

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>03/04/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>FIVE COUNTIES NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 6TH AVENUE WEST LEMMON, SD 57638</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p><i>addendum noted with an asterisk per 4/1/15 email from facility administrator. KWISDDBH/MF</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 26632 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/3/15 through 3/4/15. Areas surveyed included resident assessment, safety, abuse, and neglect. Five Counties Nursing Home was found not in compliance with the following requirements: F223, F224, F225, F226, F309, F490, F493, F501, and F520.</p>	F 000	F223 pg 1 of 34 (door and fall and employee discipline follow up) Each resident has the right to be free from abuse, corporal punishment and involuntary seclusion. Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident family members or legal guardians, friends, or other individuals. Resident 2- A Resident 2 was removed from in front of the open activity door within seconds, the outside activity door was closed and Resident A was in the warm activity room with staff. According to the investigative results of the 11/16/2015 at no time was Resident A partially out to the door. The investigation did result in Nurse A being notified by the Director of Nursing at 1500hrs she was suspended until a complete investigation was completed. Upon being notified of her suspension Nurse A resigned her position immediately at 1900 hrs. She left the facility with no further contact with residents. She did not return to the facility. The incident was reported to the appropriate state agencies. There had been training for employees LPN F and C.N.A C before this incident. LPN F had signed she received and understood training on: 5.20.2014 Resident Abuse Policy Job Description 5-15-2014 addresses responsibilities to the residents' Preventing, recognizing and Reporting Resident Abuse and Resident Rights 3.12.2014 LPN F left employment on 12/12/2014 and did not return to work since that date.  C.N.A. C signed she received and understood training on: 6/18/2014 Resident Abuse Policy Job Description 6/27/2014 addresses responsibilities to the residents' 6/24/2015 Resident Rights Preventing, recognizing and Reporting Resident Abuse 6/16/2014	4/2/2015
F 223 SS=L	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632</p> <p>Surveyor: 20031 A. Based on record review, interview, and policy review, two of five staff (C and F) failed to intervene to stop a registered nurse (A) from inflicting punishment to one of two sampled residents (2) with cognitive (thinking) impairment. Those two staff were still employed and had received no re-education on abuse prevention, thus this had the potential to affect all residents. Findings include:</p>	F 223		4/2/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Chad Abel</i>	TITLE <i>Administrator</i>	(X6) DATE <i>3/27/15</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting, providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	INITIAL COMMENTS  Surveyor: 26632 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/3/15 through 3/4/15. Areas surveyed included resident assessment, safety, abuse, and neglect. Five Counties Nursing Home was found not in compliance with the following requirements: F223, F224, F225, F226, F309, F490, F493, F501, and F520.	<del>F 000</del>	* On March 3, 2015 Administrator and Director of Nursing visited with CNA C. concerning the incident with Resident J. There is no written documentation of the meeting that can be located in the facility. There has been a formal work performance evaluation completed on April 1, 2015 with CNA C. CNA C has completed the Resident Rights in-service. KW/SDD/HMF  * The Abuse Prohibition Review form will be used to guide and train all staff of the facility. Additional training regarding abuse and neglect per title of training article in Resident Rights sponsored by the SD Dep. of Social Services will be completed by May 31, 2015. KW/SDD/HMF		
F 223 SS=L	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION  The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.  The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.  This REQUIREMENT is not met as evidenced by: Surveyor: 26632  Surveyor: 20031 A. Based on record review, interview, and policy review, two of five staff (C and F) failed to intervene to stop a registered nurse (A) from inflicting punishment to one of two sampled residents (2) with cognitive (thinking) impairment. Those two staff were still employed and had received no re-education on abuse prevention thus this had the potential to affect all residents. Findings include:	F 223			

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

TITLE

(X8) DATE

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

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OMB NO. 0938-0391

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F 223	<p>Continued From page 1</p> <p>1. Review of the 11/18/14 allegation (accusation) of abuse of an elderly resident investigation report revealed:</p> <p>*The director of nursing (DON) had conducted the interviews of all staff involved in that allegation.</p> <p>*It had been alleged registered nurse (RN) A had propelled resident 2 in her wheelchair up to the patio door and had the door held open, as resident 2 had stated she wanted to go home.</p> <p>*Certified nursing assistants (CNA) B, D, and E had been asked by RN A to open the door for her. They had refused and stated "This isn't right."</p> <p>*CNA C and licensed practical nurse (LPN) F had held the door open while RN A positioned resident 2 partially out the door.</p> <p>*CNAs B, D, and E reported this to the Minimum Data Set (MDS) assessment and the DON was also called.</p> <p>*The DON started the investigation, and the administrator had also been notified.</p> <p>*During the investigation the DON and administrator had determined to suspend RN A until the investigation was completed.</p> <p>*RN A resigned before the investigation had been completed.</p> <p>*CNA C and LPN F were still employed, and there was no record of any disciplinary action or re-education for them.</p> <p>Surveyor:26632 Interview on 3/3/15 at 11:25 a.m. with a CNA who wished to not be identified revealed: *She had been concerned after the above incident as CNA C and LPN F were still employed. *She was not aware of any education provided to any staff in regards to preventing abuse to residents.</p>	F 223	<p>Employees B, D, and E did respond appropriately by saying "this isn't right" and refused to follow Nurse A instructions. Employees B, D, E ensured at the time of this incident no other residents were harmed or in danger.</p> <p>Resident 1- B pg 4 of 34 Upon reviewing resident file information and staff documentation reports Resident 1 was found on the floor by staff, made as comfortable as possible by C.N.A staff; licensed nurse assessment completed; pain medication given; transferred to hospital for evaluation and treatment, the incident was reported to appropriate state agencies on 1/5/2015. Resident 1 was readmitted to the nursing facility 1/12/2015.</p> <p>On December 3, 2014 Five Counties Nursing Home was found in compliance with federal participation requirement with "NO" deficiencies cited during the survey completed as documented on letter head from the Department of Health date December 10, 2015. The immediate jeopardy was given March 3 and removed March 4, 2015. On 3/4/2015 All staff training included the following topics; Abuse investigations</p> <ol style="list-style-type: none"> <li>1. Abuse Prevention Program</li> <li>2. Investigating Unexplained Injuries</li> <li>3. Preventing Resident Abuse</li> <li>4. Protection of Residents During Abuse Investigations</li> <li>5. Recognizing Signs and Symptoms of Abuse/Neglect</li> <li>6. Reporting Abuse to Facility Management</li> <li>7. Reporting Abuse to State Agencies and Other Entities/Individuals</li> <li>8. Reporting Suspected Cases and/or Incidents of Rape</li> <li>9. Resident to Resident Altercations</li> <li>10. Zero Tolerance policy on abuse</li> <li>11. Chain of Command</li> <li>12. Types, Signs and Prevention of abuse and neglect</li> </ol> <p>the training began on March 3, 2015 to ensure all staff including employees C</p>	
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F 223	<p>Continued From page 2</p> <p>Interview on 3/3/15 at 11:00 a.m. with the administrator revealed he:</p> <ul style="list-style-type: none"> <li>*Had not disciplined the other two staff members regarding the mistreatment of resident 2 as he did not want to lose any employees.</li> <li>*Relied on the DON to address any concerns with the nursing staff.</li> </ul> <p>Interview on 3/4/15 at 4:45 p.m. with the DON revealed:</p> <ul style="list-style-type: none"> <li>*He had completed the investigation on the incident with resident 2.</li> <li>*He had told the administrator that CNA C and LPN F should also have been suspended or terminated.</li> <li>*The administrator had told him he could not do that due to the lack of staffing.</li> <li>*LPN F was on maternity leave and had not returned to work after her maternity leave.</li> <li>*He was not aware LPN F was still considered an employee.</li> </ul> <p>Review of the provider's revised December 2009 Abuse Investigations policy included:</p> <ul style="list-style-type: none"> <li>*Employees who have been accused of resident abuse might have been reassigned to non-resident care duties or suspended from duty until the results of the investigation had been reviewed by the administrator.</li> <li>*The individual in charge of the investigation would consult daily with the administrator concerning the progress/findings of the investigation.</li> <li>*The administrator would have kept the resident and his/her representative informed of the progress of the investigation.</li> </ul> <p>Review of the provider's revised August 2006</p>	F 223	<p>and F are re-educated and reminded of the training staff receive upon hired and annual. Staff training will continue as mandated by the state and federal regulations.</p> <p>On March 27, 2015, re-education was presented to the Leadership of the facility to eliminate any misunderstanding of the expectations of the policy and procedures, reporting forms, and follow up logs listed below. The training included:</p> <ul style="list-style-type: none"> <li>a. Abuse investigations</li> <li>b. Abuse Prevention Program</li> <li>c. Investigating Unexplained Injuries</li> <li>d. Preventing Resident Abuse</li> <li>e. Protection of Residents During Abuse Investigations</li> <li>f. Recognizing Signs and Symptoms of Abuse/Neglect</li> <li>g. Reporting Abuse to Facility Management</li> <li>h. Reporting Abuse to State Agencies and Other Entities/Individuals</li> <li>i. Reporting Suspected Cases and/or Incidents of Rape</li> <li>j. Resident to Resident Altercations</li> <li>k. Zero Tolerance policy on abuse</li> <li>l. Chain of Command</li> <li>m. Types, Signs and Prevention of abuse and neglect</li> <li>n. Disciplinary Measures</li> <li>o. Re-education of Event Reports-References relevant reports power point dated 11-20-2011 24 hour LTC or 48 hour other licensed nursing facility</li> <li>p. Education of Event Reports-References relevant reports power point dated 11-20-2011 5 working day investigation report</li> <li>q. Falls Investigation Log</li> <li>r. Appropriate Staff Interactions with Residents Log</li> <li>s. Employee Disciplinary Action Log</li> <li>t. New Employee HR Orientation Checklist</li> <li>u. Employee Records and Inquires</li> </ul>	

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F 223	<p>Continued From page 3</p> <p>Abuse Prevention Program policy included: *The abuse prevention program provided policies and procedures that governed, and as a minimum included: -Identification of occurrences and patterns of potential mistreatment/abuse. -The implementation of changes to prevent future occurrences of abuse.</p> <p>Review of the provider's revised December 2006 Preventing Resident Abuse policy included: *Training all staff how to resolve conflicts. *Assisting or rotating staff working with difficult residents. *Monitoring staff on all shifts to identify inappropriate behaviors toward residents. *Involving attending physicians and the medical director when findings of abuse had been determined. *Encourage all personnel, residents, family members, visitors to report any signs or suspected incidents of abuse to facility management immediately.</p> <p>B. Based on record review, interview, and policy review, nursing staff failed to adequately respond to and assess one of two sampled residents (1) after a fall. *That lack of response had caused the resident to have prolonged pain due to a fracture. *No investigation by the administrator had been completed when staff had provided both verbal and written concerns. Findings include:</p> <p>1. Review of resident 1's medical record revealed he had been found on the floor in his room on 1/5/15 at 2:00 a.m. His physician had not been contacted until 10:06 a.m. He has not been</p>	F 223	<p>v. Supervisory Job Performance Evaluation; Re-education and training; Audit Tool w. Pain Interview tool from Point Click Care y. Quality Assessment and Assurance Committee z. Quality Assessment and Assurance Plan</p> <p>The Director of Nursing or his designee will provide training to nursing staff on rounding for audit purposes and document staff interaction/redirection residents; once on each of the three shifts in a twenty-four hour period for one month; once each shift in a twenty-four hour period on the first and fourth weeks of each month for three months; then once a month on the third week for one year. Immediate verbal and written education with positive educational best practices feedback to employees will occur on any negative interaction. The negative interactions will be a written document with time, date, behaviors observed; disciplinary action or educational training will be reviewed with the employee; reported to the appropriate state agencies per the Event Reports-References document; filed in the employee HR file. Any employee disciplinary action will be reviewed, approved and action taken at the time of the event by the Administrator. He will sign off on the rounding reports weekly. The audit results will be submitted to the quarterly QAPI for further recommendations.</p> <p><i>*HR Personnel will submit the employee disciplinary action and completed staff training reports to the AI. KW/SDD/DMF</i></p>	
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F 223	Continued From page 4 transferred to the hospital until the afternoon of 1/5/15. He was later found to have suffered a left hip and a pelvic fracture.	F 223			
F 224 SS=L	2. Refer to F309, finding 1. 483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Surveyor: 26632  Surveyor: 20031 Based on record review, interview, and policy review, the provider failed to ensure all forty-five of forty-five residents currently residing in the facility were safe from potential neglect, abuse, and psychological harm. The provider had not followed their policies and procedures for abuse. Repercussion and training for two of two staff (C and F) had not been completed following two incidents of resident (1 and 2) abuse with psychological harm and neglect at the facility.  NOTICE: Notice of immediate jeopardy was given to the administrator on 3/3/15 at 1:15 p.m. He was asked for a plan of correction for the following : *All residents to be free from abuse, neglect, and	F 224	F224 pg 5 of 34 (staff training)  Each resident has the right to be free from mistreatment and neglect. This includes the facility's identification of residents, whose personal histories render them at risk for abusing other residents, and development of intervention strategies to prevent occurrences, monitoring for changes that would trigger abusive behavior, and reassessment of interventions on a regular bases. The immediate jeopardy was given March 3 and removed March 4, 2015. On December 3, 2014 Five Counties Nursing Home was found in compliance with federal participation requirement with "NO" deficiencies cited during the survey completed as documented on letter head from the Department of Health date December 10, 2015.  On March 27, 2015, reeducation was presented to the leadership of the facility to eliminate any misunderstanding and clearly explain the expectations of the policy and procedures, the reporting process and follow through listed below. The training included  a. Abuse investigations b. Abuse Prevention Program c. Investigating Unexplained Injuries d. Preventing Resident Abuse e. Protection of Residents During Abuse Investigations f. Recognizing Signs and Symptoms of Abuse/Neglect g. Reporting Abuse to Facility Management h. Reporting Abuse to State Agencies and Other Entities/Individuals i. Reporting Suspected Cases and/or Incidents of Rape	4/2/2015	

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F 223	Continued From page 4 transferred to the hospital until the afternoon of 1/5/15. He was later found to have suffered a left hip and a pelvic fracture.	<del>F 223</del>	*The Abuse Prohibition Review form will be used to guide and train all staff of the facility. Resident rights sponsored by the SD Dept. of Social Services will provide additional training regarding abuse and neglect. We will also use the YouTube video "Improving Dementia Care in Nursing Homes: Best Care Practices" to further educate the staff on prevention of abuse and neglect. The American Association of Nurse Assessment Coordination (AANAC) will be used as a guide for leadership training and will be presented in addition to the team building training the medical director will be conducting. This additional training will be completed by May 31, 2015. KWS/SDH/MF	
F 224 SS=L	2. Refer to F309, finding 1. 483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Surveyor: 26632  Surveyor: 20031 Based on record review, interview, and policy review, the provider failed to ensure all forty-five of forty-five residents currently residing in the facility were safe from potential neglect, abuse, and psychological harm. The provider had not followed their policies and procedures for abuse. Repercussion and training for two of two staff (C and F) had not been completed following two incidents of resident (1 and 2) abuse with psychological harm and neglect at the facility.  NOTICE: Notice of immediate jeopardy was given to the administrator on 3/3/15 at 1:15 p.m. He was asked for a plan of correction for the following : *All residents to be free from abuse, neglect, and	F 224		

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F 224	<p>Continued From page 5 psychological harm. *All staff to have education on the provider's abuse and neglect policies. *A memo for all staff, contracted staff, and clinic employees on a zero tolerance for resident abuse. *A policy for the chain of command for reporting abuse and neglect.</p> <p><b>PLAN OF CORRECTION:</b> "A. All Residents will be free from Abuse, Neglect, and Psychological Harm. B. All resident have the potential to be affected. C. All Staff on duty will be trained regarding the above area during their shift on 3/3/15 at the time of the announced immediate jeopardy. All other staff will be trained prior to their shift on 3/3/15 or their next planed work date. D. Training to remove the Immediate Jeopardy will include all of the following: Abuse Investigations, Abuse Prevention Program, Investigating Unexplained Injuries, Preventing Resident Abuse, Protection of Residents During Abuse Investigations, Recognizing Signs and Symptoms of Abuse/Neglect, Reporting Abuse to Facility Management, Reporting Abuse to State Agencies and Other Entities/Individuals, Reporting Suspected Cases and/or Incidents of Rape, Resident-to-Resident Altercations. E. A memo will be drafted to all employees, contracted employees, and clinic staff to ensure they are aware that Five Counties Nursing Home as a Zero tolerance for any resident abuse, neglect, or psychological harm. The Administrator, DON (director of nursing), and ADON (assistant director of nursing) will also be responsible for ensuring the attached memo is read and signed by all employees. --All of the above listed people who work for</p>	F 224	<p>j. Resident to Resident Altercations k. Zero Tolerance policy on abuse l. Chain of Command m. Types, Signs and Prevention of abuse and neglect n. Disciplinary Measures</p> <p>o. Re-education of Event Reports-References relevant reports power point dated 11-20-2011 24 hour LTC or 48 hour other licensed nursing facility p. Education of Event Reports-References relevant reports power point dated 11-20-2011 5 working day investigation report q. Falls Investigation Log r. Appropriate Staff Interactions with Residents Log s. Employee Disciplinary Action Log t. New Employee HR Orientation Checklist u. Employee Records and Inquires v. Supervisory Job Performance Evaluation; Re-education and training; Audit Tool w. Pain Interview tool from Point Click Care y. Quality Assessment and Assurance Committee z. Quality Assessment and Assurance Plan</p> <p>The training began on March 3, 2015 to ensure all staff including employee C received review training to enhance their knowledge. Each staff member including the temp agency employees are required to be retrained in the above topics before clocking in for their assigned shift. The facility will ensure that all alleged violations will be reported immediately to the administrator or designee, SD DOH, and local Ombudsman, if necessary to the local legal authorities. If there is an alleged violation of potential abuse or neglect the individual(s) will be suspended without pay until the investigation is complete. The Required Nursing Facility Event Reporting dated 10/31/2011 will be completed by the staff observing the reportable event and sent to the state agencies within 24 hours and</p>	
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NAME OF PROVIDER OR SUPPLIER  <b>FIVE COUNTIES NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 6TH AVENUE WEST LEMMON, SD 57638</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 224	<p>Continued From page 6</p> <p>those entities will sign the memo to ensure they are aware of the memo and the policy.</p> <p>F. A new Chain of command policy will be implemented for any concerns, allegations, or incidents. This will be incorporated into the training identified in E.</p> <p>--All employees will sign a sheet to ensure they have read the new Chain of Command policy.</p> <p>G. Administrator, DON, or ADON will be responsible for reviewing, auditing and monitor staff providing care in regards to Abuse, Neglect, and Psychological Harm policies weekly X [times] 4 weeks then quarterly thereafter. Those reviews, audits, and monitoring reports (QAPI) [quality assurance performance improvement] will be compiled by the Administrator. QAPI results will be reported to the Administrator to the governing board weekly X 4 weeks then quarterly thereafter for 1 year."</p> <p>The plan of correction was accepted by the surveyors on 3/4/15 at 11:00 a.m., and the immediate jeopardy was removed: Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of resident 2's medical record and the provider's investigation of abuse towards her revealed they had not followed their abuse policies and procedures to ensure she and all residents would be free from abuse.</li> <li>2. Review of resident 1's medical record and personnel reports of neglect revealed those reports had not been investigated and actions to prevent further neglect for all residents had been completed.</li> <li>3. Refer to F223, F225, F226, F309, F490, F493, F501, and F520.</li> </ol>	F 224	<p>notify the Administrator. The report will be presented to the Social Worker for follow-up using the 5-Working Day Investigation Report dated 10/31/2011. The complete results and action taken will be reported using the 5 day working day investigation report form to the administrator or designee,</p> <p>SD DOH, and local Ombudsman. Comprehensive investigations have been or will be completed by the Social Worker with an official report given to administrator and human resources as appropriate for proper filing. The Required Nursing Facility Event Reporting 44:04:01:07 Reports form (s) will be used for these reports or from this date forward for reporting purposes. The Social Worker or designee will provide an on- going monitoring system using written documentation by completing the Fall Investigation Log and the Resident Grievance/Complaint Investigation Log; the reports will be reviewed weekly by the Administrator. He will sign off on the reports. The Social Worker will complete an audit weekly x 4 weeks and monthly x2 months for event reporting compliance. The audit results will be submitted to the quarterly QAPI for further recommendations.</p> <p><i>* see page 7a. KW/SDDOH/ME</i></p> <p><i>* HR personnel will submit the employee disciplinary action and completed staff training reports to QA quarterly. KW/SDDOH/ME</i></p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/04/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIVE COUNTIES NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 6TH AVENUE WEST LEMMON, SD 57638</b>		
(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 224	Continued From page 6 those entities will sign the memo to ensure they are aware of the memo and the policy. F. A new Chain of command policy will be implemented for any concerns, allegations, or incidents. This will be incorporated into the training identified in E. --All employees will sign a sheet to ensure they have read the new Chain of Command policy. G. Administrator, DON, or ADON will be responsible for reviewing, auditing and monitor staff providing care in regards to Abuse, Neglect, and Psychological Harm policies weekly X [times] 4 weeks then quarterly thereafter. Those reviews, audits, and monitoring reports (QAPI) [quality assurance performance improvement] will be compiled by the Administrator. QAPI results will be reported to the Administrator to the governing board weekly X 4 weeks then quarterly thereafter for 1 year."  The plan of correction was accepted by the surveyors on 3/4/15 at 11:00 a.m., and the immediate jeopardy was removed: Findings include:  1. Review of resident 2's medical record and the provider's investigation of abuse towards her revealed they had not followed their abuse policies and procedures to ensure she and all residents would be free from abuse.  2. Review of resident 1's medical record and personnel reports of neglect revealed those reports had not been investigated and actions to prevent further neglect for all residents had been completed.  3. Refer to F223, F225, F226, F309, F490, F493, F501, and F520.	F 224	*The Administrator and medical Director will review and investigate any situations involving one of the leadership employees, immediate supervisors or department managers as written in the process relevant to Event Reports by the SD Dept. of Health and according to Federal Law. KW/SDO/MLM  * All staff are responsible to advocate for the resident at all times and has the responsibility to implement the chain of command procedure to resolve issues when the safety of the resident becomes affected or the delivery of resident care may result in an adverse resident outcome. This includes employees, contract staff and agency personnel. Policy # 17-50 has been updated to reflect contracted staff. KW/SDO/MLM		

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F 225 SS=L	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) <b>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</b></p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</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>	F 225	<p>F 225 pg 8 of 34 (investigate/report allegations/individuals)</p> <p>The facility will not knowingly employ an individual that is unfit for service by checking the state nurse aide registry or other licensing authorities as appropriate. The facility will ensure that all alleged violations will be reported immediately to the administrator or designee, SD DOH, and local Ombudsman, if necessary to the local legal authorities. If there is an alleged violation of potential abuse or neglect the individual(s) will be suspended without pay until the investigation is complete. The Required Nursing Facility Event Reporting dated 10/31/2011 will be completed by the staff observing the reportable event and sent to the state agencies within 24 hours and the Administrator. The report will be presented to the Social Worker for follow-up using the 5-Working Day Investigation Report dated 10/31/2011. The complete results and action taken will be reported using the 5 day working day investigation report form to the administrator or designee, SD DOH, and local Ombudsman. Comprehensive investigations have been or will be completed by the Social Worker with an official report given to administrator and human resources as appropriate for proper filing. The Required Nursing Facility Event Reporting 44:04:01:07 Reports form (s) will be used for these reports or from this date forward for reporting purposes. The Administrator or designee will provide a monitoring system using written documentation by completing the Appropriate Staff Interactions with Residents; Fall Investigation Log the Resident Grievance/Complaint Investigation Log; the reports will be reviewed weekly by the Administrator. He will sign off on the reports. The reports will be submitted to the quarterly quality improvement committee for their review. The reports will be submitted to the quarterly quality improvement committee for their review. The allegations of abuse, neglect and psychological harm residents 1 and 2, and</p>	4/2/2015

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NAME OF PROVIDER OR SUPPLIER  FIVE COUNTIES NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 405 6TH AVENUE WEST LEMMON, SD 57638
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F 225	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632</p> <p>Surveyor: 20031</p> <p>Based on record review, interview, and policy review, the provider failed to thoroughly inquire about statements and further investigate the mistreatment, abuse, and neglect for two of two sampled residents (1 and 2). That failure put all residents at risk of mistreatment, abuse, and neglect. Findings include:</p> <p>1. Review of resident 2's medical record and the provider's investigation of abuse towards her revealed they had not followed their abuse policies and procedures to ensure she and all residents would be free from abuse.</p> <p>2. Review of resident 1's medical record and personnel reports of neglect revealed those reports had not been investigated and actions to prevent further neglect for all residents had been completed.</p> <p>3. Refer to F223, F224, F226, F309, F490, F493, F501, and F520.</p>	F 225	<p>the potential abuse, neglect and psychological harm of all forty-five have been addressed by: All staff training included the following topics; the training began on March 3, 2015 to ensure all staff including employees C received review training to enhance their knowledge. Staff training will continue as mandated by the state and federal regulations and the facility policy and procedures will be updated and presented to the leadership staff.</p> <ol style="list-style-type: none"> <li>Abuse investigations</li> <li>Abuse Prevention Program</li> <li>Investigating Unexplained Injuries</li> <li>Preventing Resident Abuse</li> <li>Protection of Residents During Abuse Investigations</li> <li>Recognizing Signs and Symptoms of Abuse/Neglect</li> <li>Reporting Abuse to Facility Management</li> <li>Reporting Abuse to State Agencies and Other Entities/Individuals</li> <li>Reporting Suspected Cases and/or Incidents of Rape</li> <li>Resident to Resident Altercations</li> <li>Zero Tolerance policy on abuse</li> <li>Chain of Command</li> <li>Types, Signs and Prevention of abuse and neglect</li> <li>Disciplinary Measures</li> <li>Re-education of Event Reports-</li> </ol> <p>References relevant reports power point dated 11-20-2011 24 hour LTC or 48 hour other licensed nursing facility</p>	
F 226 SS=L	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 226		

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F 225	Continued From page 8 This REQUIREMENT is not met as evidenced by: Surveyor: 26632  Surveyor: 20031 Based on record review, interview, and policy review, the provider failed to thoroughly inquire about statements and further investigate the mistreatment, abuse, and neglect for two of two sampled residents (1 and 2). That failure put all residents at risk of mistreatment, abuse, and neglect. Findings include:  1. Review of resident 2's medical record and the provider's investigation of abuse towards her revealed they had not followed their abuse policies and procedures to ensure she and all residents would be free from abuse.  2. Review of resident 1's medical record and personnel reports of neglect revealed those reports had not been investigated and actions to prevent further neglect for all residents had been completed.  3. Refer to F223, F224, F226, F309, F490, F493, F501, and F520.	F 225	p. Education of Event Reports-References relevant reports power point dated 11-20-2011 5 working day, investigation report q. Falls Investigation Log r. Appropriate Staff Interactions with Residents Log s. Employee Disciplinary Action Log t. New Employee HR Orientation Checklist u. Employee Records and Inquires v. Supervisory Job Performance Evaluation; Re-education and training; Audit Tool w. Pain Interview tool from Point Click Care y. Quality Assessment and Assurance Committee z. Quality Assessment and Assurance Plan The training began on March 3, 2015 to ensure each staff member including the temp agency employees are required to be retrained in the above topics before clocking in for their assigned shift. Staff training will continue as mandated by the state and federal regulations and the facility policy and procedures will be updated and presented to the Board of Directors on March 27, 2015 and Medical Director on or before April 3, for approval. The facility will ensure that all alleged violations will be reported immediately to the administrator or designee, SD DOH, and local Ombudsman, if necessary to the local legal authorities. If there is an alleged violation of potential abuse or neglect the individual(s) will be suspended without pay until the investigation is complete. The Required Nursing Facility Event Reporting dated 10/31/2011 will be completed by the staff observing the reportable event and sent to the state agencies within 24 hours and the Administrator. The report will be presented to the Social Worker for follow-up using the 5-Working Day Investigation Report dated		
F 226 SS=L	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced	<del>F-226</del>			

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F 225	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632</p> <p>Surveyor: 20031 Based on record review, interview, and policy review, the provider failed to thoroughly inquire about statements and further investigate the mistreatment, abuse, and neglect for two of two sampled residents (1 and 2). That failure put all residents at risk of mistreatment, abuse, and neglect. Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of resident 2's medical record and the provider's investigation of abuse towards her revealed they had not followed their abuse policies and procedures to ensure she and all residents would be free from abuse.</li> <li>2. Review of resident 1's medical record and personnel reports of neglect revealed those reports had not been investigated and actions to prevent further neglect for all residents had been completed.</li> <li>3. Refer to F223, F224, F226, F309, F490, F493, F501, and F520.</li> </ol> <p>F 226 SS=L 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 225	<p>10/31/2011. The complete results and action taken will be reported using the 5 day working day investigation report form to the administrator or designee, SD DOH, and local Ombudsman. Comprehensive investigations have been or will be completed by the Social Worker with an official report given to administrator and human resources as appropriate for proper filing. The Required Nursing Facility Event Reporting 44:04:01:07 Reports form (s) will be used for these reports or from this date forward for reporting purposes.</p> <p>The Administrator or designee will provide monitoring by using written documentation by completing the Employee Disciplinary Action Log. Administrator review and will sign off on the reports. The Human</p> <p>Recourse will complete an audit weekly x 4 weeks and monthly x2 months for event reporting compliance. The audit results will be submitted to the quarterly QAPI for further recommendations.</p> <p><i>* HR personnel will submit the employee disciplinary action and completed staff training reports to QA quarterly. KWI/SDD/HMF</i></p>	
F 226 SS=L	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced</p>	F-226		

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F 225	Continued From page 8 This REQUIREMENT is not met as evidenced by: Surveyor: 26632  Surveyor: 20031 Based on record review, interview, and policy review, the provider failed to thoroughly inquire about statements and further investigate the mistreatment, abuse, and neglect for two of two sampled residents (1 and 2). That failure put all residents at risk of mistreatment, abuse, and neglect. Findings include:  1. Review of resident 2's medical record and the provider's investigation of abuse towards her revealed they had not followed their abuse policies and procedures to ensure she and all residents would be free from abuse.  2. Review of resident 1's medical record and personnel reports of neglect revealed those reports had not been investigated and actions to prevent further neglect for all residents had been completed.  3. Refer to F223, F224, F226, F309, F490, F493, F501, and F520.	F 225	*The Abuse Prohibition Review form will be used to guide and train all staff of the facility. Resident Rights sponsored by the Dept. of Social Services will provide additional training regarding abuse and neglect. We will also use the YouTube video "Improving Dementia Care in Nursing Homes: Best Care Practices" to further educate the staff on prevention of abuse and neglect. The American Association of Nurse Assessment Coordination (AANAC) will be used as a guide for leadership training and will be presented in addition to the team building training the medical director will be conducting. This additional training will be completed by May 31, 2015. KW/SD/DH/ME	
F 226 SS=L	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced	<del>F 226</del>		

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F 226	Continued From page 9 by: Surveyor: 26632  Surveyor: 20031 Based on record review, observation, interview, and policy review, the provider failed to thoroughly investigate two of two incidents for abuse and neglect for two of two sampled residents (1 and 2). Findings include:  1. Refer to F309, finding 2.  2. Review of the undated abuse policy and procedure manual revealed: **Abuse Prevention Program. -Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. 1. Our facility is committed to protecting our resident from abuse by anyone including but not necessarily limited to: facility staff.... 3. Comprehensive polices and procedures have been developed to aid our facility in preventing abuse, neglect, or mistreatment of our residents. B. Mandated staff training/orientation programs that include such topes as abuse prevention, identification and reporting of abuse, stress management, delaying with violent behavior or catastrophic reactions, etc. c. Identification of occurrences and patterns of potential mistreatment/abuse; d. The protection of residents during abuse investigations; e. The development of investigative protocols governing resident abuse, theft/misappropriation	F 226	F226 pg 9 of 34 The facility has updated operational policies and procedures on the following components screening, training, prevention, identification, investigation, protection and reporting/response and monitoring a. Abuse investigations b. Abuse Prevention Program c. Investigating Unexplained Injuries d. Preventing Resident Abuse e. Protection of Residents During Abuse Investigations f. Recognizing Signs and Symptoms of Abuse/Neglect g. Reporting Abuse to Facility Management h. Reporting Abuse to State Agencies and Other Entities/Individuals i. Reporting Suspected Cases and/or Incidents of Rape j. Resident to Resident Altercations k. Zero Tolerance policy on abuse l. Chain of Command m. Types, Signs and Prevention of abuse and neglect n. Disciplinary Measures o. Re-education of Event Reports-References relevant reports power point dated 11-20-2011 24 hour LTC or 48 hour other licensed nursing facility p. Education of Event Reports-References relevant reports power point dated 11-20-2011 5 working day investigation report q. Falls Investigation Log r. Appropriate Staff Interactions with Residents Log s. Employee Disciplinary Action Log t. New Employee HR Orientation Checklist u. Employee Records and Inquires v. Supervisory Job Performance Evaluation; Re-education and training; Audit Tool w. Pain Interview tool from Point Click Care y. Quality Assessment and Assurance Committee z. Quality Assessment and Assurance Plan	4/2/2015

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F 226	<p>Continued From page 10 of resident property, resident-to-resident a;abuse and resident-to-staff abuse;</p> <p>f. Timely and thorough investigations of all reports and allegations of abuse;</p> <p>g. The reporting and filing of accurate documents relative to incidents of abuse;</p> <p>h. An ongoing review and analysis of abuse incidents; and</p> <p>i. The implementation of changes to prevent future occurrences of abuse."</p> <p><b>**Investigation Unexplained Injuries</b> - An investigation of all unexplained injuries Including bruises, abrasion, and injuries of unknown source) will be conducted by the Director of Nursing Services, and/or other individual appointed by the Administrator, to ensure that the safety of our resident ha not been jeopardized."</p> <p><b>**Preventing Resident Abuse</b> -Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures,a training programs, system, etc., to assist in preventing resident abuse.</p> <p>2. Our abuse prevention/intervention program includes, but is not necessarily limited to, the following:</p> <p>l. Monitoring staff on all shifts to identify inappropriate behaviors toward resident (e.g. using derogatory language, rough handling of resident, ignoring resident while giving care, ...</p> <p>j. Assessing, care planning, and monitoring resident with needs and behaviors that may lead to conflict or neglect;</p> <p>k. Assessing resident with signs and symptoms of behavior problems and developing implementing care plans to address behavioral issues."</p> <p><b>**Protection of Resident During Abuse Investigations</b> -Our facility will protect resident from harm during</p>	F 226	<p>The training began on March 3, 2015 to ensure all staff including employee C received reeducation/training. Each staff member including the temp agency employees are required to be retrained in the above topics before clocking in for their assigned shift. The facility will ensure that all alleged violations will be reported immediately to the administrator or designee, SD DOH, and local Ombudsman, if necessary to the local legal authorities. If there is an alleged violation of potential abuse or neglect the individual(s) will be suspended without pay until the investigation is complete. The Required Nursing Facility Event Reporting dated 10/31/2011 will be completed by the staff observing the reportable event and sent to the state agencies within 24 hours and the Administrator. The report will be presented to the Social Worker for follow-up using the 5-Working Day Investigation Report dated 10/31/2011. The complete results and action taken will be reported using the 5 day working day investigation report form to the administrator or designee, SD DOH, and local Ombudsman. Comprehensive investigations have been or will be completed by the Social Worker with an official report given to administrator and human resources as appropriate for proper filing. The Required Nursing Facility Event Reporting 44:04:01:07 Reports form (s) will be used for these reports or from this date forward for reporting purposes.</p> <p>The Human Resource Director will provide a monitoring system using written documentation by completing the New Employee HR Orientation Checklist. The Administrator will sign off on the reports on all reports for each new hire. The Human Resource will complete an audit weekly x 4 weeks and monthly x2 months for event reporting compliance. The audit results will be submitted to the quarterly QAPI for further recommendations.</p>	
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*\*SEE PAGE 10. KWI/SDD/HMF*

*\*SEE PAGE 13. KWI/SDD/HMF*

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NAME OF PROVIDER OR SUPPLIER  <b>FIVE COUNTIES NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 6TH AVENUE WEST LEMMON, SD 57638</b>
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F 226	<p>Continued From page 11</p> <p>investigations of abuse allegations.</p> <p>1. During abuse investigations, resident will be protected from harm by the following measures:</p> <p>a. Employees accused of participating in the alleged abuse will be immediately reassigned to duties that do not involve resident contact or will be suspended until the findings of the investigation have been reviewed by the Administrator."</p> <p>**Recognizing Signs and Symptoms of Abuse/Neglect</p> <p>-Our facility will not condone any form of resident abuse or neglect. To aid in abuse prevention, all personnel are to report any signs and symptoms of abuse/neglect to their supervisor to the the Director of Nursing Services immediately.</p> <p>1. Abuse is defined as willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.</p> <p>2. Neglect is defined as failure to provide goods and services as necessary to avoid physical harm, mental anguish, or mental illness.</p> <p>3. a. Signs of Actual physical Abuse: (8) Excessive exposure to heat or cold.</p> <p>3. b.(6) Inadequate provision of care.</p> <p>3.b.(7) Caregiver indifference to resident's personal care and needs."</p> <p>**Reporting Abuse to State Agencies and Other Entities/Individuals</p> <p>- All suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies and other entities or individual as may be required by law.</p> <p>4. The individual(s) involved in the incident will be notified of such findings, and such individual(s) will be suspended, without pay, until the State Abuse Registry has investigated the claim ad found the allegations to be true or unfounded.</p>	F 226	<p>*The Abuse Prohibition Review form will be used to guide and train all staff of the facility. Resident Rights sponsored by the Dept. of Social Services will provide additional training regarding abuse and neglect. We will also use the "YouTube video "Improving Dementia Care in Nursing Homes: Best Care Practices" to further educate the staff on prevention of abuse and neglect. The American Association of Nurse Assessment Coordination (AANAC) will be used as a guide for leadership training and will be presented in addition to the team building training the medical director will be conducting. This additional training will be completed by May 31, 2015. KWISD@HMF</p>	
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F 226	Continued From page 12 6. Records of all allegations will be filed in the accused employee's personal record..."  Surveyor: 26632 1. Refer to F309, finding 1.  2. Review of the undated abuse policy and procedure manual revealed: *"Abuse Prevention Program." -Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. 1. Our facility is committed to protecting our resident from abuse by anyone including but not necessarily limited to: facility staff.... 3. Comprehensive policies and procedures have been developed to aid our facility in preventing abuse, neglect, or mistreatment of our residents. B. Mandated staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse, stress management, dealing with violent behavior or catastrophic reactions, etc. c. Identification of occurrences and patterns of potential mistreatment/abuse; d. The protection of residents during abuse investigations; e. The development of investigative protocols governing resident abuse, theft/misappropriation of resident property, resident-to-resident abuse and resident-to-staff abuse; f. Timely and thorough investigations of all reports and allegations of abuse; g. The reporting and filing of accurate documents relative to incidents of abuse; h. An ongoing review and analysis of abuse incidents; and	F 226	* HR personnel will submit the employee disciplinary action and completed staff training reports to QA quarterly. KW/SDDH/MF	

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F 226	Continued From page 13 i. The implementation of changes to prevent future occurrences of abuse." **Investigation Unexplained Injuries - An investigation of all unexplained injuries including bruises, abrasion, and injuries of unknown source will be conducted by the Director of Nursing Services, and/or other individual appointed by the Administrator, to ensure that the safety of our resident has not been jeopardized." **Preventing Resident Abuse -Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, a training programs, system, etc., to assist in preventing resident abuse. 2. Our abuse prevention/intervention program includes, but is not necessarily limited to, the following: I. Monitoring staff on all shifts to identify inappropriate behaviors toward resident (e.g. using derogatory language, rough handling of resident, ignoring resident while giving care, ... j. Assessing, care planning, and monitoring resident with needs and behaviors that may lead to conflict or neglect; k. Assessing resident with signs and symptoms of behavior problems and developing implementing care plans to address behavioral issues."	F 226		
F 309 SS=G	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.	F 309		4/2/2015

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F 309	Continued From page 14  This REQUIREMENT is not met as evidenced by: Surveyor: 20031  Surveyor: 26632 Based on record review, interview, and policy review, the provider failed to ensure two of two sampled residents (1 and 2) had been assessed and monitored for mental distress and physical pain. Findings include:  1. Review of resident 1's interdisciplinary progress notes revealed: *1/5/15 3:16 a.m. note by the DON (director of nursing) "Resident was found on floor in room at 0200 [2:00 a.m.] Head-to-toe assessment performed; resident is AAOX2 [alert and oriented to person and place] not time, in no apparent distress, pain and discomfort indicated; observed quietly laying on floor with eyes opened; v/s [vital sign] BP=[blood pressure] 129/66; HR=[heart rate] 71; Temp=[temperature] 96.1; RR=[respiratory rate] 16; O2 Sat=[oxygen saturation] 97% room air. No injury noted. Resident given Tylenol 1000 mg [milligram] PO [by mouth] q4hr [every 4 hours] PRN [as needed] for pain. Resident tolerated care well. POA [power of attorney] _____ [name of POA] contacted today 1/5/15 at 2:40 a.m. message left of situation. No witness to fall. Resident states he was reaching to get in his wheelchair from his bed & fell. Resident was not wearing footwear. Resident assisted back to bed. Nurses continue to monitor. Call light within reach." *1/5/15 10:06 a.m. note by licensed practical nurse (LPN) I "Called and left a message for Md's [medical doctor] nurse regarding resident (1)."	F 309	F 309 pg 14 of 34 maintain the highest well being Pain can significantly affect a person's well-being, it is important that the facility recognize and address pain promptly to elevate mental distress. Resident 2 was removed from in front of the open activity door within seconds, the outside activity door was closed and Resident A was in the warm hallway with staff. Resident 1- B pg 4 of 34 Upon reviewing resident file information and staff documentation reports Resident 1 was found on the floor by staff, made as comfortable as possible by C.N.A staff, licensed nurse assessment completed; pain medication given; transferred to hospital for evaluation and treatment, the incident was reported to appropriate state agencies on 1/5/2015. Resident 1 was readmitted to the nursing facility 1/12/2015. a. Abuse investigations b. Abuse Prevention Program c. Investigating Unexplained Injuries d. Preventing Resident Abuse e. Protection of Residents During Abuse Investigations f. Recognizing Signs and Symptoms of Abuse/Neglect g. Reporting Abuse to Facility Management h. Reporting Abuse to State Agencies and Other Entities/Individuals i. Reporting Suspected Cases and/or Incidents of Rape j. Resident to Resident Altercations k. Zero Tolerance policy on abuse l. Chain of Command m. Types, Signs and Prevention of abuse and neglect n. Disciplinary Measures o. Re-education of Event Reports-References relevant reports power point dated 11-20-2011 24 hour LTC or 48 hour other licensed nursing facility p. Education of Event Reports-References relevant reports power point dated 11-20-2011 5 working day investigation report q. Falls Investigation Log	4/2/2015

\* See page 17. LMS/DW/ME

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F 309	<p>Continued From page 15</p> <p>*1/5/15 at 11:19 a.m. note by LPN I "Received call back from MD nurse to transfer resident to _____[hospital name] for further evaluation. Called and notified residents RP [responsible party] and she agreed with the plan of care."</p> <p>*1/5/15 3:13 p.m. note by registered nurse (RN) J "Alert and oriented to self with some confusion. Presented with left hip pain and ecchymosis [bruise]. Guarding his left hip and painful on movement. _____[hospital name] was called and order to send resident to _____[hospital name] was made. Resident was transferred to _____[hospital name] via stretcher ambulance. Family member _____[name of family member] was informed by _____[name of LPN I] that resident was transferred to _____[hospital name] with left hip pain and left hip ecchymosis. _____[name] RN from _____[hospital name] called at 1455 [2:55 p.m.] and reported that resident was been [being] transferred to _____[another hospital] with a broken hip and pelvic [pelvis]." Director of nurses and administrator aware."</p> <p>*1/5/15 at 5:36 p.m. note by the DON "D.O.N. discussed with POA today 1/5/15 at 17:30 hrs [5:30 p.m.] regarding resident status. POA states resident has history not communicating need for assistance. POA states she will be more involved with FCNH [Five Counties Nursing Home] regarding resident's ADLs [activities of daily living] and communication."</p> <p>*1/7/15 at 2:40 p.m. note by the dietary director ".....He does eat a very large breakfast but after fall he was said to be almost in tears and not consuming any food."</p> <p>*Review of the interdisciplinary progress notes revealed resident 1's physician had not been contacted until 1/5/15 at 10:06 a.m.</p> <p>Review of resident 1's 1/5/15 emergency room</p>	F 309	<p>r. Appropriate Staff Interactions with Residents Log</p> <p>s. Employee Disciplinary Action Log</p> <p>t. New Employee HR Orientation Checklist</p> <p>u. Employee Records and Inquires</p> <p>v. Supervisory Job Performance Evaluation; Re-education and training; Audit Tool</p> <p>w. Pain Interview tool from Point Click Care</p> <p>y. Quality Assessment and Assurance Committee</p> <p>z. Quality Assessment and Assurance Plan</p> <p>Resident 2, Resident 1 and all residents will have an up to-date pain interview assessment, Morse fall scale assessment and a cognitive patterns assessment by April 3, 2015. The results will be documented in the resident file and address on the resident care plan. The Director of Nursing or designee will complete an audit weekly x 4 weeks and monthly x2 months for event reporting compliance. The audit results will be submitted to the quarterly QAPI for further recommendations.</p> <p><i>*see page 18. KWISSDOH/ME</i></p> <p><i>*The MDS coordinator will coordinate with the social worker and DON to submit a quarterly QA report. KWISSDOH/ME</i></p>	
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F 309	<p>Continued From page 16</p> <p>note/transfer summary by his attending physician revealed:</p> <p>*He had been found on the floor with left hip pain.</p> <p>*The fall had happened around 2:00 a.m. on 1/5/15.</p> <p>**"He was helped back to bed, but really wanted to lay on his left side in the fetal position, which is unusual for him."</p> <p>*He complained of a lot of hip pain.</p> <p>Review of a 1/5/15 handwritten note to the administrator and Minimum Data Set Assessment(MDS) coordinator from certified nursing assistant K regarding resident 1 revealed:</p> <p>*She had reported she had found the resident on the floor in his room on 1/5/15 at 2:00 a.m.</p> <p>*He had been in pain and holding his left leg.</p> <p>*She had asked the other CNA L who was also on duty to find the nurse on duty, who was the DON.</p> <p>*They looked for the DON, used the overhead paging system, and called on the telephone to reach him.</p> <p>*CNA L went to the second floor of the building and found the DON sleeping on the couch.</p> <p>*When the DON came down to assess resident 1 it had been over one-half hour.</p> <p>*CNA L stated to the DON that " _____ [resident 1] is in great pain."</p> <p>**"He [DON] told _____ [resident 1] we needed to get him up and he needed to roll over on his back he put gait belt on and told us to help lift him up [roughly] into the w/c [wheelchair] and then onto bed." " _____ [resident 1] was still in great pain."</p> <p>**"Ice pack was put on leg and thigh by _____ [CNA L]"</p> <p>**"I think _____ [DON] gave him some pain med."</p> <p>**" _____ [DON] was too rough and didn't thoroughly check him."</p>	F 309	<p>*The notification of the residents' attending physician will be completed by the licensed charge nurse. This notification will include information gained from completing an assessment which may include but not limited to vitals, pain, AA-O-Awake, Alert and oriented. Charge nurse will complete the assessment. There is no time constraint in the notification of the physician, but the time guidelines are addressed in policy 11:30. K2W/KOD/UMF</p>	

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F 309	<p>Continued From page 17</p> <p>Review of resident 1's January medication administration record revealed he had received Tylenol (non-narcotic pain medication) 1000 mg on 1/5/15 at 2:00 a.m. by the DON. He had not received any other pain medication until his regular scheduled dose of Tylenol 1000 mg at 8:00 a.m. It was noted resident 1 had fell at 2:00 a.m. ,and the Tylenol had also been administered at 2:00 a.m. He had no physician orders for any stronger pain medication. There had been no documentation on what type of pain and how intense resident 1's pain had been. There had been no documentation the Tylenol had been effective.</p> <p>Interview on 3/4/15 at 5:45 p.m. with the DON revealed he:</p> <ul style="list-style-type: none"> <li>*Had been working the night shift on 1/5/15.</li> <li>*Confirmed he had been upstairs when resident 1 had fell.</li> <li>*Had done a "Cursory" (brief) assessment.</li> <li>*Had been upset with CNAs K and L as resident 1 had been soiled with bowel movement.</li> <li>*Had wanted them to clean resident 1 up first before he assessed him.</li> <li>*Had not felt resident 1 had been in a lot of pain after the fall.</li> <li>*Had not documented any more of his assessments for resident 1 for the rest of that shift.</li> </ul> <p>Review of the provider's revised April 2013 Falls - Clinical Protocol policy revealed the following:</p> <ul style="list-style-type: none"> <li>*The nurse should assess and document/report that included following: <ul style="list-style-type: none"> <li>-Muscular function, observation for change in normal range of motion and weight bearing.</li> <li>-Pain.</li> </ul> </li> </ul>	F 309	<p>*Change nurses' documentation may include but not limited to Q=question the reason for the behavior, U=Understand the reason for the behavior, A=alternatives to medications, L= look at the resident and assess them, I=initiate alternative interventions, T=TEAM=involve and educate Y= yes for success in reduction and positive outcomes. The notification of the event, results of the assessment, and documentation of the same will be provided to the care team including the MDS coordinator to ensure the care plan is updated for quality of life for the resident to protect them from substandard care and promote goal-directed, person-centered care.</p> <p>(continued page 19)</p>	

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F 309	<p>Continued From page 18</p> <p>Review of the provider's revised October 2010 Pain Assessment and Management policy revealed to observe the following:</p> <ul style="list-style-type: none"> <li>*The resident during rest and movement for signs of pain.</li> <li>*Verbal expressions such as groaning, crying, or screaming.</li> <li>*Facial expressions such as grimacing, frowning, and clenching of the jaw.</li> <li>*Behavior such as resisting care, irritability, depression, decreased participation in usual activities.</li> <li>*Limitations in his or her level of activity due to the presence of pain.</li> <li>*Guarding, rubbing, or favoring a particular part of the body.</li> <li>*Difficulty eating or loss of appetite.</li> <li>*Increased blood pressure.</li> <li>*Increase heart rate.</li> </ul> <p>2. Review of the 11/18/14 allegation of abuse of an elderly resident report regarding resident 1 to the South Dakota Department of Health revealed:</p> <ul style="list-style-type: none"> <li>*It had been documented by the DON, and he and the administrator had both signed it.</li> <li>*RN A had propelled resident 2 in her wheelchair to the patio door and had pushed her to the threshold of the door to have her stop asking to go home.</li> <li>*A nursing assessment of the resident had been conducted by the DON with CNA staff (who were not involved). No abnormal change in physical or mental status had been noted.</li> <li>*That assessment had not been documented in resident 2's medical record.</li> </ul> <p>Interview on 3/3/15 at 11: 25 a.m. with CNA E revealed:</p> <ul style="list-style-type: none"> <li>*She had witnessed and reported RN A to the</li> </ul>	F 309	<p><i>*(continued from page 18)</i></p> <p><i>This additional training will be completed by May 31, 2015. KW/SDD/HMF</i></p> <p><i>*The information on the CMS National Partnership to Improve Dementia Care in Nursing Homes and the Guidelines for Progress notes will be used to guide and train licensed staff and the acting DON of the facility. The DON at the time of this event is no longer employed. The additional training will be completed by May 1, 2015. KW/SDD/HMF</i></p> <p><i>*The licensed nurse will be available to the CNA staff. The licensed nurse who was the DON at the time of this event, is no longer employed. KW/SDD/HMF</i></p>	

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F 309	<p>Continued From page 19</p> <p>MDS coordinator and the social services designee (SSD during the incident with resident 2.</p> <p>*She stated resident 2 was "Frantic" after the incident, and it took a long time to calm her down.</p> <p>*She stated resident 2 had always asked to go home. She was easily re-directed and had never gone outside without someone with her.</p> <p>*It was cold outside that day, and there was snow on the deck.</p> <p>Review of resident 2's following interdisciplinary progress notes revealed:</p> <p>*11/14/14 at 10:53 a.m. a physician progress note that included "[resident 2] has severe dementia. She has periods where she just screams and has repetitive verbal behaviors."</p> <p>*11/16/14 at 3:49 p.m. a SSD note "Family member POA ___-[name] was contacted about an incident regarding ___[POA name] mother. Call made approximately around three o'clock pm."</p> <p>*There was no further documentation regarding the above incident.</p> <p>*There was no physical examination of resident 2 by a licensed nurse or a physician.</p> <p>*There was no documentation on resident 2's behavior after the incident or her state of mind.</p> <p>Review of the provider's revised September 2013 Reporting Abuse to Facility Management included findings of any physical examination should have been recorded in the resident's medical record.</p> <p>Surveyor: 20031</p> <p>According to the National Weather Service the average high temperature for the week of November 9, 2014 through November 16, 2014 was 14 degrees Fahrenheit (F). Average low</p>	F 309	<p>* Policy on assessment of falls and fall follow-up guidelines, including medication documentation were updated. KWR/SDDH/MF</p> <p>* The social worker and designee will interview, observe and assess the physical, mental and psychosocial wellbeing of each resident complaining of pain at current baseline and when the MDS is completed for a care conference review. KWR/SDDH/MF</p>

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F 309	Continued From page 20 temperature for that same week was -10 degrees F. Average snow fall for November 2014 was one to two inches.	F 309		
F 490 SS=L	<b>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</b>  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: 26632  Surveyor: 20031 Based on record review, observation, interview, policy review, and job description 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 forty-five residents. Findings include:  1. Interview on 3/3/15 at 11:00 a.m. with the administrator confirmed the overall operation and administration of the facility was his responsibility.  He revealed: *He had been the administrator for about fourteen months. *He had no background in the healthcare industry. *He had not read or revised any policies or procedures since he had started at the facility. *Neither he nor the director of nursing (DON) kept	F 490	F490 pg21 of 34 Administrator  The facility must be administered in a manner that enables quality of life, quality of care and facility practices to use its resources effectively and efficiently. Training was held on March 27, 2015 on the following policy and procedures, audit tools, and reviewed Plan of Correction implementations and follow through, follow-up and documentation of all employee warnings/discipline/action and the importance of mandated reporting to licensure state agencies and other legal agencies as mandated. The following policy and procedures were reviewed with administrator by a seasoned licensed nursing home administrator mentor/consultant.  a. Abuse investigations b. Abuse Prevention Program c. Investigating Unexplained Injuries d. Preventing Resident Abuse e. Protection of Residents During Abuse Investigations f. Recognizing Signs and Symptoms of Abuse/Neglect g. Reporting Abuse to Facility Management h. Reporting Abuse to State Agencies and Other Entities/Individuals i. Reporting Suspected Cases and/or Incidents of Rape j. Resident to Resident Altercations k. Zero Tolerance policy on abuse l. Chain of Command m. Types, Signs and Prevention of abuse and neglect n. Disciplinary Measures o. Re-education of Event Reports-	4/2/2015

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F 490	<p>Continued From page 21</p> <p>a record of verbal warnings to the staff.</p> <p>*He had told the DON to keep a separate record on all the employees in the DON's office. He was not aware a separate file could not be kept on employees without their knowledge of what as in the file.</p> <p>*He had not disciplined the other two staff members (C and F) regarding the mistreatment of resident 2 as he did not want to lose any employees.</p> <p>*He had not done his own investigation of the DON regarding the neglect of resident 1 as he did not want to lose the DON. He had not disciplined the DON for the same reason.</p> <p>*He relied on the DON to address any concerns with the nursing staff.</p> <p>*He had not completed any performance evaluations on the DON.</p> <p>Interview on 3/4/15 at 1:25 p.m. with a requested unidentified employee revealed:</p> <p>*The administrator was afraid of confrontation.</p> <p>*The administrator had his "pets" at the facility, and they were allowed to do what they wanted.</p> <p>*The administrator was not at the facility all the time. He regularly left the facility at 1:30 p.m. until 2:00 p.m. daily.</p> <p>Interview on 3/4/15 at 1:45 p.m. with two requested unidentified employees revealed they were aware of both incidents for residents 1 and 2. They were concerned and surprised the other two staff (C and F) involved in the incident on 11/16/14 were still employed at the facility.</p> <p>*They were surprised no additional training had been given to all employees after the 11/16/14 and 1/5/15 resident incidents.</p> <p>Interview on 3/4/15 at 4:45 p.m. with the DON</p>	F 490	<p>References relevant reports power point dated 11-20-2011 24 hour LTC or 48 hour other licensed nursing facility</p> <p>p. Education of Event Reports-References relevant reports power point dated 11-20-2011 5 working day investigation report</p> <p>q. Falls Investigation Log</p> <p>r. Appropriate Staff Interactions with Residents Log</p> <p>s. Employee Disciplinary Action Log</p> <p>t. New Employee HR Orientation Checklist</p> <p>u. Employee Records and Inquires</p> <p>v. Supervisory Job Performance Evaluation; Re-education and training; Audit Tool</p> <p>w. Pain Interview tool from Point Click Care</p> <p>y. Quality Assessment and Assurance Committee</p> <p>z. Quality Assessment and Assurance Plan</p> <p>The Five Counties Nursing Home Board of Directors has employed an outside financial consultant to evaluate the overall financial/operational functions to work with the nursing home administrator. The administrator has reached out to the state association, a major healthcare system, state agencies for financial and administrative guidance to ensure the quality of life and quality of care for the residents' highest practicable physical, mental, and psychosocial well-being will be attained.</p> <p>The Board of Directors met and reviewed with administrator on March 26, 2015 the Form CMS 255 and the plan of corrections. The Board of Directors will meet [redacted] monthly. The administrator will place on the monthly board agenda a "PoC update". The Board of Directors will continue to receive the QAPI quarterly report for the review. The Board of Directors will complete an administrator audit review every three months for one year. This report will be placed in the employee file.</p> <p><i>*The Administrator will submit the quarterly audit report to the board of directors</i></p>	<p><i>*see page 23</i></p> <p><i>kw/sddh/mf</i></p> <p><i>kw/sddh/mf</i></p> <p><i>kw/sddh/mf</i></p>
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F 490	Continued From page 22 revealed: *He was aware of both incidents that had occurred on 11/16/14 and 1/5/15. *He stated he had talked with the administrator and requested all employees involved with the incident on 11/16/14 be reprimanded and if needed dismissed from employment. He stated the administrator told him he was afraid of losing employees and did not want to confront the employees. *He stated he had investigated the incident in which he was involved in on 1/5/15. He had done that as the administrator had no knowledge of how to investigate an incident. The DON stated he had received no verbal or written warning regarding his involvement in the incident. *The DON revealed he talked with the administrator about several other concerns that included a registered nurse who had not fulfilled her duties as a charge nurse. The DON stated he had been told not to reprimand the RN as nursing staff were needed at the facility. *He stated when he had verbally reprimanded an employee they would go behind his back and talk to the administrator. After they would talk with the administrator nothing was done regarding that employee.  Review of the undated job description for the administrator of Five Counties Nursing Home revealed: **Essential Functions: -7. Establishes formal responsibilities and accountabilities of all members of the management and professional staff, and evaluates their performance regularly. -17. Ensure compliance with regulations governing the institution and the rules of accrediting bodies, by continually monitoring the	F 490	*There has been and there will be continued contact with outside nursing home professionals assisting with the education, training, financial review, reimbursement advocacy and administrator mentoring of the nursing home through the use of the state association membership, a major health system in South Dakota and a seasoned licensed nursing home administrator. KN/SDDH/ME	

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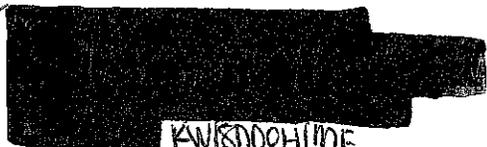
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F 490	Continued From page 23 institutions activities and initiating changes as required. -18. Formulates, establishes and enforces such procedures, rules and regulations as necessary to provide for the proper admission, care, safety and discharge of patients. *Expectations: The administrator/CEO [chief operating officer] is expected to follow and maintain established facility (Fire and Disaster Manual, Personnel Policy Manual, Standard of Performance) and department policies, procedures, and objectives."  Interviews, observations, record reviews, and policy reviews throughout the course of the survey on 3/3/15 through 3/4/15 revealed the administration had not ensured all forty-five residents attained and/or maintained their highest practicable physical, mental, and psychosocial well-being. Refer to F223, F224, F225, F226, F309, F490, F493, F501, and F520.	F 490		
F 493 SS=L	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; and responsible for the management of the facility  This REQUIREMENT is not met as evidenced by: Surveyor: 26632	F 493	The facility must have a governing body that is legally responsible for establishing and implementing policy regarding the management and operations of the facilities under an appointed licensed administrator in a manner that enables quality of life, care and facility practices to use its resources effectively and efficiently. The Administrator received a work performance review on March 26, 2015. Training and approval received for policies at the regular board meeting held on March 26, 2015 on the following policy and procedures, audit tools, the Plan of Correction/ CMS2667 referencing the LONG TERM CARE SURVEY manual and implementations. a. Abuse Investigations b. Abuse Prevention Program c. Investigating Unexplained Injuries d. Preventing Resident Abuse e. Protection of Residents During Abuse Investigations	* 4/2/15 10/15/2015

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F 493	Continued From page 24  Surveyor: 20031 Based on observation, record review, interview, and policy review, the governing body failed to ensure the facility was administered in a manner that ensured: *Two of two sampled residents' (1 and 2) incidents with mental and physical outcomes were thoroughly investigated. *Three of six staff members (A, C, and F) were reprimanded and retrained after the resident 1 and 2's incidents on 11/16/14 and 1/5/15. *One of one director of nursing (DON) had not investigated one of one sampled resident 1's incident that personally involved himself. *Abuse and neglect policies and procedures were used and implemented for two of two incidents on 11/16/14 and 1/5/15 that involved two of two residents 1 and 2. Findings include:  1. Interviews, observations, record reviews, and policy reviews throughout the course of the survey from 3/3/15 through 3/4/15 revealed the administrator and governing body had not ensured the safe management and overall well-being of all residents. Refer to F223, F224, F225, F226, F309, F490, F493, F501, and F520.  2. Interview on 3/4/15 at 5:30 p.m. with the DON revealed he had contacted one of the board members, G, concerning the overall management of the facility. He stated he had tried to talk with the administrator regarding staff members and their conduct in the facility. He revealed the administrator refused to "step-in" and reprimand or terminate employees. He stated the administrator told him he could not afford to lose any more employees. He revealed he had	F 493	f. Recognizing Signs and Symptoms of Abuse/Neglect g. Reporting Abuse to Facility Management h. Reporting Abuse to State Agencies and Other Entities/Individuals i. Reporting Suspected Cases and/or Incidents of Rape j. Resident to Resident Altercations k. Zero Tolerance policy on abuse l. Chain of Command m. Types, Signs and Prevention of abuse and neglect n. Disciplinary Measures o. Re-education of Event Reports-References relevant reports power point dated 11-20-2011 24 hour LTC or 48 hour other licensed nursing facility p. Education of Event Reports-References relevant reports power point dated 11-20-2011 5 working day investigation report q. Falls Investigation Log r. Appropriate Staff Interactions with Residents Log		

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F 493	Continued From page 25 followed the chain of command and talked to a governing board member. He had been told by that board member to talk with the administrator.  3. Interview on 3/9/15 at 8:55 p.m. via email response with board member H revealed they had not been contacted by any employees regarding the status of the nursing home.  4. Phone interview on 3/10/15 at 10:00 a.m. with the president of the board revealed he had been out of contact with the governing board and the issues at the nursing home due to personal medical issues. He stated the vice-president had taken over the presidential duties the last few months due to those medical issues. The board president revealed the following: *He had never been in the healthcare business and trusted the administrator to keep the board informed of the day-to-day functions of the nursing home. *The administrator had been hired by the previous board president. He understood the administrator had been hired because of his master's degree in education. He also understood and was aware the administrator had no experience in the healthcare industry. *He and the board were happy with the administrator's performance. *He thought the DON and the administrator worked well together. *He was not aware nor had heard if the DON had contacted any of the board members to address concerns at the nursing home. *He was aware of the incident on 11/16/14 regarding resident 1. He stated he had heard the registered nurse had pushed the resident's wheelchair to an open door as a "joke." He gave no comment nor confirmed his knowledge of the	F 493	s. Employee Disciplinary Action Log t. New Employee HR Orientation checklist u. Employee Records and Inquires v. Supervisory Job Performance Evaluation; Re-education and training; Audit Tool w. Pain interview tool from Point Click Care y. Quality Assessment and Assurance Committee z. Quality Assessment and Assurance Plan   KW/SDDCH/MF The Five Counties Nursing Home Board of Directors has employed an outside financial consultant to evaluate the overall financial/operational functions to work with the nursing home administrator in conjunction with the Board of Directors. The Board of Directors met and reviewed with administrator on March 26, 2015 the Form CMS 255 and the plan of corrections. The Board of Directors will meet  monthly. The administrator will place on the monthly board agenda a 'POC update'. The Board of Directors will continue to receive the QAPI quarterly report for the review. The Board of Directors will continue to review and approve policies that govern the facility. The Board of Directors will continue to meet with the administrator  monthly. KW/SDDCH/MF *See page 27. KW/SDDCH/MF *The Administrator will submit the quarterly QA report to the Board of Directors. KW/SDDCH/MF		

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F 493	Continued From page 26 incident on 1/5/15 regarding resident 2. *He stated he had wondered if opportunities were missed to retain or retrain employees who had left the facility. *He confirmed the interview of the administrator in which personnel and resident concerns were discussed in executive session. He stated if no action was taken in executive session, then no results were recorded. *He was not aware that not all of the incidents and concerns were reported to the governing board by the administrator. *He was not aware the quality assessment and performance improvement (QAPI) program had not been done correctly. *He confirmed the administrator only reported the last survey audits for the QAPI program. *He was not aware the administrator might not have been conveying all pertinent information to the board. He stated the administrator might have been afraid to report the concerns of the facility as it would be seen as the administrator was not doing his job. *He stated the administrator had a lot of patience and might have given employees involved in incidents and concerns a break in order to keep the employees. He also confirmed he had hoped the administrator would not keep anyone who had done harm or could do harm to a resident.	F 493	*There has been and there will be continued contact with outside nursing home professionals assisting with the education, training, financial review, reimbursement advocacy and administrator mentoring of the nursing home through the use of the state association membership, a major health system in South Dakota and a seasoned licensed nursing home administrator. KN/SD0004/MF		
F 501 SS=L	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR  The facility must designate a physician to serve as medical director.  The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility.	F 501	F501 medical director pg 27 of 34  The facility must designate a physician to serve as medical director for the purpose of coordinating and implementation of resident care. There will be a meeting the first Friday of April with the Medical Director and Leadership team; to review the following policy and procedures, the results of survey of March 3 and 4, 2015 and to discuss team building with department heads.	4/2/2015	

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F 501	<p>Continued From page 27</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632</p> <p>Surveyor: 20031 Based on record review and interview, the provider failed to ensure the medical director provided for the maintenance and collection of information of negative health care outcomes and incidents for two of two (one and two) sampled residents. Findings include:</p> <p>1. Review of the provider's quality assessment and performance improvement (QAPI) meeting minutes from July 2014 through January 23, 2015 revealed the QAPI committee had only identified areas that included the tags from the survey conducted on 7/24/14. The medical director had attended all meetings but gave no input according to the documentation.</p> <p>Interview on 3/4/15 at 1:30 p.m. with a requested unidentified employee revealed she had contacted the medical director regarding the concerns and incidents at the facility. She stated he gave no concern for the day-to-day activities of the provider. He did state he had thought the provider should start a new fall assessment program:</p> <p>Interview on 3/4/15 at 5:00 p.m. with the director of nursing (DON) revealed he would like to set-up a meeting with the medical director. He stated he had discussed that with the administrator at least twice but had heard nothing back from the administrator.</p>	F 501	<ul style="list-style-type: none"> <li>a. Abuse investigations</li> <li>b. Abuse Prevention Program</li> <li>c. Investigating Unexplained Injuries</li> <li>d. Preventing Resident Abuse</li> <li>e. Protection of Residents During Abuse Investigations</li> <li>f. Recognizing Signs and Symptoms of Abuse/Neglect</li> <li>g. Reporting Abuse to Facility Management</li> <li>h. Reporting Abuse to State Agencies and Other Entities/Individuals</li> <li>i. Reporting Suspected Cases and/or Incidents of Rape</li> <li>j. Resident to Resident Altercations</li> <li>k. Zero Tolerance policy on abuse</li> <li>l. Chain of Command</li> <li>m. Types, Signs and Prevention of abuse and neglect</li> <li>n. Disciplinary Measures</li> <li>o. Re-education of Event Reports-References relevant reports power point dated 11-20-2011 24 hour LTC or 48 hour other licensed nursing facility</li> <li>p. Education of Event Reports-References relevant reports power point dated 11-20-2011 5 working day investigation report</li> <li>q. Falls Investigation Log</li> <li>r. Appropriate Staff Interactions with Residents Log</li> <li>s. Employee Disciplinary Action Log</li> <li>t. New Employee HR Orientation Checklist</li> <li>u. Employee Records and Inquires</li> <li>v. Supervisory Job Performance Evaluation; Re-education and training; Audit Tool</li> </ul>		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/04/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIVE COUNTIES NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 6TH AVENUE WEST LEMMON, SD 57638</b>	
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F 501	Continued From page 28. Interview on 3/13/15 at 9:00 a.m. by phone call with the medical director revealed: *He confirmed he had not been made aware of all incidents at the facility. *He had been following the administrator's progress. *He had been letting him "grow" into his position as he had only been there a little over a year. *Employees had told him the administrator lacked leadership and confidence. *He understood the surveyors concerns related to the complaint survey regarding the incidents involving residents 1 and 2. Those concerns had reflected the employee interviews. *He was going to start leadership, team building, and how to take control using "Mind Tools." *He was going to start more integrated meetings with all managers and create horizontal leadership. *He stated the administrator was timid and had no strong leadership role. He needed to relay to the administrator he could not always be a friend to the employees and needed to get on with the mission of the nursing home and the care of the residents. *He was aware the DON came from a military background. He tended to treat his staff "robotic" instead of equals to step up to the daily demands of the nursing home. *He was aware of the insubordination letter the DON had drafted. He was not aware the letter had gone out to all staff. He had thought the letter dealt with a registered nurse and her questioning of the DON's instructions involving a catheter (tube inserted into bladder to release urine). He was concerned the administrator had not diffused the situation and try to intervene to retain the nurse. He stated the letter gave him a better understanding of how the DON operated and interacted with the staff.	F 501	w. Pain Interview tool from Point Click Care y. Quality Assessment and Assurance Committee z. Quality Assessment and Assurance Plan  The Medical Director will continue to actively participate in the QAPI quarterly report for the review. The Medical Director will be kept informed by the administrator of all reportable events concerning resident care. The Medical Director, the Administrator and department assigned by the administrator will schedule a bi weekly meeting during the Medical Director's rounds on Fridays in the facility for one year.  <i>*The Medical Director will actively participate by team building, staff training, reviewing, providing guidance and sign off on the quarterly QA report. This team training will be accomplished on April 10, 2015. KNI/SDD/HMF</i>  <i>*The Medical Director will submit the quarterly QA report.</i> <i>KNI/SDD/HMF</i>	

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F 501	<p>Continued From page 29</p> <p>*He was aware there were some nurses just "filling time." But, it was better to have open positions than bad employees. It would be better for the nursing home to have retention than new recruitments from outside agencies all the time.</p> <p>*He was not aware the DON had requested at least two meetings with him. He stated he is there every Friday for rounds and was upset no one had contacted him or kept him in the loop. He also stated he was concerned that when he did his rounds on Fridays the administrator's door was always closed, and the DON was never around.</p> <p>*There needed to be more construction instead of destruction among the employees, and he intended to work with the board of directors to ensure it would get done.</p> <p>According to the www. American Medical Directors Association (AMDA) on 3/13/15, the medical director is involved at all levels of individualized patient care and supervision, and for all persons served by the facility. The medical director serves as the clinician who oversees and guides the care that is provided, a leader to help define a vision of quality improvement, and an operations consultant to address day-to-day aspects of organizational function.</p> <p>According to an undated article by AMDA the following was a general guideline to be used for medical directors: *Coordination and evaluation of the medical care within the facility. To include: -Identification, evaluation, and addressing health care issues related to the quality of care and quality of life of residents. -Review of individual resident cases, as warranted, to evaluate quality of care or quality of</p>	F 501		

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F 501	Continued From page 30 life concerns or other problematic situations and take appropriate steps to resolve the situation as necessary and as requested. -Review, consider and/or act upon consultant recommendations that affect the facility's resident care policies and procedures or the care of an individual resident.	F 501		
F 520 SS=L	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary, and develops and implements appropriate plans of action to correct identified quality deficiencies.  A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.  Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.  This REQUIREMENT is not met as evidenced by:	F 520	*committee KW/SDDH/ME  F520 pg 31 of 34 The facility must maintain a quality assurance _____ consisting of the Director of Nursing, physician and 3 members of the facility staff.  a. Abuse investigations b. Abuse Prevention Program c. Investigating Unexplained Injuries d. Preventing Resident Abuse e. Protection of Residents During Abuse Investigations f. Recognizing Signs and Symptoms of Abuse/Neglect g. Reporting Abuse to Facility Management h. Reporting Abuse to State Agencies and Other Entities/Individuals i. Reporting Suspected Cases and/or Incidents of Rape j. Resident to Resident Altercations k. Zero Tolerance policy on abuse l. Chain of Command m. Types, Signs and Prevention of abuse and neglect n. Disciplinary Measures o. Re-education of Event Reports-References relevant reports power point dated 11-20-2011 24 hour LTC or 48 hour other licensed nursing facility p. Education of Event Reports-References relevant reports power point dated 11-20-2011 5 working day investigation report q. Falls Investigation Log r. Appropriate Staff Interactions with Residents Log	*4/2/15 KW/SDDH/ME

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F 520	<p>Continued From page 31 Surveyor: 26632</p> <p>Surveyor: 20031 Based on record review, policy, procedure book, and interview, the provider failed to ensure an effective quality assessment and performance improvement (QAPI) program had been maintained to:</p> <ul style="list-style-type: none"> <li>*Review residents' cares concerns, and plans.</li> <li>*Identify trends in the quality measures indicator.</li> <li>*Identify trends and tracing of infection controls.</li> <li>*Identify needs and issues with electronic medical records.</li> <li>*Review admissions and discharges for residents.</li> <li>*Discuss new and old policies and procedures.</li> <li>*Discuss the monthly pharmacist reports.</li> <li>*Discuss incident and safety reports.</li> <li>*Discuss staff concerns and needs.</li> </ul> <p>Findings include:</p> <p>1. Review of the provider's QAPI meeting minutes from July 2014 through January 23, 2015 revealed the QAPI committee had identified areas that only included the deficiencies from the survey conducted on 7/24/14.</p> <p>Interview on 3/4/15 at 11:30 a.m. with the administrator revealed:</p> <ul style="list-style-type: none"> <li>*He was the responsible party for QAPI.</li> <li>*The QAPI committee met quarterly and included himself, the director of nursing, the medical director, and other employees.</li> <li>*The QAPI meetings had identified only the deficiencies written from the last survey on 7/24/14.</li> <li>*There were no other measurable goals or interventions.</li> <li>*The monthly resident council meeting minutes</li> </ul>	F 520	<ul style="list-style-type: none"> <li>s. Employee Disciplinary Action Log</li> <li>t. New Employee HR Orientation Checklist</li> <li>u. Employee Records and Inquires</li> <li>v. Supervisory Job Performance Evaluation; Re-education and training; Audit Tool</li> <li>w. Pain Interview tool from Point Click Care</li> <li>y. Quality Assessment and Assurance Committee</li> <li>z. Quality Assessment and Assurance Plan</li> </ul> <p>The reports related to Tags 224, 225, 226, 520, 490, 493, 501 PoC but not limited to will be completed by the appropriate department leaders. The QA coordinator will organize a report ensuring that an ongoing, facility wide Quality Assessment and Assurance Program designed to monitor and evaluate the quality of resident care, pursue methods to improve care quality and resolved identified program are corrected. The Administrator will receive, review, attend and participate in the meeting along with the mandated required participants will be held at least quarterly and is on going.</p> <p><i>*The Administrator will submit the quarterly QA report to the Board of Directors. KW/KDDOHMF</i></p>	
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F 520	<p>Continued From page 32 were not reviewed for issues. *None of the above listed topics from the above introduction statement were addressed in QAPI.</p> <p>The administrator revealed the provider had implemented a safety audit on the employees due to the high insurance premiums. He also stated he was trying to implement a better admission process and packet to let all departments know of a new admission.</p> <p>Phone interview on 3/10/15 at 10:00 a.m. with the president of the board revealed: *He was not aware the QAPI program had not been done correctly. *He confirmed the administrator only reported the last survey audits from the QAPI program to the governing board.</p> <p>Review of an undated quality assurance procedure book revealed no policy could be located regarding QAPI. Interview on 3/4/15 at 1:40 p.m. with the recording secretary for QAPI revealed there was no policy for QAPI.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, MO., 2005, p. 365, revealed " ...organizations must be responsible and accountable for evaluating and improving the quality of client care services being provided to all clients. This requires health professionals at all levels to critically evaluate their practices, to incorporate the latest scientific findings into client care, and to measure the success of meeting client outcomes on an ongoing basis."</p> <p>Refer to: F223, F224, F225, F226, F309, F490, F493, and F501.</p>	F 520		

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