

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

ORIGINAL

PRINTED: 04/20/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/07/2015
NAME OF PROVIDER OR SUPPLIER FIVE COUNTIES NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 405 6TH AVENUE WEST LEMMON, SD 57638	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS Surveyor: 26632 A revisit health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted on 4/7/15. Five Counties Nursing Home was found not in compliance with the following requirements: F223, F224, F225, F226, F309, F490, F501, and F520.	{F 000}	Addendums noted with an asterisk per 4/30/15 email from facility administrator. KW/SDDH/MF	
{F 223} SS=E	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 Based on record review and interview, the provider failed to ensure the plan of correction (POC) submitted for the 3/4/15 complaint survey had been followed for training the nursing staff by the director of nursing (DON) or his designee. Findings include: 1. Review of the provider's POC from the 3/4/15 survey with a completion date of 4/2/15 revealed: **The Director of Nursing or his designee will provide training to the nursing staff on rounding [course of actions or duties for the job] for audit purposes and document staff interactions/redirecting residents; once on each of	{F 223}	Regulatory Requirement: Each resident has the right to be free from verbal sexual, physical and mental 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. Allegation: The provider failed to ensure the plan of correction (POC) submitted for the 3/4/2015 complaint survey had been followed for training the nursing staff by the director of nursing (DON) or his designee. Facility Response: On April 23, 2015 re-education was presented to the administrator and each department head of the facility to enforce the complete understanding that all staff are to be knowledgeable in the following policy and procedures <u>you are to take these policy and procedures and review them with your subordinate staff, date, time, you sign as trainer, have them sign and to HR for recording.</u> Nursing shall be completed at shift changes for C.N.A and licensed nurses during the report. <u>This must be done no later than noon on April 28th.</u> 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	4/30/15

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

TITLE

(X6) DATE

Chad Abel

Administrator

4/29/15

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.

APR 29 2015
SD DOH L&C
If continuation sheet Page 1 of 27

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{F 223}	<p>Continued From page 1</p> <p>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."</p> <p>***Immediate verbal and written education with positive educational best practices feedback to employees will occur on any negative interaction."</p> <p>***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 [human resource] file."</p> <p>***Any employee disciplinary action will be reviewed, approved and action taken at the time of the event by the Administrator."</p> <p>***He will sign off on the rounding reports weekly."</p> <p>***The audit results will be submitted to the quarterly QAPI [quality assurance performance improvement] for further recommendations."</p> <p>Review of the provider's Appropriate Staff Interactions with Residents audit tool revealed: *It included columns for the "Date, Observation, Description of Staff Behavior, Description of Interaction with a + [plus] or - [minus] beside it, Person Completing report, Date sent in, Follow-up Report sent date."</p> <p>*As of 4/7/15, only positive (+) areas were indicated.</p> <p>*It had been reviewed by the administrator.</p> <p>Interview on 4/7/15 at 2:00 p.m. with the interim DON revealed she had: *Not read nor seen the above POC. *Been tracking falls with the social service designee to ensure all falls were investigated and</p>	{F 223}	<p>h. Reporting Abuse to State Agencies and Other Entities/Individuals</p> <p>i. Reporting Suspected Cases and/or Incidents of Rape</p> <p>j. Resident to Resident Altercations</p> <p>k. Zero Tolerance policy on abuse</p> <p>l. Chain of Command</p> <p>m. Types, Signs and Prevention of abuse and neglect</p> <p>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> <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 Acting Director of Nursing or charge nurse will provide training to all nursing staff during the three report times at 6am, 2 pm and 10 pm with Certified Nurse Aides and Licensed Nurses N through Z. Each Department Leader will educate the assigned staff in the department N through Z. Signatures of those attending will be in writing and submitted to the HR director for audit purposes.</p>	
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{F 223}	Continued From page 2 reported. *Thought the previous DON would have: -Included the nursing staff training on his rounding. -Gone with the nurses during resident care for on-the-spot education. *Not done any of the rounding education with the nursing staff. *Not had any negative results to follow-upon with staff. Surveyor: 20031 Interview on 4/7/15 at 4:45 p.m. with the administrator revealed: *The past DON had given his resignation on 3/27/15 and left the facility on that date. *The past DON had written some parts of the POC. *He was not aware of the exact verbiage or contents for the POCs that he had co-written with the DON. *He had not informed the new interim DON of her responsibilities for her part of the POC. *He was not aware of what the past DON had meant in the POC. *As an example, he was not aware of what the past DON had meant by "Rounding" for some of the audits.	{F 223}	Documentation of staff interaction with residents will be completed; 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 using the Appropriate Staff Interactions with Residents form. Administrator, Department leadership, DON, Charge Nurse or any other employee may use document positive experiences. By having all employees use the form for documentation it will send a message that everyone is responsible. It will continue to build team work and the result will be to deliver quality of care and quality of life to the residents. Verbal and written reeducation will occur on negative interaction before the next scheduled working shift. The negative interactions will be a written: document with time, date, behaviors observed; signatures of employee and educator, disciplinary action or educational training will be reviewed with the employee; reported to the appropriate state agencies and documented on the In-appropriate behavior form and filed in the employee HR file. The Administrator will sign off on any employee education/disciplinary action. Administrator will sign off on the Appropriate Staff Interactions with Residents form weekly. The audit results will be submitted to the quarterly QAPI for further recommendations. <i>*by the human resources director KWS/DDC/HMF</i>		
{F 224} SS=E	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.	{F 224}	F224 pg 4 of 27 (staff training) Regulatory Requirement: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	<i>4/30/15</i>	

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{F 224}	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review and interview, the provider failed to ensure the plan of correction (POC) submitted for the 3/4/15 complaint survey had been followed for staff training and for the resident grievance/complaint log audits. Findings include:</p> <p>1. Training for all staff in the provider's POC with a completion date of 4/2/15 was to have included:</p> <ul style="list-style-type: none"> *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 [long term care] or 48 hour other licensed nursing facility. *P. Education of Event Report-References relevant reports power point dated 11-20-20115 	{F 224}	<p>Allegation: The provider failed to ensure the plan of correction (POC) submitted for the 3/4/2015 complaint survey had been followed for staff training, resident grievance/complaint log.</p> <p>Facility Response: On April 23, 2015 re-education was presented to social worker, administrator and leadership of the facility to enforce the complete understanding of staff training and resident grievance/complaint log. The Social Worker or designee will provide an on-going monitoring system using written documentation by 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>by the human resources director.</i> <i>KWR/DDH/ME</i></p>	
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{F 224}	<p>Continued From page 4 working day investigation report.</p> <ul style="list-style-type: none"> *Q. Falls Investigation Log. *R. Appropriate Staff Interactions with Residents Log. *S. Employee Disciplinary Action Log. *T. New Employee HR [human resource] Orientation Checklist. *U. Employee Records and Inquiries. *V. Supervisory Job Performance Evaluation; Re-education and training; Audit Tool. *W. Pain Interview tool from Point Click Care [provider medical record computer program]. *Y. Quality Assessment and Assurance Committee. *Z. Quality Assessment and Assurance Plan." <p>Review of the provider's POC with a completion date of 4/2/15 and employee education sign-in sheets revealed:</p> <ul style="list-style-type: none"> ***Each staff member including the temp [temporary] agency employees are required to be retrained in the above topics [A through Z] before clocking in for their assigned shift." *Training began on 3/3/15 for all staff and would have included topics A through Z. *There was no record all staff had completed training on topics A through Z. *All staff had only completed training on topics A through M. *Leadership (department managers) had completed all of the A through Z training with the exception of the dietary manager and the maintenance supervisor on 3/27/15. <p>Continued review of the provider's POC revealed "The Social Worker or designee will provide an on-going monitoring system using written documentation by completing the Fall Investigation Log and the Resident</p>	{F 224}		
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{F 224}	<p>Continued From page 5</p> <p>Grievance/Complaint Investigation Log; the reports will be reviewed weekly by the administrator. He will sign off on the reports."</p> <p>Interview on 4/7/15 at 1:30 p.m. with the social services designee (SSD) revealed:</p> <ul style="list-style-type: none"> *She had no complaints or grievances on a log. *If she had received a complaint or grievance she just took care of the problem herself. *She had not documented any of those complaints or grievances. *She had not read the POC and was not aware of what audits she was required to complete. *She had gone to the facilities leadership training on 3/27/15 and was presented the resident grievance/complaint investigation log along with the other attending leadership employees. *That was the first time she had been aware of the log. <p>Interview on 4/7/15 at 3:30 p.m. with the SSD in regards to the provider's Resident Grievance/Complaint/Investigation Log revealed:</p> <ul style="list-style-type: none"> *As of 4/7/15 she had not documented on the log until this surveyor asked for the log. *On 4/7/15 she documented for the weeks of 3/22/15 through 3/28/15 and 3/29/15 through 4/4/15 as having no grievances/complaints/or investigations. Those had been signed off by the administrator also on 4/7/15. *She had documented on 4/6/15 for two residents with a misappropriation, but it did not indicate what kind of misappropriation. *The space for the date the incident took place had "Not sure" documented. <p>Surveyor: 20031</p> <p>Interview on 4/7/15 at 2:00 p.m. with the office manager revealed she kept a binder with training</p>	{F 224}		
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{F 224}	<p>Continued From page 6</p> <p>that each employee must complete by the end of June 2015. Those trainings included the requirements mandated by the state. She stated she had kept track of those requirements. However she had not kept track of the training requirements needed for the current survey and its POC. She stated she had been told by the administrator he would keep track of what was needed for the current survey and its POC.</p> <p>Interview on 4/7/15 at 4:45 p.m. with the administrator revealed:</p> <ul style="list-style-type: none"> *The past director of nursing (DON) had given his resignation on 3/27/15 and left the facility on that date. *The past DON had written some parts of the POC. *The nursing home had a consultant who had also helped him write the POC. *He was not aware of the exact verbiage or contents that had been included for the POCs he had co-written with the DON and consultant. *The consultant had given leadership training to all the leadership staff to include the above listed topics A through Z. The dietary manager and the maintenance manager had not been part of the leadership training. *He had not considered the dietary manager and the maintenance manager part of the leadership program as they "Don't give pills and don't help the residents." He confirmed both managers supervised employees to include dietary staff, maintenance, and housekeeping/laundry staff who had day-to-day interaction with residents. *At the leadership training neither the consultant nor the administrator had provided guidance or specified what leader or department would have been responsible for certain audits under certain POCs. He confirmed that might have been why 	{F 224}		
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{F 224}	Continued From page 7 those audits, logs, or training may not have been completed. *He was the one who had added the additional topics listed under the leadership training to be a requirement of all staff. But in doing so he had not made the additional training available nor had he made it known to all staff the additional topics were required.	{F 224}		
{F 225} SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	{F 225}	F 225 pg 8 of 27 (investigate/report allegations/Individuals) Regulatory Requirement: 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. Allegation: The provider failed to ensure the plan of correction (POC) for the 3/4/15 complaint survey had been followed for staff training, resident grievance/complaint log, and appropriate staff interaction with residents' audit tools. Facility Response: On April 23, 2015 re-education was presented to social worker, administrator and leadership of the facility to enforce the complete understanding of the resident Grievance/Complaint /Investigation Log and abuse policy and procedures and audit forms. The Social Worker or designee will provide an on-going monitoring system using written documentation by 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.	4/30/15

✓ x by the Social Services Director [Signature]

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{F 225}	<p>Continued From page 8</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review and interview, the provider failed to ensure the plan of correction (POC) for the 3/4/15 complaint survey had been followed for staff training, resident grievance/complaint log, and appropriate staff interactions with residents' audit tools. Findings include:</p> <p>1. Training for all staff had been indicated in the provider's POC with a completion date of 4/2/15. It was to have included:</p> <ul style="list-style-type: none"> *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. 	{F 225}			

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{F 225}	<p>Continued From page 9</p> <ul style="list-style-type: none"> *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 [long term care] or 48 hour other licensed nursing facility. *P. Education of Event Report-References relevant reports power point dated 11-20-20115 working day investigation report. *Q. Falls Investigation Log. *R. Appropriate Staff Interactions with Residents Log. *S. Employee Disciplinary Action Log. *T. New Employee HR [human resource] Orientation Checklist. *U. Employee Records and Inquiries. *V. Supervisory Job Performance Evaluation; Re-education and training; Audit Tool. *W. Pain Interview tool from Point Click Care [provider medical record computer program]. *Y. Quality Assessment and Assurance Committee. *Z. Quality Assessment and Assurance Plan." <p>Review of the provider's POC with a completion date of 4/2/15 from the 3/4/15 survey and employee education sign-in sheets revealed:</p> <ul style="list-style-type: none"> **Each staff member including the temp (temporary) agency employees are required to be retrained in the above topics [A through Z] before clocking in for their assigned shift." *Training began on 3/3/15 for all staff and would have included topics A through Z. *There was no record all staff had completed training on topics A through Z. *All staff had only completed training on topics A through M. 	{F 225}		
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{F 225}	<p>Continued From page 10</p> <p>*Leadership (department managers) had completed all of the A through Z training with the exception of the dietary manager and the maintenance supervisor done on 3/27/15.</p> <p>Continued review of the provider's POC revealed "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."</p> <p>Interview on 4/7/15 at 1:30 p.m. with the social services designee (SSD) revealed: *She had no complaints or grievances on a log. *If she had received a complaint or grievance she just took care of the problem herself. *She had not documented any of those complaints or grievances. *She had not read the POC and was not aware of what audits she was required to complete. *She had gone to the facilities leadership training on 3/27/15 and was presented the resident grievance/complaint investigation log along with the other attending leadership employees. *That was the first time she had been aware of the log.</p> <p>Interview on 4/7/15 at 3:30 p.m. with the SSD in regards to the provider's Resident Grievance/Complaint/Investigation Log revealed: *As of 4/7/15 she had not documented on the log until this surveyor asked for the log. *On 4/7/15 she documented for the weeks of 3/22/15 through 3/28/15 and 3/29/15 through 4/4/15 as having no grievances/complaints/or investigations. Those had been signed off by the</p>	{F 225}		
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{F 225}	<p>Continued From page 11 administrator also on 4/7/15. *She had documented on 4/6/15 for two residents with a misappropriation, but it did not indicate what kind of misappropriation. *The space for the date the incident took place had "Not sure" documented.</p> <p>Review of the provider's Appropriate Staff Interactions with Residents audit tool revealed: *It included columns for the "Date, Observation, Description of Staff Behavior, Description of Interaction with a + [plus] or - [minus] beside it, Person Completing report, Date sent in, Follow-up Report sent date." *Review the audit tool completed as of 4/7/15 revealed only positive (+) areas were present. It had been reviewed by the administrator.</p> <p>Interview on 4/7/15 at 2:00 p.m. with the interim director of nursing (DON) revealed she: *Had not seen the POC. *Was tracking falls with the social service designee to ensure all falls were investigated and reported. *Thought the previous DON had included the rounding training and would have gone with the nurses during resident care for on-the-spot education. *Had not done any of the rounding education with the nursing staff. *Had not had any negative results to follow-up on with staff.</p> <p>Surveyor: 20031 Interview on 4/7/15 at 2:00 p.m. with the office manager revealed she kept a binder with training that each employee must complete by the end of June 2015. Those trainings included the requirements mandated by the state. She stated</p>	{F 225}		
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{F 225}	<p>Continued From page 12</p> <p>she had kept track of those requirements. However, she had not kept track of the training requirements needed for the current survey and its POC. She stated she had been told by the administrator he would keep track of what was needed for the current survey and its POC.</p> <p>Interview on 4/7/15 at 4:45 p.m. with the administrator revealed:</p> <ul style="list-style-type: none"> *The past DON had given his resignation on 3/27/15 and left the facility on that date. *The past DON had written some parts of the POC. *The nursing home had a consultant who had also helped him write the POC. *He was not aware of the exact verbiage or contents that had been included for the POCs he had co-written with the DON and consultant. *The consultant had given leadership training to all the leadership staff to include the above listed topics A through Z. The dietary manager and the maintenance manager had not been part of the leadership training. *He had not considered the dietary manager and the maintenance manager part of the leadership program as they "Don't give pills and don't help the residents". He confirmed both managers supervised employees to include dietary staff, maintenance, and housekeeping/laundry staff who had day-to-day interaction with residents. *At the leadership training neither the consultant nor the administrator had provided guidance or specified what leader or department would be responsible for certain audits under certain POCs. He confirmed that might have been why those audits, logs, or training may not have been completed. *He was the one who had added the additional topics listed under the leadership training to be a 	{F 225}		
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{F 225}	Continued From page 13 requirement of all staff. But in doing so he had not made the additional training available nor had he made it known to all staff the additional topics were required. *He had been told by his consultant the Appropriate Staff Interactions with Residents audit tool had been used for the DON's or designee's rounding audits. He stated any staff could report on another staff member. He was not aware if the DON was not available, designee would mean the assistant DON or charge nurse. It did not mean anyone in the facility. He was also unaware negative staff comments could not be available for review by all staff.	{F 225}		
{F 226} SS=E	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 by: Surveyor: 26632 Based on record review and interview, the provider failed to ensure the plan of correction (POC) for the 3/4/15 complaint survey had been followed for staff training. Findings include: 1. Training for all staff had been indicated in the provider's POC with a completion date of 4/2/15 from the 3/4/15 survey. It was to have included: **A. Abuse Investigations. *B. Abuse Prevention Program. *C. Investigating Unexplained Injuries.	{F 226}	F 226 pg 14 of 27 Regulatory Requirement: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Allegation: The provider failed to ensure the plan of correction (POC) for 3/4/2015 complaint survey had been followed for staff training. Facility Response: On April 23, 2015 re-education was presented to the administrator and each department head of the facility to enforce the complete understanding that all policy and procedures, A through Z, reporting forms, training documentation and audits for the QAPI reports. The Human Resource Director will provide a monitoring system using written documentation by completing the employee list and survey Audit form to ensure training has been completed. 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.	4/30/15

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{F 226}	<p>Continued From page 14</p> <ul style="list-style-type: none"> *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 [long term care] or 48 hour other licensed nursing facility. *P. Education of Event Report-References relevant reports power point dated 11-20-20115 working day investigation report. *Q. Falls Investigation Log. *R. Appropriate Staff Interactions with Residents Log. *S. Employee Disciplinary Action Log. *T. New Employee HR [human resource] Orientation Checklist. *U. Employee Records and Inquiries. *V. Supervisory Job Performance Evaluation; Re-education and training; Audit Tool. *W. Pain Interview tool from Point Click Care [provider medical record computer program]. *Y. Quality Assessment and Assurance Committee. *Z. Quality Assessment and Assurance Plan." <p>Review of the provider's POC with a completion</p>	{F 226}		
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{F 226}	<p>Continued From page 15 date of 4/2/15 from the 3/4/15 survey and employee education sign-in sheets revealed: *"Each staff member including the temp (temporary) agency employees are required to be retrained in the above topics [A through Z] before clocking in for their assigned shift." *Training began on 3/3/15 for all staff and would have included topics A through Z. *There was no record all staff had completed training on topics A through Z. *All staff had only completed training on topics A through M. *Leadership (department managers) had completed all of the A through Z training with the exception of the dietary manager and the maintenance supervisor done on 3/27/15.</p> <p>Surveyor: 20031 Interview on 4/7/15 at 2:00 p.m. with the office manager revealed she kept a binder with training that each employee must complete by the end of June 2015. Those trainings included the requirements mandated by the state. She stated she had not kept track of those requirements. However, she had not kept track of the training requirements needed for the current survey and its POC. She stated she had been told by the administrator he would keep track of what was needed for the current survey and its POC.</p> <p>Interview on 4/7/15 at 4:45 p.m. with the administrator revealed: *The past director of nursing (DON) had given his resignation on 3/27/15 and left the facility on that date. *The past DON had written some parts of the POC. *The nursing home had a consultant who had</p>	{F 226}		
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{F 226}	Continued From page 16 also helped him write the POC. *He was not aware of the exact verbiage or contents that had been included for the POCs he had co-written with the DON and consultant. *The consultant had given leadership training to all the leadership staff to include the above listed topics A through Z. The dietary manager and the maintenance manager had not been part of the leadership training. *He had not considered the dietary manager and the maintenance manager part of the leadership program as they "Don't give pills and don't help the residents". He confirmed both managers supervised employees to include dietary staff, maintenance, and housekeeping/laundry staff who had day-to-day interaction with residents. *He was the one who had added the additional topics listed under the leadership training to be a requirement of all staff. But in doing so he had not made the additional training available nor had he made it known to all staff the additional topics were required.	{F 226}			
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review and interview, the	{F 309}	F 309 pg 17of maintain the highest well being Regulatory Requirement 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. Allegation: The provider failed to ensure the plan of correction (POC) for the 3/4/2015 complaint survey had been followed for staff training, the resident pain interview assessment, and the Morse fall scale assessment audits.	4/30/15	

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{F 309}	<p>Continued From page 17</p> <p>provider failed to ensure the plan of correction (POC) for the 3/4/15 complaint survey had been followed for staff training, the resident pain interview assessment, and the Morse fall scale assessment audits. Findings include:</p> <ol style="list-style-type: none"> 1. Training for all staff had been indicated in the provider's POC with a completion date of 4/2/15. It was to have included: <ul style="list-style-type: none"> *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 [long term care] or 48 hour other licensed nursing facility. *P. Education of Event Report-References relevant reports power point dated 11-20-20115 working day investigation report. *Q. Falls Investigation Log. *R. Appropriate Staff Interactions with Residents Log. *S. Employee Disciplinary Action Log. 	{F 309}	<p>Facility Response: Residents will have an up to-date pain interview assessment, Morse fall scale assessment and a cognitive patterns assessment by April 28, 2015. The Acting Director of Nursing or designee will complete a pain interview assessment, Morse fall scale assessment and the cognitive patterns assessment on each resident by April 28, 2015. The results will be documented in the resident</p> <p>tile and address on the resident care plan. The MDS coordinator will complete a resident audit weekly x 4 weeks and once x 2 months and quarterly to ensure assessments are completed in conjunction with the MDS well-being and reporting compliance. The audit results will be submitted to the quarterly QAPI for further recommendations.</p> <p><i>*by the MDS coordinator KN/SDD/HMF</i></p> <p><i>*The MDS coordinator will do all MDS assessments due on each week. KN/SDD/HMF</i></p>	
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{F 309}	<p>Continued From page 18</p> <ul style="list-style-type: none"> *T. New Employee HR [human resource] Orientation Checklist. *U. Employee Records and Inquiries. *V. Supervisory Job Performance Evaluation; Re-education and training; Audit Tool. *W. Pain Interview tool from Point Click Care [provider medical record computer program]. *Y. Quality Assessment and Assurance Committee. *Z. Quality Assessment and Assurance Plan." <p>Review of the provider's POC with a completion date of 4/2/15 revealed:</p> <ul style="list-style-type: none"> *The above training was included in the POC. *Further review of the POC revealed it did not indicate which staff was to have completed the training and by when. **"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 [DON] or designee will complete an audit weekly x [times] 4 weeks and monthly x 2 months for event reporting compliance. The audit results will be submitted to the quarterly QAPI [Quality Assurance Performance Improvement] for further recommendations." <p>Interview on 4/7/15 at 2:30 p.m. with the Minimum Data Set (MDS) assessment coordinator revealed she:</p> <ul style="list-style-type: none"> *Had not read the POC for the 3/4/15 survey. *Was not aware an audit of residents' assessments for pain, Morse fall scale, and cognitive patterns was to have been completed. *Had not re-assessed all the residents for pain, falls, and cognitive patterns. 	{F 309}		
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{F 309}	<p>Continued From page 19</p> <p>*All the residents were current in those assessments according to their scheduled MDS assessments.</p> <p>Interview on 4/7/15 at 2:00 p.m. with the interim DON revealed she was not aware of any audits for completing up-to-date pain, fall, and cognitive patterns assessments.</p> <p>Surveyor: 20031</p> <p>Interview on 4/7/15 at 2:00 p.m. with the office manager revealed she kept a binder with training that each employee must complete by the end of June 2015. Those trainings included the requirements mandated by the state. She stated she had kept track of those requirements. However, she had not kept track of the training requirements needed for the current survey and its POC. She stated she had been told by the administrator he would keep track of what was needed for the current survey and its POC.</p> <p>Interview on 4/7/15 at 4:45 p.m. with the administrator revealed:</p> <p>*The past DON had given his resignation on 3/27/15 and left the facility on that date.</p> <p>*The past DON had written some parts of the POC.</p> <p>*The nursing home had a consultant who had also helped him write the POC.</p> <p>*He was not aware of the exact verbiage or contents that had been included for the POCs he had co-written with the DON and consultant.</p> <p>*The consultant had given leadership training to all the leadership staff to include the above listed topics A through Z. The dietary manager and the maintenance manager had not been part of the leadership training.</p> <p>*He had not considered the dietary manager and</p>	{F 309}		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 04/07/2015
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 309}	Continued From page 20 the maintenance manager part of the leadership program as they "Don't give pills and don't help the residents". He confirmed both managers supervised employees to include dietary staff, maintenance, and housekeeping/laundry staff who had day-to-day interaction with residents. *At the leadership training neither the consultant nor the administrator had provided guidance or specified what leader or department would be responsible for certain audits under certain POCs. He confirmed that might have been why those audits, logs, or training may not have been completed. *He was the one who had added the additional topics listed under the leadership training to be a requirement of all staff. But in doing so he had not made the additional training available nor had he made it known to all staff the additional topics were required. *He would have expected new pain, fall, and cognitive assessments to have been completed for each resident to meet the intentions of the POC.	{F 309}			
{F 490} SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review and interview, the provider failed to ensure the plan of correction	{F 490}	F490 pg21 of 27 Administrator Regulatory Requirement 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 to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Allegation: The provider failed to ensure the plan of correction (POC) for the 3/4/2015 complaint survey had been followed: audit for the resident, grievance/complaint/investigation log, appropriate staff interactions with residents, pain interview assessments, Morse fall scale assessments and cognitive patterns assessments.	4/30/15	

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{F 490}	<p>Continued From page 21 (POC) for the 3/4/15 complaint survey had been followed as written for the correction of eight of nine cited tags (F223, F224, F225, F226, F309, F501, and F520). Findings include:</p> <p>1. Review of the POCs for F223, F224, F225, F226, F309, F501, and F520 cited for the 3/4/15 survey revealed the administrator had not ensured: *Those POCs had been followed. *Audits for the resident grievance/complaint/investigation log, appropriate staff interactions with residents, pain interview assessments, Morse fall scale assessments, and cognitive patterns assessments had been completed.</p> <p>Surveyor: 20031 Interview on 4/7/15 at 2:00 p.m. with the office manager revealed she kept a binder with training that each employee must complete by the end of June 2015. Those trainings included the requirements mandated by the state. She stated she had kept track of those requirements. However, she had not kept track of the training requirements needed for the current survey and its POC. She stated she had been told by the</p>	{F 490}	<p>Facility Response On April 22, 23, and 24, 2015 re-education was presented to the administrator by the consultant Form CMS2557, Policy and Procedures A through Z, audit for the resident grievance/complaint/investigation log, appropriate staff interactions with residents, pain interview assessments, Morse fall scale assessments and cognitive patterns assessments. The facility will continue to have the Administrator meet monthly with a seasoned licensed administrator once a month for 3 months, (April, May and June), one a month for the months of August, October and December, and once in March of 2016. ^</p> <p>*The consultant administrator and administrator will report those monthly meetings to the board. Those meetings will review all items listed in regards to progress towards compliance and continued compliance. KWN/SDDH/ME</p>	
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{F 490}	Continued From page 22 administrator he would keep track of what was needed for the current survey and its POC. Interview on 4/7/15 at 4:45 p.m. with the administrator revealed: *He was the one responsible for the POC, its initiation, and its completion. He would attend the exit conference alone to hear the findings by the surveyors. *The past director of nursing (DON) had written some parts of the POC. *The nursing home had a consultant who had also helped him write the POC. *He was not aware of the exact verbiage or contents that had been included for the POCs he had co-written with the DON and consultant. *At the leadership training, neither the consultant nor the administrator had provided guidance or specified what leader or department would be responsible for certain audits under certain POCs. He confirmed this might have been why those audits, logs, or training might not have been completed.	{F 490}			
{F 501} SS=E	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. This REQUIREMENT is not met as evidenced by: Surveyor: 20031	{F 501}	F501 medical director pg 27 of 34 Regulatory Requirement: The facility must designate a physician to serve as medical director for the purpose of coordinating and implementation of resident care. Allegation: The provider, failed to ensure all parts of the POC for the 3/4/15 complaint survey had been completed by attending and participating in the quarterly QAPI meeting, medical director always informed of reportable events concerning resident care, and schedule bi weekly meetings.	4/30/15	

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{F 501}	<p>Continued From page 23 Surveyor: 26632 Based on interview, and plan of correction (POC) review, the provider failed to ensure all parts of the POC for the 3/4/15 complaint survey had been completed. Findings include:</p> <p>1. Review of the provider's POC with a completion date of 4/2/15 from the 3/4/15 complaint survey revealed: *The Medical Director will continue to actively participate in the QAPI [quality assurance performance improvement] 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, 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."</p> <p>Review of a 4/1/15 letter from the medical director to the administrator regarding the survey results and POC revealed: *He had returned from vacation on 3/31/15 and had reviewed the survey information the administrator had forwarded to him. *He had reviewed the policy and procedures related to abuse and neglect.</p> <p>Review of the provider's undated Investigating Unexplained Injuries Policy #9.10 revealed "The Medical Director or Attending Physician shall review and verify conclusions about the possibility of a medical or similar cause of the findings."</p> <p>Surveyor: 20031 Interview on 4/7/15 at 4:45 p.m. with the</p>	{F 501}	<p>Facility Response: On April 4, 2015 the <i>the</i> Medical Director <i>the</i> completed a Teambuilding training with leadership staff. On April 17, 2015 the <i>the</i> Medical Director <i>the</i> completed a QAPI challenges and the problem solving process with leadership staff. On April 17, 2015 the <i>the</i> Medical Director <i>the</i> attended the quarterly QAPI meeting. The Medical Director will be kept informed of reportable events concerning resident care by the Administrator. The attending physician of the resident will be informed of the reportable incident by the charge nurse. There will a review of the reportable event and verify conclusion of the findings. The bi weekly meetings between Administrator and Medical Director have been held on April 10, & 17, 2015 and will continue twice a month through April 2016. Verification of meetings will be submitted to the quarterly QAPI meeting for further review.</p> <p><i>x-the medical director</i> <i>the administrator</i></p>	<p><i>the</i> <i>the</i> <i>the</i></p>
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{F 501}	Continued From page 24 administrator revealed he: *Had not informed the medical director of recent reportable incidents involving resident concerns since the survey. *Stated the medical director had been out of town. *Had not realized email would have been a form of communication to keep the medical director informed of any news at the facility.	{F 501}		
{F 520} SS=E	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.	{F 520}	520 QAPI meeting pg 25 of 27 Regulatory Requirement: The facility must maintain a quality assurance committee consisting of the Director of Nursing, physician and 3 members of the facility staff. Allegation: the provider failed to ensure the plan of correction (POC for the complaint survey on 3/4/2015 for deficiencies 224,225,226,520, 493, and 501. Facility Response: QAPI was held on April 17, 2015 with Director of Nursing, Medical Director and 8 other members of the facility staff present. The reports related to July 2014, March 3, 2015, and April 7, 2015 deficiencies per state surveys. The Administrator served as the QAPI organizer at the April 17, 2015 QAPI meeting. A QAPI coordinator will be appointed by May 15, 2015. A special QAPI meeting will be held May 22, 2015 for the purpose of auditing deficiencies completeness for F 224,225,226,520, 493 and 501. 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.	4/30/15

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{F 520}	<p>Continued From page 25</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632</p> <p>Based on record review and interview, the provider failed to ensure the plan of correction (POC) for the complaint survey on 3/4/15 had been followed, Findings include:</p> <p>1. Review of the POC revealed: *"Reports related to Tags [deficiencies] 224, 225, 226, 520, 490, 493, 501 PoC but not limited to will be completed by the appropriate department leaders. The QA [quality assurance] 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." *"Administrator will submit the quarterly QA report to the Board of Directors."</p> <p>Surveyor: 20031</p> <p>Interview on 4/7/15 at 4:45 p.m. with the administrator revealed: *He was responsible for the quality assurance performance improvement (QAPI) committee.</p>	{F 520}		
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{F 520}	Continued From page 26 *He had not compiled any reports, logs, audits, training, or meetings in regards to the survey and its POC to report at the next QAPI meeting. *He confirmed had he kept an on-going record of what was expected in the POC by all staff and departments, he might have known not all aspects of the POC had been completed.	{F 520}			