

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

ORIGINAL

PRINTED: 02/03/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/21/2016
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NAME OF PROVIDER OR SUPPLIER DOW RUMMEL VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1321 W DOW RUMMEL ST SIOUX FALLS, SD 57104
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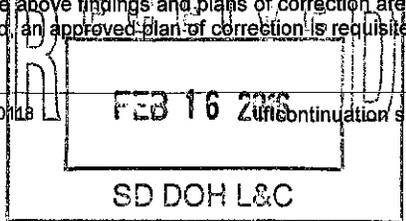
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F 000	<p><i>*Addendums noted with an asterisk per 2/13/16 per telephone with facility administrator.</i> Surveyor: 26180 CS/SDDOH/EL</p> <p>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/19/16 through 1/21/16. Dow Rummel Village was found not in compliance with the following requirements: F221, F280, F281, F329, F368, F371, F431, F441, F490, F492, and F514.</p> <p>Surveyor: 32331 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/19/16 through 1/21/16. Areas surveyed included resident neglect and dietary services. Dow Rummel Village was found not in compliance with the following requirement: F368.</p>	F 000	<p>Preparation, submission and implementation of the Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</p> <p>F221 RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The Interdisciplinary Team (IDT) met on 2/10/16 to review. The team felt all policies were in place regarding the use of side rails. Resident #10 had a physician order for side rails dated 3/16/15. The resident's medical chart had been thinned and the physician order was located in the medical records department.</p> <p>MDS Coordinator has reviewed residents #1, #7, and #10. Physical Restraint Elimination Review form will be completed at least quarterly going forward in coordination with their MDS completion by the MDS Coordinator or designee to determine restraint reduction or elimination.</p> <p>The MDS Coordinator or designee will complete a Physical Restraint</p> <p>(F221 continued to next page...)</p>	3/11/16
F 221 SS=E	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on observation, record review, interview, and policy review, the provider failed to ensure three of five sampled residents (1, 7, and 10) with side rails or positioning bars had completed quarterly assessments for the appropriateness of use. Findings include:</p>	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rebecca Tarish</i>	TITLE <i>Administrator</i>	(X6) DATE <i>2/13/16</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FEB 16 2016



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F 221	<p>Continued From page 1</p> <p>1. Observation on 1/19/16 at 2:00 p.m. of resident 10 revealed a quarter side rail on the right side of the bed in the upright position.</p> <p>Review of resident 10's medical record revealed: *On 3/13/15 an initial assessment was completed for the use of side rails. *No physician's order was located in the medical record for the use of the side rail. *A quarterly MDS assessment on 11/11/15 revealed: -Extensive assistance of two people was needed with bed mobility. -The bed rail was not coded as being used as a restraint. *Her undated care plan addressed turning and repositioning with the use of the side rail but also the resident's difficulty in doing so. *No documentation of quarterly assessments to evaluate the ongoing need for the positioning bar was present in the medical record.</p> <p>2. Observation on 1/20/16 at 7:20 a.m. of resident 1 revealed he: *Had a positioning bar on the right side of his bed in the upright position. *Used the bar to turn in bed and for assistance in getting to an upright position on the side of the bed.</p> <p>Review of resident 1's medical record revealed: *On 3/13/15 an initial assessment was completed for the use of the positioning bar. *On 3/16/15 a physician's order was obtained for its use. *A quarterly Minimum Data Set (MDS) assessment on 12/16/15 revealed: -Extensive assist of one person was needed with bed mobility.</p>	F 221	<p>Elimination Review for all other residents with side rails or other restraints at least quarterly in coordination with their MDS completion to determine restraint reduction or elimination. As part of the MDS Protocol, the MDS Coordinator or designee will document the appropriate use of side rails or other restraints.</p> <p>The MDS Coordinator or designee will meet with the Administrator or designee and furnish a list of residents due for physical restraint elimination review to the Administrator or designee weekly for one month, then monthly for three months.</p> <p>The Administrator or designee will report results to the Quality Assurance Performance Improvement (QAPI) Committee for a period of 4 months or until substantial compliance has been achieved and maintained as determined by the QAPI Committee.</p> <p><i>*On 2/16/16 an inservice with nursing staff occurred. The policy on restraints was reviewed by the director of nurses. CS/SPDO/HJL</i></p>	3/11/16

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F 221	<p>Continued From page 2</p> <p>-The bed rail was not coded as being used as a restraint.</p> <p>*His undated care plan did not address the use of the positioning bar.</p> <p>*No documentation of quarterly assessments to evaluate the ongoing need for the positioning bar.</p> <p>Surveyor: 35121</p> <p>3. Review of resident 7's medical record revealed:</p> <p>*A pre-restraining evaluation was completed on 5/19/14 that stated to review tabs and half side rails usage, appropriateness, reduction, and/or elimination monthly.</p> <p>*A physical restraint elimination review had been completed on 7/20/14, 10/29/14, and 1/28/15.</p> <p>*No other restraint review was found in the medical record.</p> <p>4. Interview on 1/21/16 at 9:00 a.m. with the MDS nurse regarding side rail assessments revealed she:</p> <p>*Did not complete assessments on a quarterly basis to evaluate the continued need and safety of the side rails or positioning bars.</p> <p>*Acknowledged "I don't keep up with that."</p> <p>Interview on 1/21/16 at 11:30 a.m. with the director of nursing regarding side rails and positioning bars revealed it was her expectation assessments would be completed in a timely manner.</p> <p>Review of the provider's 4/23/14 Restraint Use and Assessment policy and procedure revealed: ***Side rails are included in the CMS definition of restraints if they are used to keep a resident from voluntarily getting out of bed, as opposed to enhancing mobility while in bed.**</p>	F 221		

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F 221 F 280 SS=D	<p>Continued From page 3</p> <p>*It did not address the frequency of ongoing assessments for the use of side rails to verify they had not become a restraint.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, record review, interview, and policy review, the provider failed to ensure 2 of 12 sampled residents' (5 and 6) care plans had been revised as changes occurred. Findings include:</p> <p>1. Review of resident 6's entire medical record</p>	F 221 F 280	<p>F280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE</p> <p>Resident #5 & #6 had their care plans reviewed and revised to ensure that their comprehensive care plan was reflective of current approaches/interventions to meet the resident's needs.</p> <p>On 2/11/16 the healthcare leadership team collaborated with an Answers on Demand Consultant (our electronic medical records software) to improve our notification system to departments responsible for updating their sections of the care plan when there are changes in orders.</p> <p>MDS Coordinator or designee and interdisciplinary team will develop and complete a comprehensive care plan within 7 days after the completion of the comprehensive assessment as determined by the resident's needs. Resident or resident representative(s) will participate to the extent practicable. There will be periodic review and revision by the IDT after each assessment. MDS Coordinator, DON, or designee will review and revise resident care plans to keep resident care plans up to date between comprehensive assessments.</p> <p>(F280 continued to next page...)</p>	3/11/16
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F 280	<p>Continued From page 4</p> <p>revealed she: *Had fractured her lower left leg on 11/18/15 and had a cast on it. *Was an insulin dependent diabetic and had neuropathy (nerve pain). *Had a catheter (external device that bladder empties into).</p> <p>Random observations of resident 6 on 1/19/16 in the afternoon, and on 1/21/16 revealed the resident was frequently sleeping in her wheelchair.</p> <p>Review of resident 6's 11/30/15 Minimum Data Set (MDS) significant change assessment following her hospitalization for the fractured leg revealed she: *Had good recall and decision making. *Had moderate indicators of depression including decreased interest, sleep issues, felt tired, and felt sad about herself. *Had no indicators of psychosis. *Exhibited verbal behaviors. *Rated her pain 8 on a scale of 0-10. -Received scheduled and PRN (as needed) pain medications.</p> <p>Review of resident 6's physician's orders revealed: *A fax was sent to her physician on 12/3/15 stating "Resident has been having severe anxiety and states of panic. Today has been severe." -The physician had ordered Risperidone (Risperdal) (antipsychotic) 0.25 mg BID (twice a day) for insomnia and restlessness.</p> <p>Review of resident 6's 11/26/15 care plan revealed: *Problem:</p>	F 280	<p>The comprehensive care plan will reflect current problems, goals, and approaches to meet the resident's needs.</p> <p>The Administrator or designee will meet with the MDS Coordinator or designee to check for completion of a comprehensive care plan for each comprehensive assessment on a weekly basis for a month, then monthly for three months. The Administrator or designee will report results to the QAPI Committee for a period of 4 months or until substantial compliance has been achieved and maintained as determined by the QAPI Committee.</p>	3/11/16

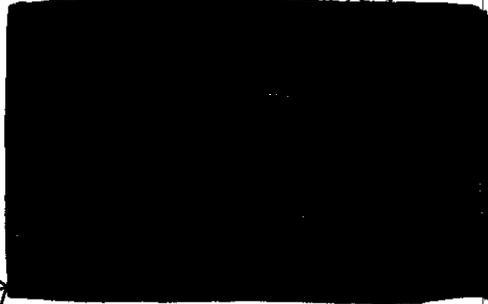
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F 280	<p>Continued From page 5</p> <ul style="list-style-type: none"> - Mood state: "I have a diagnosis of depression as well as dementia and anxiety." -Psychotropic Drug Use: related to depression and dementia. Risperdal started on 12/8/15 due to restlessness and insomnia. *Interventions included: <ul style="list-style-type: none"> -Nursing offers psychotropic meds (medications). -"Validate my feelings when I share a sense of loss or loneliness." *The care plan did not address: <ul style="list-style-type: none"> -Why she was on the antipsychotic medication. -An appropriate reason to have been on an antipsychotic medication. -Any specific preventative interventions to reduce the anxiety, depression, and sense of loss. -A specific plan to reduce the use of the antipsychotic medication. <p>Interview on 1/21/16 at 8:15 a.m. with the registered nurse (RN)/MDS coordinator revealed resident 6's care plan had not been updated to address the areas identified above. Surveyor: 32331</p> <p>2. Observation at random mealtimes revealed resident 5 was not at the assisted table and was independently eating his meals on:</p> <ul style="list-style-type: none"> *1/19/16 at the supper meal. *1/20/16 at breakfast. *1/20/16 at lunch. *1/21/16 at breakfast. <p>Interview on 1/20/16 at 8:50 a.m. with resident 5 revealed he denied needing help with his meals and setup.</p> <p>Interview on 1/20/16 at 8:55 a.m. with certified nursing assistant B revealed he had not needed assistance with meals.</p>	F 280			

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F 280	Continued From page 6 Review of resident 5's 8/30/15 care plan revealed he was to have sat at an assisted dining table with supervision and help with set-up. 3. Review of the provider's 11/1/15 assessment and care plan policy revealed "The POC [plan of care] will be reviewed regularly and revisions made as needed by the interdisciplinary team."	F 280	F281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS All residents have the right to have appropriately licensed health care professionals. A policy and procedure on License or Certification for Associates was developed. <i>*CS/SDDOHEL</i>	3/11/16
F 281 SS=D	Surveyor: 36413 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 A. Based on employee personnel file review, interview, and job description review, the provider failed to ensure professional standards were enforced in hiring of one of one licensed personnel (A). Findings include: 1. Review of employee A's personnel file on 1/21/16 at 8:00 a.m. with the human resources director (HRD) revealed: *Employee A had been hired as a registered nurse (RN) on 10/15/15. *A review of the South Dakota Board of Nursing (SD BON) website did not have a license documented for him. *A later interview with HRD revealed he had spoken with RN A and had been told he was an RN applicant.	F 281	 The Human Resources Director will assure all applicants meet licensing requirements. Human Resource Director will submit to Administrator a report on every nurse hired giving date of hire, license number and date of license renewal monthly for three months. Based on findings, the committee will make recommendations to continue or discontinue audit. (F281 continued to next page...) <i>*by verifying with the Board of Nursing prior to being hired.</i> <i>*on 01/21/16 Employee A was removed from the nursing schedule.</i> <i>CS/SDDOHEL</i>	

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F 281	Continued From page 7 Observations from 1/19/16 through 1/21/16 of RN applicant A revealed he worked as a nurse on the floor. Telephone call on 1/21/16 at 10:45 a.m. with the SD BON regarding RN applicant A revealed: *He had applied for the RN boards in 2013 but was unsuccessful in passing the examination. *That same year he applied for a temporary permit to practice as an RN applicant and to re-take the examination. He was unsuccessful in passing the second examination. -That temporary permit was a one time only option and expired when he failed the second examination. *In October 2015 he had re-applied to take the examination but had not done so yet. *At this time he was not eligible to work as an RN applicant, and he should not have been working on the floor in that capacity. Interview on 1/21/16 at 10:55 a.m. with the administrator revealed she was unaware RN applicant A was not licensed as an RN. Interview on 1/21/16 at 11:30 a.m. with the director of nursing regarding RN applicant A revealed: *When he was hired, he acknowledged he had taken the nursing examination one time and had not passed. *He had recently reapplied to take the examination but had not received any further information from the SD BON. Interview on 1/25/16 at 11:55 a.m. with the SD BON Program specialist revealed the above guidance was based on SD BON regulation	F 281	Resident #6's MAR was reviewed on 1/21/16 by the Director of Nursing. The Director of Nursing consulted with an Answers on Demand Consultant (our electronic medical records software) and established a 30 minute alert for PRN effectiveness charting that will alert nurses and/or Certified Medication Aides after 30 minutes from time of PRN administration for follow up with the resident who received the PRN medication. Director of Nursing or designee will conduct weekly MAR auditing for 1 month and then monthly for 3 months. These audits will be brought to the QAPI committee for 4 months, with further direction being given by the QAPI committee. <i>*All staff who administer medications were trained on the PRN medication alert procedure on 2/16/16. CS/SDDOH/EL</i>	3/11/16

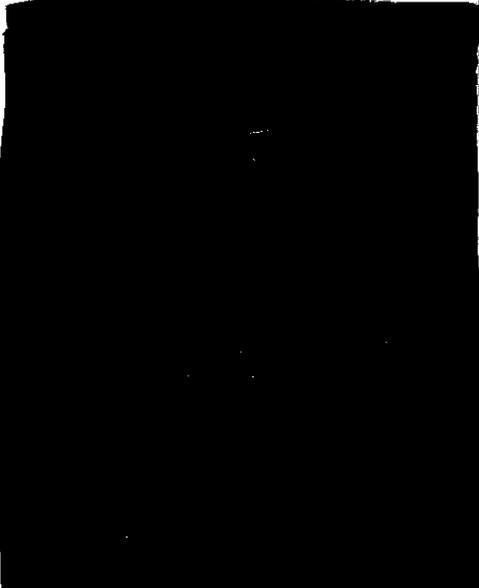
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F 281	<p>Continued From page 8</p> <p>36-9-31.1. That regulation stated "Temporary permit for applicant pending examination-Practice under supervision required. Upon application and payment of the required fee, the board may issue a temporary permit to practice as a registered nurse to an applicant who has completed an approved program and is awaiting the results of the first examination she is eligible to take after the permit is issued. The permit shall become invalid upon notification to the applicant of the results of the first examination. The holder of such temporary permit may practice only under the supervision of a registered nurse."</p> <p>B. Based on record review, interview, and professional standard review, the provider failed to ensure follow-up documentation for one of one sampled resident (6) who received as needed (PRN) medication. Findings include:</p> <p>1. Review of resident 6's medication administration record (MAR) revealed: *In November 2015 she had received PRN medications fifty times. There was follow-up with the effectiveness of those medications one time. *In December 2015 she had received PRN medications sixty-five times. There was follow-up to the effectiveness six times. *From 1/1/16-1/20/16 she had received PRN medications thirty-two times. There was no follow-up to their effectiveness.</p> <p>Interview on 1/21/16 at 9:30 a.m. with the DON revealed she confirmed there was not appropriate documentation of follow-up to PRN medications.</p> <p>Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, p. 578, revealed "Sometimes the prescriber</p>	F 281			

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F 281	Continued From page 9 orders a medication to be given only when a patient requires it. This is a prn order. When administering medications, document the assessment findings that show why the patient needs the medication and the time of administration. Frequently evaluate the effectiveness of the medication and record findings in the appropriate record."	F 281	F329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	3/11/16
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced	F 329	Ongoing monitoring of all residents is being done by the medical director, consulting pharmacists and the interdisciplinary team to support environmental modifications and non-pharmacologic therapy on at least a monthly basis at Quality of Life Meeting. On 2/11/16 the healthcare leadership team collaborated with an Answers on Demand Consultant (our electronic medical records software) to improve the behavior monitoring in our electronic records to enhance the quality of care and life of the residents. *CS/SD/DHEL 	

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F 329	<p>Continued From page 10</p> <p>by: Surveyor: 26180</p> <p>Based on observation, record review, interview, and policy review, the provider failed to ensure one of five sampled residents (6) receiving an antipsychotic medication had an appropriate diagnosis for the medication. Findings include:</p> <p>1. Review of resident 6's entire medical record revealed she:</p> <ul style="list-style-type: none"> *Had fractured her lower left leg on 11/18/15 and had a cast on it. *Was an insulin dependent diabetic and had neuropathy (nerve pain). *Had a catheter (external device that bladder empties into). *The entire medical record had no documentation for the use of an antipsychotic medication. <p>Random observations of resident 6 on 1/19/16 in the afternoon, and on 1/21/16 revealed the resident was frequently asleep in her wheelchair.</p> <p>Review of resident 6's 11/30/15 Minimum Data Set (MDS) significant change assessment following her hospitalization for the fractured leg revealed she:</p> <ul style="list-style-type: none"> *Had good recall and decision making. *Had moderate indicators of depression including decreased interest, sleep issues, felt tired, and felt sad about herself. *Had no indicators of psychosis. *Exhibited verbal behaviors (yelling out). *Rated her pain 8 on a scale of 0-10. -Received scheduled and PRN (as needed) pain medications. <p>Review of resident 6's behavior documentation from 11/15/15 through 12/14/15 revealed she:</p>	F 329	<p>*Resident #6's medical records were reviewed by our consulting pharmacy team. The resident has a diagnosis of dementia and showed several behaviors that were consistent with the diagnosis, Behavioral and Psychological symptoms of dementia (BPSD), which is a qualifying diagnosis to warrant antipsychotic therapy.</p> <p>CS/SDPOTT/EL</p> <p>*An inservice was held on 2/16/16 with nursing staff to review the procedure for using psychotropic medications and determining the appropriateness by the director of nurses. CS/SDPOTT/EL</p>	

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F 329	<p>Continued From page 11</p> <p>*Had three verbal "out of character" responses"; none of which were threatening to others nor screaming at others.</p> <p>*There were no physical behaviors such as hitting, scratching, or other physical symptoms.</p> <p>Review of resident 6's nurses progress notes revealed on 12/4/15:</p> <p>*Nursing staff informed the resident's son she was "requiring 1:1 due to her restlessness and anxiety."</p> <p>**"Resident remains severely anxious and hollering out."</p> <p>-She was on the floor next to her bed.</p> <p>Review of resident 6's physician's orders revealed:</p> <p>*A fax was sent to her physician on 12/3/15 stating "Resident has been having severe anxiety and states of panic. Today has been severe. She has attempted to stand and/or roll herself out of her bed numerous times, five times from 1800 to 1950 (6:00 to 7:50 p.m.)since my arrival."</p> <p>-Resident had been taken to her room and placed on the bedpan. She later rolled herself down her right knee to the floor and laid on the floor. The nurse requested the physician review the resident's medications and consider adding something to her regamine or PRN as "she is becoming dangerous to herself."</p> <p>*The physician ordered Risperidone (Risperdal) 0.25 mg BID (twice a day) for insomnia and restlessness on 12/4/15.</p> <p>Review of resident 6's December 2015 and January 2016 medication administration records (MAR) revealed:</p> <p>*She received the following medications for mood and behaviors:</p>	F 329			

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F 329	<p>Continued From page 12</p> <p>-Risperdal (for psychosis) 0.25 milligrams (mg) twice a day and was started on 12/16/15 for behavioral or psychological symptoms of dementia.</p> <p>-Amytriptyline (antidepressant) 25 mg two tablets at bedtime.</p> <p>-Lorazepam 1 mg every eight hours PRN for anxiety.</p> <p>*She received the following medications for pain management:</p> <p>-Tylenol ES (extra strength) one tablet every six hours PRN.</p> <p>-Acetaminophen 325 mg tablet one tablet every four hours PRN.</p> <p>-Tramadol 50 mg one tablet three times a day PRN.</p> <p>*She had an order to check her blood sugar PRN.</p> <p>Review of resident 6's MARs from 11/17/15 through 12/4/15 revealed she:</p> <p>*Only received the PRN Tylenol twice.</p> <p>*Had never had her blood sugar checked to see if that might cause her anxiety.</p> <p>*Only received the lorazepam one time per day, instead of the three times she could have received it.</p> <p>*Received the acetaminophen one time per day, instead of the four times per day she could have received it.</p> <p>*Received the Tramadol one time per day, instead of the three times she could have received it.</p> <p>Review of resident 6's 11/26/15 care plan revealed:</p> <p>*Problem:</p> <p>- Mood State: "I have a diagnosis of depression as well as dementia and anxiety."</p> <p>-Psychotropic Drug Use: related to depression</p>	F 329			

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F 329	<p>Continued From page 13 and dementia. Risperdal started on 12/8/15 due to restlessness and insomnia.</p> <p>*Interventions included: -Nursing offers psychotropic meds [medications]. -Validate my feelings when I share a sense of loss or loneliness.</p> <p>*The care plan had not addressed: -Why she was on the antipsychotic medication. -An appropriate indication to have been placed on an antipsychotic medication. -Any specific preventative interventions to reduce the anxiety, depression, and sense of loss. -A plan to reduce the use of the antipsychotic medication.</p> <p>Review of the 12/16/15 pharmacist note to resident 6's physician revealed: **[Resident Name] has a new order for Risperidone 0.25 mg for "anxiety." Anxiety is not a qualifying diagnosis to be on an antipsychotic medication in the nursing home setting. Could you please clarify the diagnosis from the choices below which are qualifying diagnoses. *Conditions other than dementia: -Delusional disorder. -Dementia related Behavioral or psychological symptoms of dementia." *The last one had been circled by the physician and dated 12/16/15.</p> <p>Interview on 1/21/16 at 8:15 a.m. with the registered nurse (RN)/MDS coordinator regarding resident 6's antipsychotic medication revealed: *She had wondered why the physician had ordered an antipsychotic medication on 12/4/15. -The resident had not had an appropriate diagnosis for that. *The pharmacist had reviewed the resident's medication then requested the physician change</p>	F 329			

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F 329	Continued From page 14 the diagnosis for the antipsychotic to fit the requirement for that type of medication. *That resident had not exhibited any psychosis. *They had not really determined if her increased anxiety could have been related to pain, discomfort related to the catheter, or if her blood sugar was low before requesting additional medications. Review of the provider's undated Complete Medication Review Process for Monthly Consultant Reviews policy revealed: ***Regulatory issues are addressed. -Gradual dose reduction. -Reason for initiation for psychoactive medications. -Responses to recommendations include clinical justification."	F 329	F368 FREQUENCY OF MEALS/SNACKS AT BEDTIME All residents are to be offered a bedtime snack. Dietary staff will pass a variety of bedtime snacks and record acceptance, refusal, or sleeping at time of pass, by a newly created form. The Certified Dietary Manager (CDM) will keep a written record of those documents and complete a weekly audit form. CDM or designee will include hs snack acceptance in quarterly documentation on resident IDT notes.	3/11/16
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. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.	F 368	Administrator, DON, RD, CDM, and Dietary Director initially met on 1/22/16 to review bedtime snack pass. The IDT team met again on 2/10/14 to review and revise Policy for Nourishments and Supplements. On 2/11/16 the Admin, CDM, and DON consulted with an Answers on Demand Consultant (our electronic medical records software) and reviewed documentation set up for dietary and CNA charting. CDM or designee will give a monthly summary of completed audits to the QAPI committee for the next three months. The QAPI committee will give recommendations for further action. (F368 continued to next page...)	

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F 368	<p>Continued From page 15</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180</p> <p>Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to ensure bedtime snacks were offered consistently to 11 of 12 sampled residents (1, 2, 3, 4, 5, 6, 7, 9, 10, 11, and 12). Findings include:</p> <p>1a. Interview on 1/20/16 at 1:45 p.m. with resident 5 and a family member revealed he: *Had been receiving his snacks "just sometimes" at bedtime. *Usually went to bed about 9:00 p.m. to 9:30 p.m. each evening.</p> <p>Record review of the provider's Dietary Intake Report 12/1/15 through 1/20/16 for resident 5 revealed: *The bedtime snack had been offered and documented: -December 2015, seven days out of thirty-one days. -1/01/16 through 1/20/16, four days out of a total of twenty days. *There were a total of forty bedtime snacks not documented.</p> <p>Surveyor: 26180 b. Interview on 1/20/16 at 9:30 a.m. with resident 6 revealed she had not been offered a snack before she went to bed.</p> <p>Surveyor: 32331 c. Record review of the provider's Dietary Intake</p>	F 368	<p>Initial education was given to dietary staff on 1/26/16 and hs snacks were mandatory each evening starting that day. Further training on new policy for all snacks will be given to dietary and nursing on February 16'</p> <p>*2016. CS/SDDOHEL</p>	

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F 368	<p>Continued From page 16</p> <p>Report 12/1/15 through 1/20/16 for residents (1, 2, 3, 4, 6, 7, 9, 10, 11, and 12) revealed: *The bedtime snack had been offered and documented: -December 2015, zero days out of a total of thirty-one days. -1/01/16 through 1/20/16, zero days out of a total of twenty days. *There were a total of fifty-one bedtime snacks not documented.</p> <p>d. Interview on 1/20/16 at 4:45 p.m. with the consultant registered dietitian (RD) regarding the bedtime snacks revealed her expectation was all residents on oral diets would have been offered a bedtime snack.</p> <p>Interview on 1/21/16 at 7:50 a.m. with registered nurse applicant A regarding the above revealed dietary was responsible for delivering the bedtime snacks at around 8:00 p.m. each evening.</p> <p>Interview on 1/21/16 at 8:00 a.m. with certified nursing assistant I regarding the above revealed: *The bedtime snacks were being put on a table next to the Allen Wing kitchenette area by dietary staff. *Not all residents were being offered bedtime snacks. *Residents would have needed to come to the Allen King kitchenette to have received a bedtime snack. *A snack cart was not being taken around to the resident rooms for a bedtime snack.</p> <p>Interview on 1/21/16 at 8:30 a.m. with dietary assistant H regarding the above revealed: *The last scheduled shift in the dietary department in the evenings ended at 8:00 p.m.</p>	F 368			

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F 368	<p>Continued From page 17</p> <p>*Residents were not being consistently offered a bedtime snack. *She was unsure on the department responsible for offering the bedtime snacks.</p> <p>Interview on 1/21/16 at 10:30 a.m. with the resident care supervisor regarding the above revealed: *The bedtime snacks were to have been offered around 8:00 p.m. *The dietary department was responsible for preparing the bedtime snacks. *The nursing department was responsible for delivering and documenting snacks that had been a physician's order or the RD's recommendation. -Those were the only snacks the nursing department were offering on a consistent basis to residents. *The dietary department was responsible for offering bedtime snacks from the snack cart. *Residents could come to the nurses desk to ask for a bedtime snack. *Snacks were always available in the resident refrigerator in the staff lounge that included: -Ice cream. -Jello. -Pudding. -Ensure (a nutritional supplement). *The Allen Wing kitchenette had sandwiches, chips, fruit, bread, and soup available.</p> <p>Interview on 1/21/16 at 11:30 a.m. with the director of nursing regarding the above revealed it had been the responsibility of dietary at 7:30 p.m. to 8:00 p.m. to offer bedtime snacks.</p> <p>Interview on 1/21/16 at 10:15 a.m. with the dietary manager regarding the above revealed: *The dietary department was responsible for</p>	F 368			

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F 368	Continued From page 18 offering the bedtime snacks. *The "AW3" (Allen Wing three) staff position scheduled for 4:30 p.m. through 8:00 p.m. position each day was scheduled to pass the bedtime snacks. -That person was to have offered the snacks in the residents' rooms. Review of the provider's 2013 Meal Times and Frequency policy revealed: *The bedtime snack was to have been served from 7:00 p.m. to 7:30 p.m. *The policy did not specify the department to have offered and documented the bedtime snack for the residents.	F 368		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Surveyor: 36413 Based on observation, testing, interview, record review, and policy review, the provider failed to ensure sanitary conditions were maintained that might have resulted in a potential for	F 371	<p><i>*Dietary staff met on 1/25/16 and reviewed the dietary checklist. CS/8DDO/H/EL</i></p> <p>F371 FOOD PROCEDURE, STORE/PREPARE/SERVE - SANITARY</p> <p>All residents have the right to sanitary food prep conditions.</p> <p>The fan was removed from the kitchen wall on 2/5/16.</p> <p>Kitchen Manager or designee will monitor the kitchen weekly through a cleaning checklist. The cleaning checklist will be audited monthly by the Director of Dietary Services (DDS), Administrator, or designee. The DDS or designee will furnish these audits to the QAPI committee for three months. QAPI committee will determine further action.</p>	3/11/16

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F 371	<p>Continued From page 19</p> <p>cross-contamination (bacteria from one area to another area) with one of one fan in the dish machine area in the kitchen. Findings include:</p> <p>1. Observation and testing on 1/19/16 from 1:40 p.m. through 2:10 p.m. in the kitchen revealed: *In the dish machine area there was a large fan mounted on the wall above the dirty dishes on the dirty end of the dish machine. *The fan had multiple built-up brown, black, and tan spots on the spokes and on the blades. -It was located on the wall between the window for placement of the dirty dishes and the sink with the garbage disposal. -Dietary assistant (DA) F was loading dirty dishes into the dish machine next to that running fan. -DA G was unloading clean dishes from the dish machine and placing them on the clean end of the dish machine. *Testing with a napkin on the clean end of the dish machine revealed: -It was blowing directly onto the dishes on the clean end of the dish machine that were being stored there.</p> <p>Surveyor: 32331 Observation and interview on 1/20/16 at 4:45 p.m. with consultant registered dietitian in the dish machine area in the kitchen revealed: *The fan contained multiple brown, black, and tan spots on the spokes and the blades. *It was attached to the wall in the dish room and was blowing over the dirty dishes to the clean dishes stored there. *The fan should not have been blowing from dirty to clean in the dish room. *That was a potential for cross-contamination. *There should have been a separation of the dirty from the clean and that included air movement</p>	F 371			

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F 371	Continued From page 20 from the fan. Observation and interview on 1/21/16 at 10:10 a.m. with the environmental services director and the dietary manager (DM) in the dish machine area in the kitchen revealed: *The environmental services director stated the cleaning of the fan in the kitchen was the responsibility of the dietary department staff. *The DM agreed the fan needed to have been cleaned. *Both agreed the fan should not have been blowing from dirty to clean, and that was a potential for cross-contamination. *Both agreed there was not a specific policy for cleaning the fan in the dish machine area in the kitchen. Review of the provider's undated cleaning schedule revealed no documentation of the fan having been cleaned. Review of the provider's undated General Sanitation of Kitchen policy reviewed the staff would have maintained the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule. Review of the provider's 2013 Sample Cleaning Schedule policy revealed no listing for cleaning of the fan. Review of the provider's undated Handling Clean Equipment and Utensils revealed clean equipment and utensils would have been handled to prevent contamination.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	Continued From page 21 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 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. 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. This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on observation, interview, and policy	F 431	F431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The residents were not at risk for harm as the medications (Milk of Magnesia and Artificial Tears) had a manufacturer's expiration date that was still current. The facility reviewed the policy and procedure on dating of products once opened with Pharmacy consultant and revised the policy. *Nursing staff was trained on this policy on 2/16/16 by the director of nurses. CS/SDOCH/EL Medications with shortened expiration dates per pharmacy recommendations will be dated when opened. Director of Nursing or designee will do a medication labeling and storage audit monthly X 3. Results of the findings will be reported at QAPI for recommendations to continue or discontinue audits.	3/11/16	

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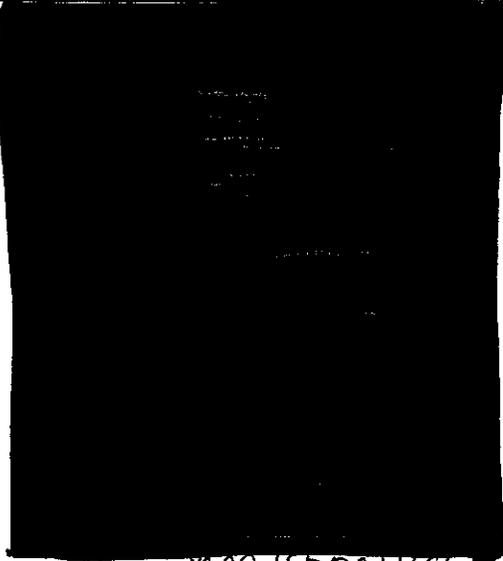
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F 431	<p>Continued From page 22</p> <p>review, the provider failed to ensure an open date was placed on multi-dose containers of resident medication in two of three unnamed medication carts. Findings include:</p> <p>1. Observation on 1/21/16 at 10:35 a.m. of certified nursing assistant/medication aide (CNA/MA) L with the first unnamed medication cart revealed: *There were no dates written on the following multi-use containers when they were opened: -Eye drops. -Nebulizer (delivered through a mist) medications. *A bottle of prescribed eye drops had a 12/2/14 opened date. -CNA/MA L notified the nurse and removed the eye drops from the cart.</p> <p>Observation and interview on 1/21/16 at 11:00 a.m. with RN J regarding the second unnamed medication cart revealed: *There were no dates written on multi-use containers when they were opened. That included: -Eye drops. -Multiple bottles of milk of magnesia (a laxative medication). *RN J stated she would have written an opened date and her initials on the medication bottle.</p> <p>Interview on 1/21/16 at 11:30 a.m. with the director or nursing revealed it was her expectation the nursing staff would follow the policy with the dating of medications on each of the carts.</p> <p>Review of the November 2011 Specific Medication Administration policy and procedure revealed "When opening a multi-dose container,</p>	F 431		

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F 431	Continued From page 23 place the date on the container."	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. (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.	F 441	F441 Infection Control, Prevent Spread, Linens RN C has been re-educated on hand washing/hygiene policy and procedure during cares with Resident 8 and all other resident's with similar complex dressing changes. The policy and procedure on Hand Washing/Hand Hygiene was reviewed. All associates will complete the mandatory training on Relias Learning – Handwashing Training by March 11, 2016. RN C will be randomly monitored during complex dressing changes by Director of Nursing or designee every week x 4 to ensure compliance. Observations will be reported to the QAPI committee for further follow up. <i>*CS/SDDOHEL</i>	3/11/16

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F 441	Continued From page 24 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 hand hygiene and wound cleaning technique by one of two licensed nurses (C and M) during one of three observed dressing changes for one of three residents (8). *Proper disinfection of one of one observed whirlpool cleaning by one of one certified nurse aid (CNA) B. *Proper transportation of clean linen by two of two randomly observed staff (D and E). * Proper transportation of soiled linen by one of one randomly observed staff (K). Findings include: 1. Observation and interview on 1/20/16 at 8:19 a.m. with registered nurse (RN) C during dressing changes on skin wounds for resident 8 revealed: *Multiple wound areas on the resident's bottom and both ankles. *RN C had: -Cleaned the wound beds with dermal wound cleansing spray. -Used a gauze dressing to pat dry a wound and then used that same gauze to dry other wounds. -She repeated that process on the wounds located on the residents bottom and both ankles. -Changed gloves multiple times without washing her hands and continued the dressing change process. *Interview with RN C revealed she should have: -Washed her hands after removing soiled gloves. -Not touched a clean wound with a soiled gauze	F 441	 <i>*CS/SDDO/H/EL</i> The policy and procedure on Whirlpool Bath Cleaning/Disinfection was reviewed. All CNA's working in the bath aide position will complete the Relias Learning, "Dow Rummel Whirlpool Tub Cleaning" by March 10, 2016. RCS or designee will conduct random observations/audits of the disinfectant procedure of whirlpool weekly x 4 to ensure compliance. Results will be reported to the QAPI committee for further action. All residents have the potential to be affected by proper linen handling and infection control practices. On 1/20/16 Staff D and E were given re-education on proper (F441 continued to next page...)	3/11/16	

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F 441	<p>Continued From page 25 dressing. -Used a clean gauze to pat dry each wound.</p> <p>2. Observation and interview on 1/20/16 at 9:57 a.m. of CNA B regarding disinfection of the whirlpool tub revealed she: *Had added an unknown amount of water and disinfectant to the whirlpool tub. *Was not sure how much water or disinfectant she had added. *Stated "I just dump a bunch in there" when asked how much disinfectant she used. *Confirmed the directions for disinfecting the whirlpool tub were taped to the side of the whirlpool. *Agreed she had not followed those directions for disinfecting the whirlpool tub.</p> <p>3. Interview on 1/21/16 at 11:14 a.m. with the director of nursing (DON) confirmed they: *Should have washed their hands after removing soiled gloves during the dressing change. *Should have used a clean gauze dressing to dry each wound. *Do not have a specific wound care or dressing change policy. *Did not follow their policies for handwashing and disinfecting the whirlpool tub.</p> <p>Review of the provider's revised 2/26/15 Handwashing policy revealed hands should have been washed: **"Before and after contact with non-intact skin and dressing changes." **"When moving from a contaminated body site to a clean body site during resident care." **"After removing and disposing of personal protective equipment including gloves." **"After handling soiled linens, equipment or</p>	F 441	<p>linen handling and infection control practices.</p> <p>By 2-15-16 housekeeping staff will be given an in-service on proper handling of both clean and soiled linen.</p> <p>The Director of Housekeeping will do weekly checks for one month, bi-weekly check for two months and monthly for ten months to ensure proper handling of linens. In-service and documentation of checks will be reported to the QAPI team for review and recommendation.</p> <p><i>*Of linen handling</i> <i>CS/SDDOCH/EL</i></p> <p><i>monthly for 4 months.</i> <i>CS/SDDOCH/EL</i></p>		

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F 441	<p>Continued From page 26 utensils or leaving a soiled utility room."</p> <p>Review of the provider's revised 4/10/12 Standard Precautions policy revealed "Hand hygiene is always performed after the removal of gloves."</p> <p>Review of the provider's revised 12/18/13 Whirlpool Bath Cleaning/Disinfection policy revealed: *The tub and lift chair were to be cleaned and disinfected between each use following the manufacturer's directions using two ounces of disinfectant to one gallon of water. *Staff were to hold the disinfect jets button that would dispense the properly mixed dilution of disinfectant through the air jet system. *They were to hold the disinfect jets button until about a gallon of disinfectant solution was in the foot well of the tub. *They were to use that solution to disinfect the tub and chair.</p> <p>3a. Observation and interview on 1/20/16 at 8:45 a.m. of staff D and E revealed: *Staff D had removed clean linen from a cart and left the cart uncovered and unattended in the hallway. *Staff E had moved an unoccupied wheelchair in front of the cart with the wheel touching clean linens. *Interview with staff D revealed he agreed he should have not left the cart uncovered and unattended.</p> <p>Surveyor: 32331 Surveyor: 36413 b. Observation and interview on 1/19/16 at 2:20 p.m., in the hallway by room 761, with housekeeping assistant K revealed she:</p>	F 441			

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F 441	<p>Continued From page 27</p> <p>*Was carrying an uncovered bucket of white cloths.</p> <p>*Stated those cloths were dirty, and she was delivering them to the laundry area.</p> <p>*Stated the above had been used to clean resident:</p> <ul style="list-style-type: none"> -Bathrooms. -Floors. -Walls. <p>*The above bucket of dirty linen had been uncovered in a resident hallway.</p> <p>c. Interview on 1/21/16 at 10:23 a.m. with the director of environmental services confirmed:</p> <ul style="list-style-type: none"> *Staff had not followed the proper procedure for transporting clean and soiled linens. *All linens should have been covered. *Soiled cloths should have been covered. <p>Review of the provider's revised 4/10/12 Standard Precautions policy revealed "Linens are handled and transported in a manner that prevents skin and mucous membrane exposure, contamination of clothing, and avoids transfer of microoggoranisms [microorganisms] to other residents and environments."</p> <p>Review of the provider's revised 5/14/13 Soiled Linen and Laundry Handling policy revealed:</p> <ul style="list-style-type: none"> ***All soiled linens and laundry be handled in a way that prevents contamination of the air and persons handling the linen." ***All soiled linens shall be handled as though potentially infectious." ***Soiled laundry and bedding must be placed in a a bag at the usage site (resident room, bath house, etc)." <p>Surveyor: 32331</p>	F 441		

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F 441	Continued From page 28	F 441			
F 490	Surveyor: 36413				
SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING	F 490			
	<p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, employee personnel file review, interview, and job description review, the provider failed to ensure the facility was administered in a manner that upheld all applicable state laws and professional standards in the hiring of one of one sampled registered nurse applicant (A) that required professional licensing. Findings include:</p> <p>1. Review of employee A's personnel file on 1/21/16 at 8:00 a.m. with the human resources director (HRD) revealed: *Employee A had been hired as a registered nurse (RN) on 10/15/15. *A review of the South Dakota Board of Nursing (SD BON) website did not have a license documented for him. *A later interview with HRD revealed he had spoken with RN A and had been told he was an RN applicant.</p> <p>Observations from 1/19/16 through 1/21/16 of RN applicant A revealed he worked as a nurse on the floor.</p>		<p>F490 Effective Administration/Resident Well-Being</p> <p>All residents have the right to have appropriately licensed health care professionals. A policy and procedure on License or Certification for Associates was developed.</p> <p>Employee A was a graduate of USD Nursing program and had submitted the application for licensure to the Board of Nursing on 10/19/15. Employee A did not receive any written and/or verbal contact until 1/21/16 for authorization to test. On 1/21/16 Employee A was removed from the nursing schedule.</p> <p>The Human Resources Director will assure all applicants meet licensing requirements. Human Resource Director will submit to Administrator a report on every nurse hired giving date of hire, license number and date of license renewal monthly for three months. Based on findings, the QAPI committee will make recommendations to</p>	3/11/16	

Handwritten note:
*by verifying with the Board of Nursing prior to being hired.
CS/DOH/TEL

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F 490	Continued From page 29 Review of the provider's November 2014 charge nurse job description revealed the RN employee "Must possess a current, unencumbered, active license to practice as a RN or LPN (licensed practical nurse) in South Dakota. Telephone call on 1/21/16 at 10:45 a.m. with the SD BON regarding RN applicant A revealed: *He was not currently licensed as an RN. *He had applied for the RN boards in 2013, but he had been unsuccessful in passing the examination. *That same year he applied for a temporary permit to practice as an RN applicant and re-take the examination. He was unsuccessful in passing the second examination. -The temporary permit was a one time only option that expired when he had taken the examination for the second time and failed. *In October 2015 he had re-applied to take the examination but had not done so yet. *At this time he was not eligible to work as an RN applicant and should not have been working on the floor in that capacity. Interview on 1/21/16 at 10:55 a.m. with the executive director revealed she was unaware RN applicant A was not licensed as an RN. Interview on 1/21/16 at 11:30 a.m. with the director of nursing regarding RN applicant A revealed: *When he was hired he acknowledged he had taken the nursing examination one time and had not passed. *He had recently reapplied to take the examination but had not received any further information from the SD BON.	F 490			

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F 490	Continued From page 30 *They did not have a job description for an RN applicant. Phone interview on 1/25/16 at 11:55 a.m. with the SD BON Program specialist revealed the above guidance is based on SD BON regulation 36-9-31.1. This regulation stated "Temporary permit for applicant pending examination-Practice under supervision required. Upon application and payment of the required fee, the board may issue a temporary permit to practice as a registered nurse to an applicant who has completed an approved program and is awaiting the results of the first examination she is eligible to take after the permit is issued. The permit shall become invalid upon notification to the applicant of the results of the first examination. The holder of such temporary permit may practice only under the supervision a registered nurse." Review of the provider's executive director's undated job description revealed: *"Oversees management and supervisory responsibilities for all licensed facility operations and services. *In consultation with the CEO [chief executive officer] and Department Directors, set and implement polices and performance standards appropriate for delivering quality resident care and complying in all respects with applicable federal, state, and local laws and regulations."	F 490			
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles	F 492			

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F 492	<p>Continued From page 31 that apply to professionals providing services in such a facility.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, employee personnel file review, interview, and job description review, the provider failed to ensure all applicable state laws were followed in the hiring of one of one registered nurse (RN) applicant (A) that required professional licensing. Findings include:</p> <p>1. Review of employee A's personnel file on 1/21/16 at 8:00 a.m. with the human resources director (HRD) revealed: *Employee A had been hired as a registered nurse (RN) on 10/15/15. *A review of the South Dakota Board of Nursing (SD BON) website did not have a license documented for him. *A later interview with HRD revealed he had spoken with RN A and was told he was an RN applicant.</p> <p>Observations from 1/19/16 through 1/21/16 of RN applicant A revealed he worked as a nurse on the floor.</p> <p>Review of the provider's November 2014 Charge nurse job description revealed the RN employee "Must possess a current, unencumbered, active license to practice as a RN or LPN (licensed practical nurse) in South Dakota.</p> <p>Telephone call on 1/21/16 at 10:45 a.m. with the SD BON regarding RN applicant A revealed: *He was not currently licensed.</p>	F 492	<p>F492 COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD</p> <p>All residents have the right to have appropriately licensed health care professionals. A policy and procedure on License or Certification for Associates was developed.</p> <p>Employee A was a graduate of USD Nursing program and had submitted the application for licensure to the Board of Nursing on 10/19/15. Employee A did not receive any written and/or verbal contact until 1/21/16 for authorization to test. On 1/21/16 Employee A was removed from the nursing schedule.</p> <p>The Human Resources Director will assure all applicants meet licensing requirements. Human Resource Director will submit to Administrator a report on every nurse hired giving date of hire, license number and date of license renewal monthly for three months. Based on findings, the QAPI committee will make recommendations to continue or discontinue audit.</p>	3/11/16	

**by verifying with the Board of Nursing prior to being hired.*
CS/SD/DAHEL

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/21/2016
NAME OF PROVIDER OR SUPPLIER DOW RUMMEL VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 W DOW RUMMEL ST SIOUX FALLS, SD 57104		
(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 492	<p>Continued From page 32</p> <p>*He had applied for the RN boards in 2013, but was unsuccessful in passing the examination. *That same year he applied for a temporary permit to practice as an RN applicant and re-take the examination. He was unsuccessful in passing the second examination. -The temporary permit was a one time only option that expired when he had taken the examination for the second time. *In October 2015 he had re-applied to take the examination but had not done so yet. *At that time he was not eligible to work as a RN applicant, and should not have been working on the floor in that capacity.</p> <p>Interview on 1/21/16 at 10:55 a.m. with the administrator revealed she was unaware RN applicant A was not licensed as an RN.</p> <p>Interview on 1/21/16 at 11:30 a.m. with the director of nursing regarding RN applicant A revealed: *When he was hired, he had acknowledged he had taken the nursing examination one time and had not passed. *He had recently reapplied to take the examination but had not received any further information from the SD BON. *They did not have a job description for a RN applicant.</p> <p>Interview on 1/25/16 at 11:55 a.m. with the SD BON Program specialist revealed the above guidance is based on SD BON regulation 36-9-31.1. This regulation stated "Temporary permit for applicant pending examination-Practice under supervision required. Upon application and payment of the required fee, the board may issue a temporary permit to practice as a registered</p>	F 492			

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NAME OF PROVIDER OR SUPPLIER DOW RUMMEL VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 W DOW RUMMEL ST SIOUX FALLS, SD 57104	
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F 492	Continued From page 33 nurse to an applicant who has completed an approved program and is awaiting the results of the first examination she is eligible to take after the permit is issued. The permit shall become invalid upon notification to the applicant of the results of the first examination. The holder of such temporary permit may practice only under the supervision a registered nurse."	F 492	F514 RECORDS- COMPLETE/ACCURATE/ACCESSIBLE	3/11/16
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to ensure documentation of scheduled nutritional supplements for 8 of 12 sampled residents (3, 4, 5, 7, 8, 9, 10, and 11). Findings include: 1. Record review on 1/20/16 of resident 3's medical record, the 1/19/16 Allen Wing Diet List, and meal card revealed the following scheduled	F 514	Certified Dietary Manager (CDM) reviewed supplement charting for residents 3,4,5,7,8,9, 10 and 11 on 1/26/16. Supplement labels were updated on 1/22/16 and continue to be on an as-needed basis. Administrator, DON, RD, CDM, and Dietary Director initially met on 1/22/16 to review supplement pass and charting. The IDT team met again on 2/10/16 to review and revise Policy for Nourishments and Supplements. On 2/11/16 the Admin, CDM, and DON consulted with an Answers on Demand Consultant (our electronic medical records software) and reviewed documentation set up for dietary and CNA charting, clearly assigning who would chart and document the supplements brought for meals and those done between meals. On 2/12/16 the AOD consultant along with the CDM and Administrator created an electronic report to monitor and audit supplement intake. CDM or designee will audit supplement documentation by utilizing clinical software reports weekly for 3 months then monthly for 3 months. CDM will report audit results (F514 continued to next page...)	

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NAME OF PROVIDER OR SUPPLIER DOW RUMMEL VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 W DOW RUMMEL ST SIoux FALLS, SD 57104		
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F 514	<p>Continued From page 34</p> <p>supplement times had been documented: *December 2015, forty-five times out of a total of ninety-three opportunities. *From 1/01/16 through 1/19/16, thirteen out of a total of fifty-seven opportunities. *There were a total of 92 scheduled supplement times not documented.</p> <p>2. Record review on 1/20/16 of resident 4's medical record, the 1/19/16 Allen Wing Diet List, and meal card revealed the following scheduled supplement times had been documented: *December 2015, thirty times out of a total of ninety-three opportunities. *From 1/01/16 through 1/19/16, thirteen out of a total of fifty-seven opportunities. *There were a total of 107 scheduled supplement times not documented.</p> <p>3. Record review on 1/20/16 of resident 5's medical record, the 1/19/16 Allen Wing Diet List, and meal card revealed the following scheduled supplement times had been documented: *December 2015, thirty-one times out of a total of ninety-three opportunities. *From 1/01/16 through 1/19/16, nineteen out of a total of fifty-seven opportunities. *There were a total of 100 scheduled supplement times not documented.</p> <p>4. Record review on 1/20/16 of resident 7's medical record, the 1/19/16 Allen Wing Diet List, and meal card revealed the following scheduled supplement times had been documented: *December 2015, thirty-two times out of a total of ninety-three opportunities. *From 1/01/16 through 1/19/16, thirty out of a total of fifty-seven opportunities. *There were a total of 88 scheduled supplement</p>	F 514	<p>to the QAPI committee monthly for 6 months. QAPI committee will give recommendations for further action.</p> <p>Training on new policy for supplement documentation will be given to all dietary and nursing staff on February 16' 2015.</p>		

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NAME OF PROVIDER OR SUPPLIER DOW RUMMEL VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1321 W DOW RUMMEL ST SIOUX FALLS, SD 57104
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 514	<p>Continued From page 35 times not documented.</p> <p>5. Record review on 1/21/16 of resident 8's medical record, the 1/19/16 Allen Wing Diet List, and meal card revealed the following scheduled supplement times had been documented: *December 2015, thirteen times out of a total of thirty-one opportunities. *From 1/01/16 through 1/20/16, six out of a total of twenty opportunities. *There were a total of 32 scheduled supplement times not documented.</p> <p>6. Record review on 1/21/16 of resident 9's medical record, the 1/19/16 Allen Wing Diet List, and meal card revealed the following scheduled supplement times had been documented: *December 2015, zero times out of a total of ninety-three opportunities. *From 1/01/16 through 1/20/16, zero out of a total of sixty opportunities. *There were a total of 153 scheduled supplement times not documented.</p> <p>7. Record review on 1/21/16 of resident 10's medical record, the 1/19/16 Allen Wing Diet List, and meal card revealed the following scheduled supplement times had been documented: *December 2015, zero times out of a total of ninety-three opportunities. *From 1/01/16 through 1/20/16, zero out of a total of sixty opportunities. *There were a total of 153 scheduled supplement times not documented.</p> <p>8. Record review on 1/21/16 of resident 11's medical record, the 1/19/16 Allen Wing Diet List, and meal card revealed the following scheduled supplement times had been documented:</p>	F 514		
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NAME OF PROVIDER OR SUPPLIER DOW RUMMEL VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1321 W DOW RUMMEL ST SIOUX FALLS, SD 57104		
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F 514	<p>Continued From page 36</p> <p>*December 2015, zero times out of a total of ninety-three opportunities.</p> <p>*From 1/01/16 through 1/19/16, zero out of a total of sixty opportunities.</p> <p>*There were a total of 153 scheduled supplement times not documented.</p> <p>9. Interview on 1/20/16 at 4:45 p.m. with the consultant registered dietitian (RD) revealed she had expected all scheduled supplements to have been documented.</p> <p>Interview on 1/20/16 at 5:35 p.m. and on 1/21/16 at 11:30 a.m. with the director of nursing revealed she had expected all scheduled supplements to have been documented.</p> <p>Interview on 1/21/16 at 10:15 a.m. with the dietary manager (DM) revealed the documentation of the residents' nutritional supplement intakes: *At meals was to have been done by dietary staff. *Between meals was to have been done by nursing staff.</p> <p>Review of the provider's 2013 Snacks and Supplements policy revealed: *The DM would have ensured residents had received the supplements ordered by the physician and/or recommended by the RD or designee. *Dietary recorded supplement intake at meals in the computer. *Designated staff delivered supplements. *Nursing recorded between-meal supplement intake in the computer. *Dietary or nursing staff were to have reported intake problems to the nursing supervisor. *Nursing or dietary staff notified the DM, RD, or designee of needed changes in supplements</p>	F 514		

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NAME OF PROVIDER OR SUPPLIER DOW RUMMEL VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 W DOW RUMMEL ST SIOUX FALLS, SD 57104		
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F 514	<p>Continued From page 37 based on the resident's acceptance or lack of acceptance.</p> <p>Review of the provider's revised 10/30/13 __[name of provider] Allen Wing Standing Orders revealed "May use dietary supplements of choice per care team and/or Registered Dietitian."</p> <p>Review of the provider's undated Documenting in the Medical Record policy revealed all information regarding medical nutrition care would have been documented in the resident's medical record.</p> <p>Review of the provider's 11/15/15 Charting and Documentation policy revealed all services provided to residents was to have been documented in the resident's record either electronically or on paper.</p>	F 514			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435127	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ALLEN WING B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2016
NAME OF PROVIDER OR SUPPLIER DOW RUMMEL VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 W DOW RUMMEL ST SIOUX FALLS, SD 57104	
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 1/20/16. Dow Rummel Village was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Rebecca Garish* TITLE *Administrator* (X6) DATE *2/13/16*

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.

FEB 16 2016

SD DOH L&C

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10678	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2016
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NAME OF PROVIDER OR SUPPLIER DOW-RUMMEL VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1321 W DOW RUMMEL ST SIOUX FALLS, SD 57104
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S 000	Compliance/Noncompliance Statement Surveyor: 26180 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 1/19/16 through 1/21/16. Dow Rummel Village was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 26180 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 1/19/16 through 1/21/16. Dow Rummel Village was found in compliance.	S 000		

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

Rebecca Davis

TITLE

Administrator

(X6) DATE

2-13-16

STATE FORM

6869

LT7811

If continuation sheet 1 of 1

