. She then notified the manager on duty which had been the administrator at 11:55 p.m. She was	F 353		

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

PRINTED: 09/25/2014
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 09/11/2014
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)
F 353	Continued From page 46 instructed to call the LPNs and see if one would come in early tomorrow. *On the Warren wing: -Double doors to unit open. -All five call lights were on to identify where residents were located. If a resident put call light on these would flash all three colors and in a faster tone to identify need. -No staff was present in the Warren wing. Observation on 9/17/14 from 9:40 a.m. through 10:40 a.m. concerning staffing for the day shift of 6:00 a.m. to 6:00 p.m. revealed: *Front desk receptionist was going through mail. She stated the mail was from Saturday. She had not had time to go through the mail on Saturday. *On the center wing with forty-six residents: -Between 4:30 p.m. and 6:30 p.m. there were one MT/CNA and one nurse on duty. During this time residents would have to get to evening meal and be assisted following the meal. Interview on 9/17/14 at 7:59 p.m. with resident 35 revealed: *She had put her call light on at 6:30 p.m. following the evening meal for the assistance of one person to place a bedpan under her. *She finished and put her call light on at 6:40 p.m. to be taken off the bedpan. *She received assistance to get off the bedpan at 7:55 p.m. *She was in pain and was told there was a red area on her buttocks where the bedpan had been. Observation on 9/7/14 from 7:45 p.m. through 8:45 p.m. concerning staffing for the night shift of 6:00 p.m. to 6:00 a.m. revealed: *On the center wing with forty-six residents:	F 353	

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 09/11/2014
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 353	Continued From page 47 -Evening/bedtime snack cart was sitting at nurses station. More than half of the bin was full of food items. -The MT/CNA had been pulled off center wing and sent to Warren wing. -One nurse remained on the center wing. -There were two CNAs until 10 p.m. and a second nurse from 6:00 p.m. to 9:00 p.m. *On the east wing with thirty-two residents: -One nurse and one CNA were scheduled for the entire night shift. -One MT/CNA was leaving at 9:00 p.m. -One other CNAs was leaving at 10:30 p.m. -At 8:10 p.m. there were six residents seated in the nurses station area. Four of these were asleep in their chairs or wheelchairs. The fifth one was yelling for help. The sixth one was wheeling back and forth. -At 8:20 p.m. the administrator was wheeling the east wing's evening/bedtime snack cart to the east wing *One nurse from a temporary staffing agency was working the night shift and floating between center and east wings. Surveyor: 33265 2. One hour observations were completed two times a day, each day, during the three days of 9/5/14, 9/6/14, and 9/7/14, for a total of six different observations. During each of these observations the staff that were present was compared to the daily staffing planned. This revealed that during each twelve hours shift: *There were numerous schedule changes from	F 353		

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

PRINTED: 09/25/2014
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 09/11/2014
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 353	<p>Continued From page 48</p> <p>the staffing plan provided on 9/4/14.</p> <p>*The provider had not been able to secure the identified adequate number and type of staff needed each shift to provide for the basic needs of the residents.</p> <p>Observation on 9/5/14 from 10:48 a.m. through 11:50 a.m. concerning staffing for the day shift from 6:00 a.m. to 6:00 p.m. revealed:</p> <p>*Center wing: with forty-six residents:</p> <ul style="list-style-type: none"> -There were two CNAs scheduled for the two hours between 2:00 p.m. and 4:30 p.m. -There was one CNA scheduled for the two hour period between 4:30 p.m. and 6:30 p.m. which would include getting residents to dinner and back to their rooms after dinner. -They had pulled a MT/CNA from east wing from 5:00 p.m. to 6:00 p.m. to help on the center wing during the dinner time period. <p>*East wing with thirty-two residents:</p> <ul style="list-style-type: none"> -The scheduled MT/CNA was now orienting a new staff person. <p>*Warren wing with five residents:</p> <ul style="list-style-type: none"> -There was one CNA scheduled for an eight hour shift. At the time of the observation the schedule had been changed, and that person was staying for a total of eleven hours. -There was one nurse scheduled for a twelve hour shift. No nurse was present at the time of the observation, and no one had been found to fill in for that nurse. There was no one assigned for the last hour. Center wing staff was to address the needs of Warren wing residents during that time. <p>Observation on 9/5/14 from 9:00 p.m. through 10:00 p.m. concerning staffing for the night shift from 6:00 p.m. to 6:00 a.m. revealed:</p> <p>*Center wing with forty-six residents:</p>	F 353			

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

PRINTED: 09/25/2014
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 09/11/2014
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 353	<p>Continued From page 49</p> <p>-The evening/bedtime snack cart was sitting at the nurses station. The food bin with snacks and food had some ice remaining, and more than half of the bin was full of food items.</p> <p>-They had pulled a MT/CNA from the east wing to work on center between 6:00 p.m. and 8:00 p.m.</p> <p>-At 9:00 p.m. there were four residents' call lights on, and two residents were in wheelchairs against a wall by the nurses station waiting to be assisted to bed.</p> <p>-They had one CNA scheduled for an eight hour shift. That person was to be there until 10:30 p.m.</p> <p>- After 10:30 p.m. there would be one nurse and one MT/CNA for forty-six residents from 10:30 p.m. to 6:30 a.m. to answer lights, administer medications, and meet all resident needs.</p> <p>*East wing with thirty-two residents:</p> <p>-Evening/bedtime snack cart was sitting at the nurses station. The food bin with snacks and food had some ice remaining, and the food bin was full of food items.</p> <p>-There was one nurse present from 6:00 p.m. to 6:30 a.m.</p> <p>-One CNA had been scheduled from 6:00 p.m. to 8:00 p.m.</p> <p>-They had pulled one MT/CNA from the Warren wing for 6:00 p.m. to 6:30 a.m. to help on the east wing.</p> <p>*Warren wing with five resident had one nurse from 6:00 p.m. to the 6:30 a.m. shift.</p> <p>Interview on 9/6/14 at 11:45 a.m. with resident 35 revealed:</p> <p>*She required two staff to assist her in transferring using the Hoyer lift (mechanical device used to raise and lower residents).</p> <p>**"Only had one CNA on last night." "I need two people to help me." "Had to wait forever to go the the bathroom."</p>	F 353			

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 09/11/2014
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 353	Continued From page 50 Observation on 9/6/14 from 11:10 a.m. through 12:10 p.m. concerning staffing for the day shift from 6:00 a.m. to 6:00 p.m. revealed: *Center wing with forty-six resident: -There were no CNAs assigned and present for the entire twelve hour shift. Four CNAs were scheduled for parts of the twelve hour shift. One of those was only scheduled to be on center wing for two hours of the twelve hour shift. *East wing with thirty-two residents: -Two licensed practical nurses (LPN) had been assigned on the schedule to come in. One was an error. -One LPN was present during the twelve hour day shift. -Only one CNA was assigned and present for the entire twelve hour shift. Three other CNAs were assigned and present for part of the twelve hour shift. One of those was only scheduled for four hours of the twelve hour shift. *Warren wing with five residents had one nurse for the day shift. No CNA was scheduled on that wing. Observation on 9/6/14 from 11:10 p.m. through 9/7/14 at 12:10 a.m. concerning staffing for the night shift from 6:00 p.m. to 6:00 a.m. revealed: *Center wing with forty-six residents: -Evening/bedtime snack cart was sitting at the nurses station. The food bin with snacks and food had very little ice remaining, and more than half of the bin was full of food items. -The scheduled MT/CNA for center had to add the five residents from the Warren wing to her resident list. -One CNA remained on the center wing as the second one was pulled to the east wing to assist until people were in bed.	F 353		

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 09/11/2014
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 353	<p>Continued From page 51</p> <ul style="list-style-type: none"> -One nurse was present on the center wing. *East wing with thirty-two residents: <ul style="list-style-type: none"> -Evening/bedtime snack cart was sitting at nurses station. The food bin with snacks and food had very little ice remaining, and more than half of the bin was full of food items. -Four residents were seated in the nurses station, two of them were asleep in their chairs or wheelchairs. The third was yelling for help. The fourth was wheeling back and forth in the hall. -One CNA had gone on break at 7:15 p.m. and never returned. The nurse had reported her as missing to the police. The police had checked and found her at home in bed. She did not intend to return to work. -A second CNA had not shown up for work, had not called, and could not be reached. -One nurse and one CNA remained for the duration of the night shift to assist the residents. -A CNA from center wing was pulled to the east wing to assist until people were in bed. Once all were in bed she would be going home. -The nurse on duty had attempted to call all the off-duty staff to ask if they would come in and assist on the night shift. No one had agreed to come in. She then notified the manager on duty who had been the administrator at 11:55 p.m. She was instructed to call the LPNs and see if one would come in early tomorrow morning to assist in getting residents up after the nights sleep. *Warren wing with five residents had no staff were present. Center wing staff were to cover this wing also. To do so they: <ul style="list-style-type: none"> -Opened the double doors to the Warren wing so the Warren wing residents' call lights could be seen from the center wing. -Turned on all five resident call lights to identify where the residents were located. 	F 353		

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 09/11/2014
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)
F 353	<p>Continued From page 52</p> <p>-If a Warren wing resident put on their call light the light would change from a steady beam to all three colors (white, red, and green) flashing with a fast audible tone to identify the immediate need for assistance.</p> <p>Observation on 9/7/14 Sunday, from 9:40 a.m. through 10:40 a.m. concerning staffing for the day shift from 6:00 a.m. to 6:00 p.m. revealed:</p> <p>*The front desk receptionist was going through mail. She stated the mail was from Saturday. She had not had time to go through the mail on Saturday.</p> <p>*Center wing with forty-six residents:</p> <p>-Between 4:30 p.m. and 6:30 p.m. there were one MT/CNA and one nurse on duty. During that time residents would have to get to the evening meal and be assisted following the meal.</p> <p>*East wing with thirty-two residents:</p> <p>-There was only one CNA scheduled for the full twelve hour shift. Three others were scheduled for part of a twelve hour shift. Two of those were for four hours of the twelve hour shift.</p> <p>*Warren wing with five residents:</p> <p>-Had one nurse scheduled for the twelve hour shift. No CNA was present on the Warren wing.</p> <p>Interview on 9/7/14 at 7:59 p.m. with resident 35 revealed:</p> <p>*She had put her call light on at 6:30 p.m. following the evening meal for the assistance of one person to place a bedpan under her.</p> <p>*She had finished and put her call light on at 6:40 p.m. to be taken off the bedpan.</p> <p>*She received assistance to get off the bedpan at 7:55 p.m.</p> <p>*She was in pain and was told there was a red area on her buttocks where the bedpan had been.</p>	F 353	
			(X5) COMPLETION DATE

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 09/11/2014
NAME OF PROVIDER OR SUPPLIER SOUTHRIDGE HEALTHCARE 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 353	Continued From page 53 Observation on 9/7/14 from 7:45 p.m. through 8:45 p.m. concerning staffing for the night shift from 6:00 p.m. to 6:00 a.m. revealed: *Center wing with forty-six residents: -Evening/bedtime snack cart was sitting at the nurses station, and more than half of the bin was full of food items. -The MT/CNA had been pulled from the center wing and sent to the Warren wing. -One nurse remained on the center wing. -There were two CNAs until 10:00 p.m. and a second nurse from 6:00 p.m. to 9:00 p.m. *East wing with thirty-two residents: -One nurse and one CNA were scheduled for the entire night shift. -One MT/CNA was leaving at 9:00 p.m. -One other CNA was leaving at 10:30 p.m. -At 8:10 p.m. there were six residents seated at the nurses station area. Four of those were asleep in their chairs or wheelchairs. The fifth one was yelling for help. The sixth one was wheeling back and forth in the hall. -At 8:20 p.m. the administrator was wheeling the east wing's evening/bedtime snack cart to the east wing *One nurse from a temporary staffing agency was working the night shift and floating between the center and the east wings. *Warren wing with five resident: -Had one MT/CNA scheduled for the twelve hour shift. -A nurse had been listed on the Daily Employee Assignment Schedule form for that wing and shift, but that nurse was not present.	F 353			
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356			

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

PRINTED: 09/25/2014
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 09/11/2014	
NAME OF PROVIDER OR SUPPLIER SOUTHRIDGE HEALTHCARE 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 356	<p>Continued From page 54</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law).. - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review and interview, the provider failed to ensure the twenty-four hour nursing staff posting reflected the actual staffing that was on duty to provide the basic care needs to all ninety-three residents. Findings include:</p>	F 356	<ol style="list-style-type: none"> 1. Nurse staffing data is posted at the nurses' stations for each unit. 2. Any staffing changes are updated on the nurse staffing data. A signature line has been added to the form for accessibility. 3. The nursing scheduler or designee will check the nurse staffing data daily. The Administrator or designee (Manager of Director) will randomly verify, on a daily basis for a month and then at least three times a week on a continuous basis, that the nurse staffing data is updated and accurate. 	10/10/14

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

PRINTED: 09/25/2014
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 09/11/2014	
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 356	<p>Continued From page 55</p> <p>1. Review of random twenty-four hour nursing staff postings from 8/18/14 through 9/7/14 revealed: *8/30/14, There was no documentation a twenty-four hour nursing staff posting had been completed for that day. *8/31/14, There was no documentation a twenty-four hour nursing staff posting had been completed for that day. *9/5/14, The nursing schedule reflected a medication technician (MT)/ certified nursing assistant (CNA) was scheduled to work from 2:00 p.m. to 9:00 p.m. That was not documented on the twenty-four hour nursing staff posting. The nursing schedule reflected two CNA were to work from 6:00 p.m. to 6:30 a.m. The twenty-four hour nursing staff posting reflected three CNA worked from 6:00 p.m. to 6:30 a.m. *9/7/14, The nursing schedule reflected two registered nurses (RN) were scheduled to work from 6:00 p.m. to 6:30 a.m. The twenty-four hour nursing staff posting reflected two RN were scheduled to work from 10:00 p.m. to 6:30 a.m. *Review of the remainder of the twenty-four hour nursing staff postings showed many discrepancies between what was documented on them and the actual nursing schedule.</p> <p>Interview on 9/4/14 at 10:30 a.m. with business manager A revealed she: *Had been doing scheduling for about a month and one-half to two months. *Had been put in the position the end of July 2014 after the human resource staff who had been doing the scheduling left. She had received minimal training for the position. *Completed the twenty-four hour nursing staff postings and hung them out on the nursing units.</p>	F 356		

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 09/11/2014
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 356	Continued From page 56 *Tried to document on the twenty-four hour nursing staff postings what was on the nursing schedule. It was up to the charge nurses who worked the shifts to make changes on the twenty-four hour nursing staff posting to reflect what actual staff worked and the hours they worked. Interview on 9/8/14 at 4:00 p.m. with the director of nursing regarding the twenty-four hour nursing staff postings revealed she: *Agreed there were discrepancies in the nursing schedule to what staff actually worked and their hours on the twenty-four hour nursing staff postings. *Felt it was up to the charge nurses to make the changes on the twenty-four hour nursing staff postings so they reflected the actual staff that was working.	F 356		
F 368 SS=F	483.35(1) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.	F 368	1. Clinical record review for Resident 13 determined the resident had no negative outcome related to not receiving evening snacks. All residents who are at risk for weight loss and/or are dependent on staff for hydration were reviewed to determine no negative outcomes related to the lack of evening snacks. 2. Evening snacks, for all residents, will be distributed to the nurses' stations by the dietary department no later than 7:30, and nursing staff will distribute to residents at that time or no later than 8:00 pm. Nursing and dietary staff were educated on the snack cart	10/10/14

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 09/11/2014
NAME OF PROVIDER OR SUPPLIER SOUTHRIDGE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105	
(X4) 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 368	Continued From page 57 This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, interview, record review, and policy review, the provider failed to ensure bedtime snacks were offered to all residents consistently. Findings include: 1. Group interview with ten residents who preferred to remain anonymous on 9/3/14 at 11:00 a.m. revealed: **"A snack cart comes out but nobody passes it." *A snack cart was wheeled out of the kitchen nightly and placed at the nurse's station. *Occasionally a nurse would wheel the bedtime snacks through the halls and pass snacks, but that was not routinely done. *Most evenings the snack cart remained at the nurse's station. *If the residents could get to the snack cart on their own, they could have the snack. *If one male resident hollered loud enough, the staff would bring him a snack. Surveyor: 32331 2. Interview on 9/3/14 at 6:00 p.m. with the certified dietary manager (COM) in the kitchen regarding the bedtime snack carts revealed: *The carts were set-up by dietary staff each evening after the supper meal. *There were three carts with snacks for the following areas: -East hall. -Warren (rehabilitation) hall. -Center hall. *Each of those snack carts were placed at the nurses station on each hall.	F 368	procedure. The consultant Registered Dietitian will review the records for all residents who are at risk for weight loss and/or dependent on staff for hydration and will report any issues at the weekly Wound and Weight committee meeting. 3. At monthly QAPI meetings, the Director of Nursing and consultant Registered Dietitian will provide a collaborative report about effectiveness of the education and collaborative accountabilities for the evening snack distribution process. Based on report, further education and/or corrective action will be planned and carried out. These reports will occur until the QAPI committee determines otherwise.	

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 09/11/2014
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 368	<p>Continued From page 58</p> <p>*The memory care unit had been stocked with snacks to use throughout the evening as needed. *Those extra snacks each evening included the following: -Three sandwiches. -Two fruit cups. -Two ice creams cups. -Two applesauce cups. *There were extra snacks in addition to the snack cart sent to the Warren hall each evening that included the following: -Three sandviches. -One apple. -Two fruit cups. *There were two scheduled residents, 3 and 5, that received a specific bedtime snack. *The nursing department was responsible for offering the snacks to the residents at bedtime.</p> <p>Interview on 9/8/14 at 3:22 p.m. with the COM regarding the residents being offered a bedtime snack revealed: *She agreed all residents on oral diets needed to have been offered a bedtime snack. *The bedtime snacks were delivered around 7:30 p.m. each evening by the dietary department. *The nursing department was responsible for offering the bedtime snacks.</p> <p>Interview on 9/9/14 at 2:30 p.m. with the consultant registered dietitian regarding residents being offered a bedtime snack revealed: *Her expectation was all residents on oral diets were to have been offered a bedtime snack. *The dietary department was responsible for preparing the bedtime snacks. *The nursing department was responsible for offering the bedtime snacks.</p>	F 368			

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 09/11/2014	
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 368	Continued From page 59 Review of the provider's 9/4/14 Frequency of Meal Service policy revealed: *Snacks were available at any time per resident request *The HS (bedtime) snack carts were passed between 7:30 p.m. through 8:00 p.m. to all residents.	F 368		
F 371 SS=D	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 This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, product information sheet review, and policy review, the provider failed to identify the date and time of the tube feeding formula for one of two residents (1) on a tube feeding. Findings include: 1. Observation on 9/8/14 at 1:30 p.m. in resident 1's room next to the resident's chair revealed: *A 1000 cc ready-to-hang prefilled tube feeding container of Jevity 1.2 (a tube feeding formula). *That container was turned over and suspended, using the hanging feature on the bottom of the container, and attached to an IV pole.	F 371	1. Observation and clinical record review for Resident 1 were conducted to ensure the feeding pump was working at the appropriate flow rate, the formula bag was dated, and weekly weights were conducted. All other residents on tube feeding were changed to weekly weights and other interventions were implemented. 2. All licensed nurses will be re-educated by the consultant pharmacist on tube feeding policy and procedures, and will also be educated on adequate intake and output regarding residents who receive tube feeding. 3. At monthly QAPI meeting, the Director of Nursing and the Registered Dietitian will provide a collaborative report, on a continuous basis, about effectiveness of the education on the tube feeding policy and procedures to ensure outcomes reflect an understanding and implementation of effective	10/10/14

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

PRINTED: 09/25/2014
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 _____ 8. WING	(X3) DATE SURVEY COMPLETED C 09/11/2014
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 371	<p>Continued From page 60</p> <p>*That container had none of the following: -Resident name. -Room number. -Date. -Start time. -Rate of the feeding.</p> <p>Review of the 2008 Ready-To-Hang Suggested Setup Procedure product information sheet for the manufacturer's prefilled tube feeding container revealed the following: *Fill in information on label with: -Patient (resident) name. -Room. -Date. -Start time. -Rate. -Proper identification and dating were essential for patient (resident) safety.</p> <p>Interview on 9/9/14 at 10:35 a.m. with the consultant registered dietitian (RD) regarding the tube feeding container revealed: *She had stated that once the container had been opened it needed to have been dated and timed when opened. *Her expectation was this was to have been done each time a feeding had been started.</p> <p>Interview on 9/10/14 at 8:15 a.m. with the director of nursing regarding the tube feeding container revealed: *It was a standard of care to consistently have written the following: *Name of the resident. *The date. *The start time of the feeding. *That was to have been done on each bottle of tube feeding formula.</p>	F 371	practices. Based on the report, further education and/or corrective action will be planned and carried out.	

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 09/11/2014
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 371	Continued From page 61 Interview on 9/9/14 at 3:15 p.m. with the consultant RD and the certified dietary manager regarding the dating and time of the tube feeding formula revealed: *The tube feeding formula was considered a food item. *The food items needed to be have been dated and labeled when opened. Review of the provider's 7/16/14 Food Storage poiicy revealed: *Proper food storage was important for a safe and sanitary food service. *Foods that had been prepared would have been dated and labeled.	F 371		
F 490 SS=I	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently 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 22452 Based on observation, interview, record review, and policy review, the provider failed to ensure the facility was operated and administered in a manner that attained or maintained the highest practicable physical, mental, and psychosocial well-being of all ninety-three residents. Findings include: 1. Interview on 9/9/14 at 9:00 a.m. with the	F 490	1. The Administrator will direct and/or oversee the plans of correction for all system changes and QAPI audits related to tags F157, F164, F166, F204, F221, F222, F224, F225, F226, F241, F248, F252, F278, F279, F280, F281, F309, F314, F322, F323, F325, F327, F332, F333, F353, F356, F368, F371, F385, F425, F428, F431, F441, F505, F514, and F520. 2. Correction of the above-listed tags will indicate compliance with this requirement.	10/10/14

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

PRINTED: 09/25/2014
FORM APPROVED
OMB NO 0938-0391

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 09/11/2014
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)
F 490	<p>Continued From page 62</p> <p>administrator revealed:</p> <ul style="list-style-type: none"> *He reported to the chief financial officer (CFO) any concerns or problems he had with the facility. *He usually informed the CFO on the phone or in e-mails of any concerns he had. He had not kept any of the e-mails he had sent to the CFO. *He had informed the CFO the end of July 2014 or first part of August 2014 of staffing issues. The CFO's response to him at that time had been "Figure it out with the staff you have." *He felt the CFO had a "bad taste" regarding the big financial bill that was run up last year from using the staffing agencies. *"Maybe I did a bad job explaining to him how dire we were." *He was told about two weeks ago when the previous director of nursing (DON) left he could use the staffing agencies. *He had called three staffing agencies on 8/21/14 and was told "We were too late in the game and all staff were on contract with another facility. It was going to be difficult to get us any staff. Someone that was on contract would have to cancel before we could get any staff. He had requested two day certified nursing assistants (CNA) twelve hour shifts and two night CNAs twelve hour shifts. *One staffing agency told them they had to establish a contract with them before they could provide staff. He developed a contract with them on 8/26/14. Their option with that facility was only nurses as the CNAs were not certified. *Two staffing facilities had not been able to supply them with any staff. *One staffing facility had sent them a CNA on 8/27/14 and on 9/9/14. They sent them a licensed practical nurse on 9/7/14 that they utilized as a CNA. *He or business manager A called the staffing 	F 490	

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

PRINTED: 09/25/2014
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 09/11/2014
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 490	Continued From page 63 agencies every two to three days after 8/21/14 and their response was always the same "They did not have any staff they could send us." *The second time we called the staffing agencies they changed their request to eight hour CNAs stead of twelve hour CNAs to increase their chances of getting help. Phone interviews on 9/9/14 at 9:30 a.m. with the three staffing agencies revealed: *None of the agencies were aware when the initial request from the facility had been for staff. *It was usually business manager A they had spoken to from the facility. *None of the agencies had documentation the facility had requested eight hour shift CNAs instead of twelve hour shift CNAs. *Only one of the staffing agencies had been able to supply them any staff as the administrator had confirmed. Interviews, observations, record reviews, and policy reviews throughout the course of the survey revealed the administration had not ensured all residents attained and/or maintained their highest practicable physical, mental, and psychosocial well-being. Refer to F221, F222, F225, F248, F309, F333, F353, and F356.	F 490		
F 493 SS=I	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required;	F 493	1. The governing body will oversee the plans of correction for all system changes and QAPI audits related to tags F157, F164, F166, F204, F221, F222, F224, F225, F226, F241, F248, F252, F278, F279, F280, F281, F309, F314, F322, F323, F325, F327, F332, F333, F353, F356, F368, F371, F385,	10/10/14

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 09/11/2014	
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 493	<p>Continued From page 64 and responsible for the management of the facility</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, interview, and policy review, the governing body failed to ensure the facility was administered in a manner that ensured:</p> <ul style="list-style-type: none"> *An antianxiety medication was appropriately administered to 1 of 1 sampled resident (5) to treat a medical condition instead of for staff convenience. *One of one sampled nursing staff (D) who had allegations of simple assault had been thoroughly investigated previous to hire. *One of one sampled resident (2) who was on hospice (end of life care) was assessed and monitored for pain management. *Acceptable parameters of nutritional status was maintained for 1 of 2 sampled residents (1) who received an enteral feeding. *Sufficient staff was on duty all shifts to provide basic resident care needs to all ninety-three residents. *The nursing staff information posted daily was accurate and reflected the current schedule. <p>Findings include:</p> <p>1. Interview on 9/8/14 at 11:00 a.m. with the chief financial officer regarding the above revealed:</p> <ul style="list-style-type: none"> *He and the owner were the governing body of the facility. *The administrator reported to him, and he reported to the owner. *He was responsible for the accounting, the books, and the reporting. 	F 493	<p>F425, F428, F431, F441, F505, F514, and F520.</p> <p>2. Correction of the above-listed tags will indicate compliance with this requirement.</p>	

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

PRINTED: 09/25/2014
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 09/11/2014
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 493	<p>Continued From page 65</p> <p>*He recently became aware of a lot of things but primarily staffing. He was told by the administrator that staffing was "challenged." He had told the administrator and the director of nursing (DON) about two weeks ago if they had exhausted all their staff for staffing to call a staffing agency.</p> <p>*He thought it was about the third week of August the administrator had informed him of the staffing issues, and he informed the owner.</p> <p>*He would have thought the administrator would have called the staffing agency at that time.</p> <p>*He thought the last time the administrator used a staffing agency was in August 2013. The facility had occurred a large bill with the staffing agency that took them awhile to pay off.</p> <p>*He and the owner had felt any information from the administrator "had been dwindling for awhile."</p> <p>"If the administrator informed birt1 of anything it was usually on the phone, texts, or e-mails.</p> <p>*He was not sure if had kept any of the e-mails or texts but would provide them for the surveyor if he had. No texts or e-mails were provided to the surveyor by the end of the survey on 9/11/14.</p> <p>*He had usually come to the facility once a month, but the last month had come a couple of times a week.</p> <p>*He and the owner had concerns since the information provided by the administrator had been dwindling.</p> <p>*When they would ask the administrator how things were he would usually voice no concerns or that he had everything under control.</p> <p>*The facility had a lot of nursing students during the 2014 summer and had put no plan in place to replace them when they had returned to school.</p> <p>*When the previous director of nursing (DON) left about a month ago she had voiced no concerns to him.</p> <p>*The present DON had been hired to be the staff</p>	F493			

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

PRINTED: 09/25/2014
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 09/11/2014
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 493	Continued From page 66 development person but had agreed to be the interim DON. *They had put cameras in the facility a couple months ago related to missing items. Interviews, observations, record reviews, and policy reviews throughout the course of the survey from 9/2/14 through 9/11/14 revealed the governing body had not ensured the safe management and overall well-being of all ninety-three residents. Refer to F221, F222, F225, F248, F309, F333, F353, and F356.	F 493		