

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

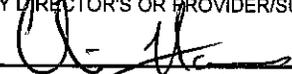
ORIGINAL

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FORM APPROVED
OMB NO. 0938-0391

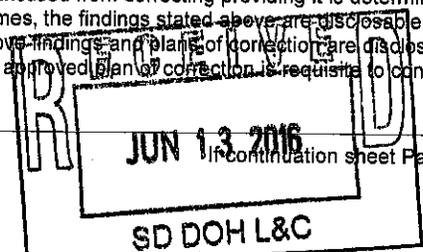
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/18/2016
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NAME OF PROVIDER OR SUPPLIER ALCESTER CARE AND REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 101 CHURCH STREET ALCESTER, SD 57001
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p><i>*Addendums noted with an asterisk per 6/30/16 per F 000 telephone with facility administrator: DK/SDDO/H/EL</i></p> <p>Surveyor: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/16/16 through 5/18/16. Alcester Care and Rehab Center, Inc was found not in compliance with the following requirements: F176, F202, F226, F250, F309, F368, F431, and F441.</p> <p>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/16/16 through 5/18/16. The area surveyed included facility staffing. Alcester Care and Rehab Center, Inc was found in compliance.</p>		<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:</p>	
F 176 SS=E	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation and interview, the provider failed to ensure two of two randomly observed residents (14 and 15) were assessed and able to self-administer medication through a nebulizer (device to administer medication to lungs). Findings include:</p> <p>1. Observation and interview on 5/17/16 at 9:10 a.m. of medication administration with the interim director of nursing (DON) in resident 14's room</p>	F 176	<p>Resident 14 and 15's medical record was reviewed and revised to reflect the current status of care including, but not limited to obtaining physicians' orders for self-administration of medications and self-administration of medication assessments for those on nebulizer treatments to ensure appropriateness and accuracy.</p> <p>All other resident's medical records were reviewed and obtained physician orders for self-administration of medications and self-administration of medication assessments for those receiving nebulizer treatments to ensure appropriateness and accuracy.</p> <p>DON, administrator, and interdisciplinary team reviewed and revised as necessary the policy and procedures about</p>	7/7/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X8) DATE 6/11/2016
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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 due possible 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 due possible 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 176	<p>Continued From page 1 revealed:</p> <p>*The resident was to receive medication through a nebulizer.</p> <p>*The DON prepared the medication in the nebulizer, placed the nebulizer mask over the resident's face, and started the nebulizer machine.</p> <p>-She stated she would be back, and she left the room.</p> <p>*The DON returned ten minutes later and removed and cleaned the nebulizer mask and its parts.</p> <p>*She stated that was the usual process for administration of nebulizer medications.</p> <p>2. Observation on 5/17/16 at 9:20 a.m. of medication administration with the interim DON in resident 15's room revealed:</p> <p>*The resident was to receive medication through a nebulizer.</p> <p>*The DON prepared the medication in the nebulizer, placed the nebulizer mask over the resident's face, and started the nebulizer machine.</p> <p>-She stated she would be back, and she left the room.</p> <p>*She returned ten minutes later and removed and cleaned the nebulizer mask and its parts.</p> <p>Observation on 5/17/16 at 9:40 a.m. of medication administration with the interim DON in resident 15's room revealed:</p> <p>*The resident was to receive a second medication through a nebulizer.</p> <p>*She prepared the medication in the nebulizer, placed the nebulizer mask over the resident's face, and started the nebulizer machine.</p> <p>-She stated she would be back, and she left the room.</p>	F 176	<p>physicians' orders for self-administration of medications and self-administration assessments of nebulizer treatments.</p> <p>DON or designee will provide education on self-administration of medication, and self-administration assessments for those on nebulizer treatment to staff responsible for this task.</p> <p>DON or designee will audit resident medical records per MDS schedule or on significant change to ensure resident's current status of care one time per week for 4 weeks and once per month for two months.</p> <p>DON or designee will present the audit findings at the monthly QAPI meeting for review.</p>		

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F 176	Continued From page 2 *She returned ten minutes later and removed and cleaned the nebulizer mask and its parts.	F 176			
F 202 SS=D	3. Interview on 5/18/16 at 1:30 p.m. with the DON revealed they had not obtained physicians' orders for self-administration of a medication nor completed self-administration of medication assessments for those above residents on nebulizer treatments. Interview on 5/18/16 at 3:00 p.m. with the administrator revealed he was unable to find a policy on self-administration of medications. 483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section. This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on interview, record review, and policy review, the provider failed to document the transfer for one of one sampled discharged resident (12). Findings include: 1. Record review and interview on 5/18/16 at 1:15 p.m. with the interim director of nursing (DON)	F 202	DON, administrator, Social Service designee, and Interdisciplinary Team reviewed and revised as necessary the policy and procedures including but not limited in obtaining a physician order, signing a transfer notice, and documenting the resident transfer and discharge. RN A was re-educated on proper transfer and discharge procedure, and physician notification. All staff responsible for transfer and discharge were re-educated for proper procedure. DON or designee will audit documentation regarding proper policy and procedure for resident transfer, discharge, signed transfer notice, and receiving physician notification once per week for 4 weeks and once per month for two more months. <i>*all A. DW/SDO/HJL</i>	7/1/16	

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F 202	<p>Continued From page 3</p> <p>and registered nurse (RN) A regarding the transfer of resident 12 revealed:</p> <p>*He had been admitted on 4/29/16.</p> <p>*He had been exhibiting inappropriate social behaviors from 5/2/16 to 5/8/16.</p> <p>*On 5/9/16 at an unidentified time the social services designee notified a social worker at the hospital that provided care for the resident. She informed the social worker of the inappropriate social behaviors. She documented she was told to send him to the emergency department.</p> <p>*RN A was working and was told by another RN she would not need to do a transfer form so she had not completed one.</p> <p>*RN A believed she had documented the transfer in the nurses progress notes, but no documentation was found.</p> <p>*There had been no documentation of the notification of the resident's physician.</p> <p>*There had been no documentation of who transferred the resident, how the resident was transferred, when the resident was transferred, where the resident was transferred to, or why the resident was transferred.</p> <p>*The DON agreed there should have been a transfer form, and the physician should have been notified of the change of condition of the resident regarding behaviors.</p> <p>Record review and interview on 5/18/16 at 1:20 p.m. with the social services designee regarding the above for resident 12 revealed:</p> <p>*She had made the call to the social worker at the hospital.</p> <p>*She had not recorded a time in her documentation and was unable to remember the time she had contacted the social worker at the hospital.</p> <p>*She had not gone any further with the transfer,</p>	F 202	DON or designee will present the audit findings at the monthly QAPI meeting for review.		

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F 202	<p>Continued From page 4 as she believed that was the nurse's responsibility.</p> <p>Review of the 8/15/13 Social Services Designee job description revealed she was to: *Assist in organizing all social service needs of the residents including discharge planning and completion of required forms. *Compile and maintain current and accurate information. *Coordinate discharge plans between resident, family, physician, facility personnel, and outside resources. *Responsible for documenting the discharge plan in the medical record.</p> <p>Interview on 5/18/16 at 3:00 p.m. with the administrator revealed he agreed there should have been documentation of the transfer of the resident to another facility.</p> <p>Review of the provider's 9/3/08 Notification of Change in Resident Status policy and procedure revealed the facility was to have immediately informed the resident's physician if there was a decision to transfer or discharge the resident from the facility.</p> <p>Review of the provider's 12/11/09 Discharge/Transfer of the Resident policy and procedure revealed: *A physician's order for transfer was to have been obtained unless the transfer was an emergency. *A signed transfer notice was to have been completed and sent with the responsible party transferring the resident. *The transfer form was to have been completed, and any information necessary for the care of the resident copied and sent with resident.</p>	F 202		
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F 226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35121 Based on record review, interview, and policy review, the provider failed to report a fracture to the South Dakota Department of Health (SD DOH) for one of two sampled residents (4) who had an injury after a fall. Findings include:</p> <p>1. Review of resident 4's medical record revealed: *On 1/8/16 at: -1: 30 p.m. she had an unwitnessed fall. -3:30 p.m. she had complained of right hand pain. -11:00 p.m. there was "slight swelling noted above R [right] thumb on hand." *On 1/9/16 her physician was notified of that fall. *On 1/11/16 a physician's order was received to "Wrap with ACE; if not improving should get X-ray of R [right] wrist." *She had complained of right wrist pain on six days from 1/8/16 to 1/22/16. *She had swelling of her right hand and/or wrist on nine days from 1/8/16 to 1/25/16. *On 1/10/16 she had refused to let staff unwrap her right wrist for assessment. *On 1/11/16 she had: -Refused personal care. -"Manipulative behaviors." *On 1/14/16 she had requested:</p>	F 226	<p>DON and Interdisciplinary Team reviewed and revised as necessary the policy and procedure for Resident Accident Prevention and Required Nursing Facility Event Reporting Form.</p> <p>DON was re-educated on reporting a fracture to the South Dakota Department of Health and using the Required Nursing Facility Event form.</p> <p>All staff responsible reporting a fracture to the South Dakota Department of Health were re-educated using proper procedure.</p> <p>DON or designee will audit incident reporting requirements to the South Dakota Department of Health once per week for 4 weeks and once per month for two months.</p> <p>DON or designee will present the audit findings at the monthly QAPI meeting for review.</p> <p><i>*all DH/SDDOH/EL</i></p> <p><i>*resident 4's medical record was reviewed and could not be revised. DH/SDDOH/EL</i></p>	7/1/16

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F 226	<p>Continued From page 6</p> <p>-Her right wrist to be wrapped. -Pain medications twice. *On 1/15/16 she had refused personal care. *On 1/19/16 she: -Was lethargic (tired, fatigued). -Had requested more medication. -Had refused to move her right hand.</p> <p>On 1/22/16 she had been seen by her physician and an X-ray of her right wrist was ordered. *On 1/25/16 she had refused care. *On 1/26/16: -An X-ray was performed on her right wrist at an emergency department. -The emergency department discharge instructions had shown a "closed extra-articular fracture of distal end of right radius [broken wrist]." *No documentation was found indicating the facility had informed the SD DOH of that fracture.</p> <p>Interview on 5/18/16 with the interim director of nursing revealed she: *Confirmed the SD DOH was not notified of that fracture. *Had not been aware the SD DOH was to have been notified of fall when an injury had been discovered after the fall.</p> <p>Review of the provider's June 1, 2015 Resident Accident Prevention Policy revealed "Severe injuries that result in an immediate physician exam or ER [emergency room] visits will be sent within 2 hours to the Department of Health."</p> <p>Review of the provider's revised 6/10/14 Vulnerable Adult Abuse and Neglect/Alleged or Suspected Elder Abuse Required Nursing Facility Event Reporting and Investigation policy</p>	F 226		

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F 226	Continued From page 7 revealed: *They were to refer to the Instructions for Use of Required Nursing Facility Event Reporting Form. *That form stated "If a fall occurs and the provider determines there were no injuries at that time but later there is discovery of an injury and it is of a serious nature, then the event should be reported." *The provider's policy's definition of a serious bodily injury was "an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or requiring medical intervention such as surgery, hospitalization, or physical rehabilitation."	F 226		
F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services 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: 33265 Based on observation, interview, record review, job description review, and policy review, the provider failed to intervene for: *One of one recently admitted sampled resident (6) with multiple unmet needs. *One of one sampled resident (12) transferred from the facility. Findings include: 1. Interview on 5/18/16 at 9:40 a.m. with the	F 250	Facility reviewed list of resident 6's unmet needs and intervened to make sure they are addressed. All other residents with unmet needs were reviewed and addressed. DON, administrator, and interdisciplinary team reviewed and revised as necessary the policy and procedures regarding resident rights relating to physician and ombudsman services, admission agreement and the social service designee's job description. Administrator or designee will implement a new progress note to include a date and time column to establish a link between documentation and services provided. Administrator or designee will audit the resident care plan progress notes per MDS	7/1/16

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F 250	<p>Continued From page 8</p> <p>social services designee regarding resident 6 revealed:</p> <p>*The resident repeatedly had been calling physicians. The provider preferred to have nursing fax physicians questions instead of residents calling physicians.</p> <p>*The resident repeatedly had been calling the ombudsman.</p> <p>*The resident was assigned her present physician by the social worker at the hospital she was transferred from. Her present physician was one of two physicians who came to the facility from Canton.</p> <p>*The social services designee had given the resident the social history form to fill in on admission.</p> <p>-The social service designee had not received the form back from her, nor had asked her about it since giving her the form.</p> <p>*The social services designee talked to the resident once or twice daily, but had not documented the daily visits.</p> <p>*If the resident wanted to see her physician of choice she would have had to pay for the transportation to Sioux Falls. The Minimum Data Set (MDS) coordinator would explain the reason for that.</p> <p>*The resident got a bath twice a week, and her hair was braided then.</p> <p>*The social services designee stated the diet pop the resident liked was in the facility, but the resident had not received any yet.</p> <p>Review of the 8/15/13 Social Services Designee job description revealed she was expected to:</p> <p>*Work with interdisciplinary team to provide psychological support to residents.</p> <p>*Counsel the resident and assist in development of needs.</p>	F 250	<p>schedule or significant change to ensure proper documentation of the services provided once a month for three months.</p> <p>Administrator or designee will develop an admission checklist to include social history, admission agreement documentation and forms to ensure appropriateness and timeliness.</p> <p>DON, administrator, and Interdisciplinary Team reviewed and revised as necessary the policy and procedures for obtaining physician orders, signing a transfer notice, and documenting the resident transfer and discharge.</p> <p>All staff responsible for transfer and discharge were re-educated for proper procedure.</p> <p>DON or designee will audit documentation regarding proper resident transfer and discharge procedure once per week for 4 weeks and once per month for two more months.</p> <p>DON or designee will present the audit findings at the monthly QAPI meeting for review.</p> <p><i>*all DISCLOSED</i></p>		

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F 250	<p>Continued From page 9</p> <ul style="list-style-type: none"> *Assist in organizing all social services needs of the resident including completion of required forms. *Develop and maintain involvement with residents. *Assess resident's social, emotional, and psychological needs throughout their stay and utilize resources to meet needs. *Continually maintain contact with residents concerning all aspects of their residency. *Gather resident's social history during admission process. *Ensure resident's needs are met. *Communicate pertinent information to essential personnel. *Able to express self in writing. *Documentation of plan and progress. *Be the resident advocate at all times. *Identify psychosocial needs of the resident and make referrals as necessary. *Assist with taking residents to appointments as necessary. *Assist in coping with and solving issues with resident's every day lives and relationships. *Inform residents of their rights. <p>Refer to F309 finding B.1.</p> <p>2. Record review regarding the transfer of resident 12 revealed:</p> <ul style="list-style-type: none"> *He had been admitted on 4/29/16. *He had been exhibiting inappropriate social behaviors from 5/2/16 to 5/8/16. *On 5/9/16 at an unidentified time the social services designee notified a social worker at the hospital that provided care for the resident. She informed the social worker of the inappropriate social behaviors. She documented she was told to send him to the emergency department. 	F 250			

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NAME OF PROVIDER OR SUPPLIER ALCESTER CARE AND REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 101 CHURCH STREET ALCESTER, SD 57001
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F 250	<p>Continued From page 10</p> <p>*There had been no documentation of the notification of the resident's physician.</p> <p>*There had been no documentation of who transferred the resident, how the resident was transferred, when the resident was transferred, where the resident was transferred to, or why the resident was transferred.</p> <p>Interview on 5/18/16 at 1:15 p.m. with the DON revealed she agreed there should have been a transfer form. And the physician should have been notified of the change of condition of the resident regarding behaviors.</p> <p>Record review and interview on 5/18/16 at 1:20 p.m. with the social services designee regarding the above for resident 12 revealed:</p> <p>*She had made the call to the social worker at the hospital.</p> <p>*She had not recorded a time in her documentation and was unable to remember the time she had contacted the social worker at the hospital.</p> <p>*She had not gone any further with the transfer, as she believed that was the nurse's responsibility.</p> <p>Review of the 8/15/13 Social Services Designee job description revealed she was to:</p> <p>*Assist in organizing all social service needs of the residents including discharge planning and completion of required forms.</p> <p>*Compile and maintain current and accurate information.</p> <p>*Coordinate discharge plans between resident, family, physician, facility personnel, and outside resources.</p> <p>*Responsible for documenting the discharge plan in the medical record.</p>	F 250		

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F 250	Continued From page 11 Interview on 5/18/16 at 3:00 p.m. with the administrator revealed he agreed there should have been documentation of the transfer of the resident to another facility. Review of the provider's 9/3/08 Notification of Change in Resident Status policy and procedure revealed the facility was to have immediately informed the resident's physician if there was a decision to transfer or discharge the resident from the facility. Review of the provider's 12/11/09 Discharge/Transfer of the Resident policy and procedure revealed: *A physician's order for transfer was to have been obtained unless the transfer was an emergency. *A signed transfer notice was to have been completed and sent with the responsible party transferring the resident. *The transfer form was to have been completed, and any information necessary for the care of the resident copied and sent with resident.	F 250			
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. This REQUIREMENT is not met as evidenced by:	F 309	Resident 4's care plan were reviewed and revised as necessary to include following physician orders, effective pain management and assessment. All other resident's care plan were reviewed and revised as necessary for following physician orders, effective pain management and assessment. DON or designee will provide education to all staff responsible for tasks relating to following physician orders, effective pain management and assessment.	7/7/16	

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F 309	Continued From page 12 Surveyor: 35121 A. Based on record review, interview, and policy review, the provider failed to: *Obtain medical services for one of two sampled residents (4) who had a fall with an injury. *Completely document pain assessments for one of one sampled resident (4) who had complaints of wrist pain. Findings include: 1. Review of resident 4's medical record revealed: *On 1/8/16 at: -1: 30 p.m. she had an unwitnessed fall. -3:30 p.m. she had complained of right hand pain. -11:00 p.m. there was "slight swelling noted above R [right] thumb on hand." *On 1/9/16: -Her physician was notified of the 1/8/16 fall. -She had complained of "R [right] wrist pain - tender and swollen." *On 1/10/16: -Her right hand was wrapped in an elastic bandage (ACE). -She refused to let staff unwrap it for assessment. *1/11/16: -A physician's order was received to "Wrap [her right wrist] with [an] ACE (elastic bandage); if not improving should get X-ray of R [right] wrist." -Physical therapy was to assess and treat the right wrist that day. -She refused assistance with personal care. -It was documented that she had "manipulative behaviors." *The 12/1/15 Minimum Data Set (MDS) assessment indicated she was cognitively intact. *The 2/20/16 MDS indicated she had disorganized thinking and modified independence (some difficulty in new situations only).	F 309	DON or designee will provide education to all staff responsible for tasks relating to following physician orders, effective pain management and assessment. DON, administrator, and interdisciplinary team reviewed and revised physician services policy, admission agreement and Medicare Benefits Policy Manual. All staff responsible for following physician services, admission agreement and Medicare Benefits Policy were re-educated to ensure appropriateness. Resident 8's care plan was reviewed to include emergency intervention for the dialysis fistula care. All other residents on dialysis care plans were reviewed and revised as necessary to include emergency intervention for the dialysis fistula care. DON, administrator, and interdisciplinary team reviewed the dialysis and fistula policy. DON and interdisciplinary team will provide education for dialysis intervention and fistula care. Resident 9's care plan was reviewed and revised to be individualized under hospice care. All other residents on hospice care had		

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F 309	<p>Continued From page 13</p> <p>*She had complained specifically of right wrist pain on six days from 1/8/16 to 1/22/16.</p> <p>*There was no documentation that had rated her pain on a pain scale on the above days.</p> <p>*The 12/1/15 and 2/20/16 MDS assessments indicated frequent pain with a pain rating of 8 on a 0 to 10 scale.</p> <p>*She had swelling of her right hand, wrist, arm, or fingers on nine days from 1/8/16 to 1/25/16.</p> <p>*On 1/11/16 she had refused personal care and had "Manipulative behaviors."</p> <p>*On 1/14/16 she had requested her right wrist to be wrapped and wanted pain medications twice.</p> <p>*On 1/15/16 she had refused personal care.</p> <p>*On 1/19/16 she:</p> <ul style="list-style-type: none"> -Was lethargic (tired, fatigued). -Had requested more medication. -Had refused to move her right hand. <p>On 1/22/16 she had been seen by her physician, and an X-ray of her right wrist was ordered.</p> <p>*On 1/25/16 she had refused care.</p> <p>*On 1/26/16:</p> <ul style="list-style-type: none"> -An X-ray was performed on her right wrist at an emergency department. -The emergency department discharge instructions had shown a "closed extra-articular fracture of distal end of right radius [broken wrist]." <p>*A "Y" was written on the pain assessment area on her January 2016 treatment form on days 7, 14 and 21. Day 28 area was blank.</p> <p>*There was no documentation on her January 2016 pain management flowsheet.</p> <p>*She had verbal aggression and/or refusal of care documented on her January 2016 mood and behavior flowsheet on days 4, 17, 21, and 28.</p>	F 309	<p>their care plans reviewed and revised to be individualized.</p> <p>DON or designee will audit including, but not limited to weekly pain assessments, pain flow sheet, resident intense pain assessments, individualized care plans for residents on hospice care, follow physician orders, and fistula care interventions once per week for 4 weeks and once per month for two more months.</p> <p>DON or designee will present the audit findings at the monthly QAPI meetings for review.</p>	
	Interview on 5/18/16 with the interim director of			

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F 309	<p>Continued From page 14</p> <p>nursing (DON) regarding resident 4 revealed:</p> <ul style="list-style-type: none"> *If a "Y" was written on the pain assessment area on the treatment form she would have expected to see further documentation on the pain management flowsheet. *A "Y" was written on the pain assessment area on her January 2016 treatment form on day 7, 14, and 21. Day 28 area was blank. *There was no documentation on her January 2016 pain management flowsheet. *The resident was able to rate her pain verbally on a 0 to 10 pain scale (0 meaning no pain and 10 meaning severe pain). *There was no documentation with specific number ratings for her complaints of right wrist pain. *She had been given PRN (as needed) pain medications based on her complaints of right wrist pain. *She confirmed: <ul style="list-style-type: none"> -The behaviors documented on her behavior sheets did not indicate her complaints of pain were behavior issues. -They had not followed their pain assessment policies regarding documentation and assessment of her pain. <p>The physician had ordered an X-ray if there were no signs of improvement on 1/11/16.</p> <ul style="list-style-type: none"> -Complaints of pain, swelling, refusals of care and behaviors might have been indications of a potential injury. -The X-ray was not obtained until 1/26/16. <p>She had symptoms that had indicated the 1/11/16 physician's order for an X-ray should have been followed earlier.</p> <p>Review of the provider's 8/20/12 Weekly Pain Assessment policy revealed:</p> <p>*Pain assessments were done to assess pain "on</p>	F 309		

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F 309	<p>Continued From page 15</p> <p>a routine and ongoing basis...according to the resident's cognitive abilities."</p> <p>***If the resident's pain level is less than or equal to 3 on a 0-[to]10 scale, mild, or a 1 or less on a 0-5 scale than [then] proceed with your routine pain assessment protocol."</p> <p>***If the resident's pain is greater than or equal to 4 on a 0-10 scale, moderate to severe, or greater than 1 on a 0-5 scale than [then] evaluate need for administration of current pain intervention and/or need for further/different interventions."</p> <p>Review of the provider's 4/10/10 Intense Pain Weekly Pain Assessment policy revealed:</p> <p>***In addition to weekly pain assessments, a nurse can check a resident's intense pain during pill passes, checking of weekly B/Ps [blood pressures] or any other time throughout the day."</p> <p>***If the resident's pain level is less than or equal to 3 on a 0-10 scale, mild, or a 1 or less on a 0-5 scale than [then] proceed with your weekly routine pain assessment protocol."</p> <p>***If the resident's pain is greater than or equal to 4 on 0-10 scale, moderate to severe, or greater than 2 on a 0-5 scale than [then] initiate a pain flow sheet."</p> <p>***Pain flow sheets need to be completed every 4 hours for 24 hours. If anytime in that 24 hours the resident is not getting satisfactory pain relief with non-pharmacological (not medication) and/or pharmacological (medication) interventions, the physician should be contacted."</p> <p>***The pain flow sheet may be discontinued at the end of 24 hours if the resident has achieve appropriate pain relief within the 24 hour assessment period."</p> <p>***Document all findings in the nurse's notes in the resident's chart. (Initiation of the 24 hour pain flow sheet and why, if the physician was called for</p>	F 309			

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F 309	<p>Continued From page 16 inadequate pain control, and any changes in pain regime)."</p> <p>A policy for following physician's orders was requested from the DON but one was not provided by the end of the survey on 5/18/16.</p> <p>Surveyor: 33265 B. Based on observation, record review, interview, and policy review, the provider failed to: *Ensure necessary care and services related to dietary needs, activities, and physicians services for 1 of 11 sampled residents (6) were identified and addressed. *Ensure the care plan had emergency interventions for the potential of sudden bleeding from the dialysis shunt site for one of one sampled resident (8) who received dialysis. *Ensure a coordinated plan of care was in place for one of one sampled resident (9) who received hospice services. Findings include:</p> <p>1. Observation and interview with resident 6 on 5/16/16 at 2:20 p.m. revealed: *She had been admitted on 5/4/16 for rehabilitation. *She had an ankle fracture that had not healed correctly and was causing pain when walking was attempted. *She had been living in an apartment that had a flight of stairs that she had difficulty maneuvering. *She was laying on top of her bed. Her hair was in a loose braid with several stands of hair out of the braid. *She was not happy with how she had been treated.</p> <p>*Regarding food and drink:</p>	F 309		

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F 309	<p>Continued From page 17</p> <ul style="list-style-type: none"> -She had been told they were out of yogurt, and she would have to buy her own. She would also have to buy her own real fruit juice. -On admit she had informed them she drank a certain diet soda. They did not have that in the pop machine but would get it. She was later told they had the pop, but she would have to wait for a space in the pop machine to empty out. She had not received any as of yet. -She was placed on a constant carbohydrate diet that she had not been instructed on. She received bread at every meal which she usually had not eaten. -She had not been asked her food preferences. If she had been asked she would have informed them she did not eat bread. -On 5/16/16 at breakfast she was told her fluid limit had been cut in half and was served no fluids at breakfast. She had no fluids from breakfast to lunch. At lunch that same day she was told it was an error, and she was given fluids. *Regarding physician choice: -She had not selected her present physician. She had another physician who had agreed to accept her as a patient, but that physician had not been contacted. -Her present physician was not accessible to her. She had repeatedly asked for the physician's phone number and was refused. She asked for a phone book and was refused. *She was not sure why the isolation sheet was on her door. <p>Interview on 5/16/16 at 2:35 p.m. with the interim director of nursing (DON) revealed she was not aware of where resident 6's infection was.</p> <p>Observation on 5/16/16 at 5:40 p.m. of resident 6 at dining room table revealed:</p>	F 309			

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F 309	<p>Continued From page 18</p> <p>*She received a sandwich, baked beans, tomato juice, milk, and diced pears.</p> <p>*She requested assistance from dietary staff serving the diced pears and stated she did not want all that bread. She also requested a banana instead of pears.</p> <p>Continued record review and interview with resident 6 on 5/17/16 at 11:00 a.m. revealed:</p> <p>*She still had not received any of her pop of choice. She had been told it was in the facility but not in the pop machine.</p> <p>*She went to activities if she was aware of them, but she had difficulty reading print.</p> <p>-She could not read the activities calendar taped to the wall at the end of the bed.</p> <p>*She had not been able to get to the circle activity due to conflicts with her therapy schedule.</p> <p>*She had been told there was praying of the rosary. There was no rosary prayer time listed on the May 2016 schedule posted.</p> <p>*One piece of her mail had been opened by the facility staff. The social services designee had told her they had read the first line of the address only. The first line had been the name of the facility. The second line had been the resident's name.</p> <p>*She had no living relatives to speak for her.</p> <p>*Her assigned physician had visited her the previous week and told her she was not changing any medication orders.</p> <p>-The resident started experiencing bladder spasms the weekend after the physician visit.</p> <p>-The resident had been told the physician had discontinued the medication for bladder spasms on the visit the previous week.</p> <p>-The medication was restarted.</p> <p>*She had a history of kidney failure.</p> <p>-She was on hospice for four weeks, then the</p>	F 309		

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F 309	<p>Continued From page 19</p> <p>kidneys started to function again.</p> <p>*There was no diagnosis regarding kidney function was in medical record.</p> <p>*She had a history of post traumatic stress disorder (PTSD) and requested to keep her appointment with the psychologist in June. She was told PTSD was not related to her rehabilitation, so she would not be going to that appointment.</p> <p>*She had an appointment tomorrow to see an orthopedic surgeon. She was seeking a second opinion to see if she would be able to get the ankle repaired so she would be able to walk.</p> <p>*Her hair had been in the same condition as yesterday, a loose braid with several strands of hair outside of the braid.</p> <p>-She stated only certain staff members would braid her hair.</p> <p>Observation on 5/17/16 at 12:16 p.m. of resident 6 revealed:</p> <p>*She had ordered tomato soup for lunch.</p> <p>*She was served chicken soup that she refused. She stated she had ordered tomato soup. She was told they ran out of tomato soup.</p> <p>*The table she was seated at was served last at lunch.</p> <p>Observation and interview on 5/17/16 at 4:00 p.m. with resident 6 and the activities coordinator revealed:</p> <p>*She had heard the activities coordinator was taking a group out to see a movie.</p> <p>*She had told the activities coordinator she had not known there was a movie outing.</p> <p>*The activities coordinator told her she had not told her, because she was on Medicare A and could not leave for outings.</p>	F 309		

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F 309	<p>Continued From page 20</p> <p>1. Interview on 5/18/16 at 9:40 a.m. with the social services designee regarding resident 6 revealed:</p> <p>*The resident repeatedly had been calling physicians. The provider preferred to have nursing fax physicians questions instead of residents calling physicians.</p> <p>*The resident repeatedly had been calling the ombudsman.</p> <p>*The resident was assigned her present physician by the social worker at the hospital she was transferred from. Her present physician was one of two physicians who came to the facility from Canton.</p> <p>*The social services designee had given the resident the social history form to fill in on admission.</p> <p>-The social service designee had not received the form back from her, nor had asked her about it since giving her the form.</p> <p>*The social services designee talked to the resident once or twice daily, but had not documented the daily visits.</p> <p>*If the resident wanted to see her physician of choice she would have had to pay for the transportation to Sioux Falls. The Minimum Data Set (MDS) coordinator would explain the reason for that.</p> <p>*The resident got a bath twice a week, and her hair was braided then.</p> <p>*The social services designee stated the diet pop the resident liked was in the facility, but the resident had not received any yet.</p> <p>Interview on 5/18/16 at 10:00 a.m. with the dietary manager regarding resident 6 and her diet revealed:</p> <p>*She and the dietitian had attempted to visit with the resident yesterday, but the resident was on</p>	F 309			

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F 309	<p>Continued From page 21</p> <p>the telephone when they had attempted.</p> <p>*The dietitian had educated the dietary staff on the constant carb diet yesterday. No one had asked the resident about questions regarding the constant carb diet or her food preferences yet.</p> <p>*The resident had requested yogurt at every meal. They had run out of yogurt and had to wait for supplies. The type of yogurt she wanted was not an item they could order from their supplier.</p> <p>*When asked how the resident received her bedtime snack the dietary manager said she assumed the certified nursing assistant (CNA) had brought it to her.</p> <p>*The dietary manager had not known if the resident was instructed she would need to ask for snacks to be brought to her room. She supplied the snacks and nursing was responsible after that.</p> <p>Interview on 5/18/16 at 10:10 a.m. with resident 6 revealed:</p> <p>*She had awoken at 2:30 a.m. and was hungry and in pain.</p> <p>*She had called for assistance, and CNA B responded.</p> <p>*She requested he tell the nurse she needed something for pain and also needed a snack.</p> <p>*She received neither.</p> <p>*The dietary manager had spoken to her yesterday, and the dietary manager was aware she wanted an afternoon snack. She had not received one.</p> <p>*At supper the previous evening she had eaten a banana, a yogurt, and coffee. She had refused the sandwich. She had no bedtime snack.</p> <p>*She was not aware there were bedtime snacks made for the residents.</p> <p>*She was not aware she had to ask for those snacks to be brought to her room.</p>	F 309		

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F 309	<p>Continued From page 22</p> <p>Interview and activity calendar review on 5/18/16 at 10:40 a.m. with the activities coordinator regarding resident 6 revealed: *She was aware the resident needed large print books to read. She would get an activity calendar at the bedside for the resident. *There was a volunteer that would say the rosary with people. That was not on the calendar. *There was now a Catholic mass scheduled twice a month. She had not added that on the May 2016 calendar.</p> <p>Interview on 5/18/16 at 10:53 a.m. with the MDS coordinator regarding resident 6 revealed: *The resident had requested to see her psychologist but was not going to be able to go while she was on Medicare A. *The resident had requested to see a physician she had contacted in Sioux Falls. She would not be able to, because the facility would have to pay for the transportation. They used the physicians in Canton who came to the facility. *Resident 6 would not be going on outings while on Medicare A, because the only outings allowed were those related to rehabilitation. *When documentation was requested to support the above the Medicare Benefit Policy Manual, chapter 8, coverage of extended care was provided.</p> <p>Observation and interview on 5/18/16 at 1:00 p.m. with resident 6 revealed: *She had missed her appointment with her orthopedic surgeon. *The facility van had been sent elsewhere. *She believed she would be out of rehabilitation benefits before she would be able to see the orthopedic surgeon again.</p>	F 309			

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F 309	<p>Continued From page 23</p> <p>Interview on 5/18/16 at 1:35 p.m. with the administrator revealed the facility van driver had taken another resident to Canton. Instead of returning to take resident 6 to her appointment in Sioux Falls, the driver had waited for the other resident at Canton.</p> <p>Interview and record review on 5/18/16 at 3:00 p.m. with the administrator regarding resident 6 revealed he agreed:</p> <ul style="list-style-type: none"> *The resident was not satisfied with her present treatment. *Agreed the resident should not have missed her appointment with the orthopedic surgeon. *Agreed Medicare A was not a reason to withhold short outings or previous physician appointments. *Thought the resident was agreeable to waiting for her pop until a space became available in the pop machine. *Thought the resident had agreed to the present physician assigned to her. *Was not aware staff had refused to provide the physician's phone number and/or a phone book to her. *Was not aware she had not been instructed in her new diet. *Was not aware the social services designee was not documenting all visits with residents regarding their needs. <p>Review of the provider's 4/17/10 Physician Services policy revealed the resident had a right to choose a personal attending physician.</p> <p>Review of the 10/16/15 Medicare Benefits Policy Manual supplied by provider revealed a resident was able to be granted a pass to attend outings while on Medicare A.</p>	F 309		

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F 309	<p>Continued From page 24</p> <p>Review of the 8/15/13 Social Services Designee job description revealed she was expected to:</p> <ul style="list-style-type: none"> *Work with interdisciplinary team to provide psychological support to residents. *Counsel the resident and assist in development of needs. *Assist in organizing all social services needs of the resident including completion of required forms. *Develop and maintain involvement with residents. *Assess resident's social, emotional, and psychological needs throughout their stay and utilize resources to meet needs. *Continually maintain contact with residents concerning all aspects of their residency. *Gather resident's social history during admission process. *Ensure resident's needs are met. *Communicate pertinent information to essential personnel. *Able to express self in writing. *Documentation of plan and progress. *Be the resident advocate at all times. *Identify psychosocial needs of the resident and make referrals as necessary. *Assist with taking residents to appointments as necessary. *Assist in coping with and solving issues with resident's every day lives and relationships. *Inform residents of their rights. <p>Review of the provider's 10/30/15 MDS Coordinator job description revealed she was to:</p> <ul style="list-style-type: none"> *Assist in planning, organizing, and directing the activities of the nursing department. *Work towards the goal of reaching the highest level of functioning and independence for each 	F 309			

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F 309	<p>Continued From page 25 resident.</p> <p>Review of the provider's undated dietary department information in the admission packet revealed: *If at any time meal options were not appealing, the resident should request short order items in advance and the kitchen staff would do their best to accommodate the request. *There was no information on snacks provided.</p> <p>Review of the provider's undated Meal Times policy revealed bedtime snacks were available at the nurses station.</p> <p>2. Review of resident 8's undated care plan revealed there was no emergency intervention for sudden bleeding from the dialysis shunt site documented.</p> <p>On 5/18/16 at 2:05 p.m. the administrator was asked for a policy on dialysis resident care or dialysis shunt care.</p> <p>Interview and record review on 5/18/16 at 3:00 p.m. with the administrator revealed he: *Was unable to locate a policy or procedure on dialysis resident care or dialysis shunt care. *Agreed there was no emergency intervention for sudden bleeding from the dialysis shunt site documented on the care plan.</p> <p>Surveyor: 32335</p> <p>3. Review of resident 9's medical record revealed: *She had started hospice services on 1/5/16. *Her undated care plan had the following hospice interventions:</p>	F 309		

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F 309	Continued From page 26 -For mood and behaviors it stated "On hospice care." -For weight loss it stated "Hospice is involved in my care." -For communication it stated "On hospice care." -For social history it stated "On hospice care." -For discharge planning it stated "On hospice care." -For terminal prognosis it stated "Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met." *The hospice provider had a separate care plan that had not been individualized to resident 9. Interview on 5/18/16 at 10:00 a.m. with the MDS coordinator revealed the care plans were not coordinated and had not identified the specific roles of each provider. She was unaware of who was providing what cares each day. Review of the provider's 2/1/15 services agreement with the hospice agency revealed the plan of care should have reflected the participation and services of the Hospice, Facility, and Hospice patient and family to the extent possible.	F 309			
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.	F 368	Dietary Manager and Registered Dietitian reviewed and revised the bedtime snack policy and to ensure snacks are offered as well as available to residents. Dietary Manager will provide education for facility staff regarding the policy and procedure for delivering bedtime snacks. Dietary Manager or designee will audit the	7/1/16	

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F 368	<p>Continued From page 27</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on interview and policy review, the provider failed to offer snacks to all residents at bedtime. Findings include:</p> <p>1. Interview on 5/17/16 at 10:30 a.m. with resident 7 revealed they were not offered snacks at bedtime.</p> <p>Review of the provider's undated Meal Times policy revealed bedtime snacks were available at the nurses station.</p> <p>Interview on 5/17/16 at 11:00 a.m. with the dietary manager revealed dietary put the bedtime snacks into the refrigerator by the nurses station. The certified nursing assistants (CNA) were responsible for passing them out.</p> <p>Interview on 5/18/16 at 2:00 p.m. with CNAs C and D revealed they did not have time to pass snacks at night. They used to take the cart around to each room, but they did not anymore. If residents asked for them they would go get one for them.</p>	F 368	<p>delivery of snacks once per week for 4 weeks and once per month for two more months.</p> <p>Dietary Manager or designee will present the audit findings at the monthly QAPI meetings for review.</p>	
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F 368	Continued From page 28 Surveyor: 33265 2. Interview on 5/18/16 at 10:10 a.m. with resident 6 revealed: *At supper the previous evening she had eaten a banana, a yogurt, and coffee. She had refused the sandwich. She had no bedtime snack. *She was not aware there were bedtime snacks made for the residents. *She was not aware she had to ask for those snacks to be brought to her room. 3. Review of the provider's undated Snack Available policy revealed bedtime snacks were stocked in the refrigerator in the nursing department. There had been no procedure on who was responsible for passing the bedtime snack.	F 368			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the	F 431	DON, administrator and interdisciplinary team reviewed and revised as necessary the policy and procedure for medication labeling and expiration of medication. DON or designee will provide education on the policy and procedure for medication labeling and proper disposal of expired medication. DON or designee will audit medication labeling and expiration of medication once per week for 4 weeks and once per month for two more months. DON or designee will present the audit findings at the monthly QAPI meetings for review.	7/7/16 *TO ALL staff responsible DH/SDDCH/EL	

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F 431	<p>Continued From page 29</p> <p>facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation and interview, the provider failed to ensure: *Three of three randomly observed hand-held inhalers for single resident use in the west wing medication cart were labeled with the resident's name, instructions for use, and expiration date. *Medications past the expiration dates were removed from the west wing medication cart. Findings include:</p> <p>1. Observation and interview on 5/18/16 at 1:55 p.m. with the interim director of nursing (DON) while reviewing the west wing medication cart revealed: *Three hand held inhalers for single resident use were in the top drawer of the medication cart. *None of the three inhalers had a label identifying the name of the resident, instructions for use, or the expiration date.</p>	F 431		
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F 431	Continued From page 30 *The interim DON stated those had been at the residents' bedside. *She was able to identify who two of the three inhalers belonged to. *She agreed the inhalers should have had the name of the resident, instructions for use, and the expiration date on the inhalers. *A packet of four warfarin (blood thinning medication) tablets was found in the top drawer of the west medication cart. *The DON stated those were from the stock supply and were not able to be returned to the pharmacy so were kept in the drawer. *The expiration date on the packet was 1/10/16. *She agreed the medication should have been removed and destroyed. Review of the provider's 6/2/15 Medication Administration and Storage policy revealed all medications were to be checked for expiration and if the date of expiration had occurred and was passed, the medication was to have been removed from the medication cart and destroyed or returned to pharmacy. Policies and procedures for medication labeling were requested from the administrator on 5/18/16 at 2:05 p.m. On 5/18/16 at 3:00 p.m. the administrator stated he was unable to locate policies related to the above topics.	F 431			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	DON, administrator and interdisciplinary team reviewed and revised as necessary the policy and procedure for sterile wound dressing changes, non-sterile wound dressing changes, handwashing, and properly sanitizing glucometer.	7/7/16	

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F 441	Continued From page 31 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Surveyor: 35121 Based on observation, record review, interview, and policy review, the provider failed to ensure proper infection control practices were followed for:	F 441	DON or designee will provide education on proper handwashing and sanitizing glucometer for staff responsible for this task. DON or designee will audit proper handwashing and glucometer sanitization once per week for 4 weeks and once per month for two more months. <i>*to include residents 6, 8, and 16.</i> <i>DISPOOTHEL</i> DON or designee will present the audit findings at the monthly QAPI meetings for review.		

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F 441	<p>Continued From page 32</p> <ul style="list-style-type: none"> *Two of two dressing changes for two of two observed residents (8 and 16). *One of two observed catheter cares for one of two sampled residents (6). *Two of two observed glucometer (equipment to measure blood sugar level) cleanings. <p>Findings include:</p> <p>1. Observation and interview on 5/17/16 at 10:19 a.m. with the interim director of nursing (DON) regarding a dressing change for resident 16 revealed she:</p> <ul style="list-style-type: none"> *Removed a soiled dressing from his forearm wound with gloved hands. *Discarded the soiled dressing and gloves into the garbage. *Had not washed her hands. *Had put on another pair of gloves and applied a clean dressing. *Agreed she should have washed her hands or used alcohol hand gel after removing the soiled dressing and gloves. <p>Interview on 5/17/16 at 2:45 p.m. with the infection control nurse confirmed:</p> <ul style="list-style-type: none"> *She would have expected the above nurse to have washed her hands after removing the gloves. *Their wound dressing change policies were not accurate and should have been updated to reflect standard hand washing practices. *They did not follow their own standard precautions policy. <p>2. Observation and interview on 5/18/16 at 8:45 a.m. with registered nurse (RN) A regarding a dressing change for resident 8 revealed she:</p> <ul style="list-style-type: none"> *Applied gloves. *Removed a soiled dressing and cleansed the 	F 441			

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NAME OF PROVIDER OR SUPPLIER ALCESTER CARE AND REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 101 CHURCH STREET ALCESTER, SD 57001		
(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 441	<p>Continued From page 33 wound.</p> <ul style="list-style-type: none"> *Removed her soiled gloves and discarded them. *Had not washed her hands. *Applied new gloves. *Removed soiled elastic gauze wrap from another wound. *Removed clean gauze from a bag with her soiled gloved hand. *Had cleansed that wound with that gauze. *Removed her soiled gloves and discarded them. *Had not washed her hands. *Applied new gloves. *Confirmed she should have washed her hands each time after she had removed the gloves. *Agreed she had contaminated the gauze in the bag by touching it with her soiled gloved hand. <p>Review of the provider's revised 4/17/10 Sterile Wound Dressing Change policy revealed the following steps:</p> <ul style="list-style-type: none"> **"Put on sterile gloves." **"Remove soiled dressings and discard in plastic bag." **"Remove gloves and put on second pair of sterile gloves." **"Wash hands." <p>Review of the provider's revised 4/17/10 Non-Sterile Wound Dressing Change policy revealed the following steps:</p> <ul style="list-style-type: none"> **"Put on clean gloves." **"Remove soiled dressings and discard in plastic bag." **"Remove gloves and put on clean gloves." <p>Review of the provider's revised 6/22/11 Standard Precautions policy revealed they were to wash their hands immediately after gloves had been removed.</p>	F 441			

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

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NAME OF PROVIDER OR SUPPLIER ALCESTER CARE AND REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 101 CHURCH STREET ALCESTER, SD 57001
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F 441	<p>Continued From page 34</p> <p>A specific handwashing policy was requested from the DON and the administrator, but none had been provided before the end of the survey on 5/18/16.</p> <p>Surveyor: 33265</p> <p>3. Observation and interview on 5/17/16 at 9:30 a.m. with the interim director of nursing (DON) in resident 6's room for supra pubic catheter (tube placed directly into bladder to drain urine) care revealed:</p> <ul style="list-style-type: none"> *She had assembled the equipment needed and washed her hands. *She put on clean gloves. *She cleaned the supra pubic opening area. *She discarded the used supplies and the gloves in the garbage. *She put on clean gloves without washing her hands. *She applied cream to the reddened area around the site, then removed her gloves, and discarded them in the garbage. *She washed her hands seven seconds. *She agreed that was her standard process for supra pubic catheter care. <p>4. Observation on 5/16/16 at 4:35 p.m. with the interim DON during medication administration pass revealed:</p> <ul style="list-style-type: none"> *Resident 17's blood sugar level was tested. *Following the test the glucose meter (device used) was scrubbed for eight seconds with a Super Sani-Cloth disinfectant. *The glucose meter was then placed in the medication cart drawer for storage. The Super Sani-Cloth wipe was placed on top of the box of clean lancets (used to prick skin for blood 	F 441		
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NAME OF PROVIDER OR SUPPLIER ALCESTER CARE AND REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 101 CHURCH STREET ALCESTER, SD 57001
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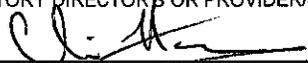
F 441	<p>Continued From page 35 sample).</p> <p>Continued observation and interview on 5/16/16 at 5:03 p.m. with the interim DON during the medication administration pass revealed:</p> <ul style="list-style-type: none"> *The used Super Sani-Cloth was removed from the top of the clean lancets and thrown in the garbage. *Resident 6's blood sugar level was tested. *Following the test the glucose meter was scrubbed for seven seconds with a Super Sani-Cloth disinfectant. *The glucose meter was then placed in the medication cart drawer for storage. The Super Sani-Cloth wipe was thrown in the garbage. *She agreed that was her usual process for cleaning the glucose meters after use. <p>Review of the manufacturers' instructions for cleaning the glucose meter and interview on 5/18/16 at 3:00 p.m. with the administrator revealed he agreed they were not following the cleaning time as directed by the manufacturer.</p> <p>Review of the undated manufacturer's instructions for the glucose meter disinfecting revealed they were to follow disinfectant manufacturer's directions.</p> <p>Review of the Super Sani-Cloth germicidal wipe label revealed they were to keep the surface wet with the solution for two minutes.</p>	F 441		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435062	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2016
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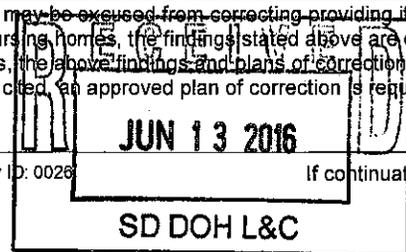
NAME OF PROVIDER OR SUPPLIER ALCESTER CARE AND REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 101 CHURCH STREET ALCESTER, SD 57001
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K 000	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 5/17/16. Alcester Care And Rehab Center, Inc. was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies upon correction of the deficiency identified at K038 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and interview, the provider failed to install a paved path of exit discharge to the public way at one of two lower level exits (south walk-out exit discharge). Findings include: 1. Observation at 10:30 a.m. on 5/17/16 revealed the south exit discharge from the lower level had a concrete sidewalk connecting the nursing home to the apartments. Previously the nursing home was connected to the apartments with an enclosed walkway. Interview with the maintenance supervisor at the time of the observation indicated the apartments were sold. The enclosed walkway had recently been removed. The new unenclosed exit would require a sidewalk approximately 200 feet long to the	K 038	The south walk-out exit discharge requiring a sidewalk to the nearest paved surface will be constructed. A bid has been approved. All other fire exits were reviewed for an appropriate sidewalk to a paved surface. Environmental Services Director or designee will audit all exit discharge paved surface once per month for three months. Environmental Services Director or designee will report the results of the audits at the monthly QAPI meetings for review.	7/7/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 6/1/16
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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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NAME OF PROVIDER OR SUPPLIER ALCESTER CARE AND REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 101 CHURCH STREET ALCESTER, SD 57001		
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K 038	Continued From page 1 nearest paved surface (street). The deficiency had the potential to affect only the staff as the lower level contains the laundry, maintenance, housekeeping, and staff break room. Ref: 2000 NFPA 101 Section 19.2.7, 7.7.1	K 038			

SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10591	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/18/2016
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NAME OF PROVIDER OR SUPPLIER ALCESTER CARE AND REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 101 CHURCH ST ALCESTER, SD 57001
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S 000	Compliance/Noncompliance Statement Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 5/16/16 through 5/18/16. Alcester Care and Rehab Center, Inc was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 5/16/16 through 5/18/16. Alcester Care and Rehab Center, Inc was found in compliance.	S 000		

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

TITLE

(X6) DATE



Administrator

6/11/2016