South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10771	A. BUILDING: _____ B. WING _____	C 04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRMONT GRAND SENIOR CARE	405 E FAIRLANE DRIVE RAPID CITY, SD 57701

(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) COMPLETE DATE
S 000	Compliance Statement A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted on 4/29/24 through 4/30/24. The area surveyed was resident neglect. Fairmont Grand Senior Care was found not in compliance with the following requirements: S680, S681 and S838.	S 000		6.14.2024
S 680	44:70:07:08 Medication Records And Administration A facility shall establish and implement written policies and procedures to check the resident's medication administration records against the physician, physician assistant, or nurse practitioner's orders to verify accuracy. Each medication administered must be recorded in the resident's care record and signed by the individual administering the medication. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure physician orders were being followed for one of one sampled resident's (1) prescribed antibiotic. Findings included: 1. Review of resident 1's electronic medical record (EMR) revealed he: *Was admitted to the hospital on 4/2/24 due to an infection in his left hand. -He had punctured the skin in his palm with his fingernails.	S 680	S680 1) Resident #1 unable to correct noncompliance 2.All residents have the potential to be affected by this deficiency 3) Medication Refill Policy has been updated to include the following: a. The Designated staff person contacts the dispensing pharmacy to obtain a refill at least seven (7) days prior to running out of a medication, unless medication is on a cycle refill with the pharmacy. b. Designated Staff member in charge of ordering resident medication refills has had additional training and oversight by DON to ensure compliance and accuracy for all reorders. c. If necessary, the prescribing physician is contacted for a new order. In the event the residents PCP is not available to authorize medication refill, the facilities Medical Director will be able to authorize short term refill until the residents PCP responds. d. Medications are never allowed to run out unless directed to by the physician (obtain this direction in writing). e. New containers are inspected to ensure all information on the label is correct. f. Any changes in instructions and/or medication are noted; for example, change in dosage, change to generic brand, etc. g. Pharmacy "Consulted Delivery Sheet" is verified for accuracy upon delivery of medications. h. The Designated staff person or DON will discuss any changes in medications with the resident, responsible party and appropriate staff. 4) DON/Designee will ensure all clinical staff have been educated on the revised Medication Refill Policy referencing how to obtain medication refills from the pharmacy of the resident's preference. 5) DON/Designee will audit three resident MAR's to monitor for availability of medications and that proper administration has been completed. weekly times 4 weeks, then monthly times 3 months, then monthly thereafter until substantial compliance is continuously met. 6) The results of these audits will be brought to the QA committee monthly for their review and advisement until substantial compliance has been met for 3 consecutive months.	6.14.2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Lisa Maciejewski — Executive Director — Lisa Maciejewski — 5/23/2024

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S 680	Continued From page 1 *Had a chronic contracture of his left hand. *Had surgery for a contracture tendon release and debridement of the left-hand wound. *Had infectious disease consulted and it was recommended that six weeks of oral Augmentin should be started. *Returned to the assisted living facility (ALF) on 4/9/24. Record review of resident 1's Medication Administration Record (MAR) revealed: *On 4/9/24 he started on Amoxicillin-Potassium Clavulanate Oral Tablet 875-125 milligram (MG) 1 tablet by mouth two times a day for infection Lead for 60 adminstrations. *He had continued his antibiotics twice a day through 4/23/24. *On 4/24/24 the MAR indicated the medication was not available and continued to not be available through 4/30/24. Review of resident 1's progress notes revealed: *On 4/23/24 a note referenced "Amoxicillin-Potassium Clavulanate Oral Tablet medicine given at the time was the last one in the bottle." *On 4/24/24 a note referenced "Amoxicillin-Potassium Clavulanate Oral Tablet medicine not available will notify nursing." -There was no documentation indicating a nurse was notified that the medication was not available. Interview on 4/30/24 at 9:40 a.m. with MT E regarding resident 1 revealed: *He returned from the hospital on 4/9/24. *He had been on an antibiotic since he returned from the hospital. *He had taken the last pill in the bottle seven days ago.	S 680		

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S 680	Continued From page 2 *She thought he had received his full dose of antibiotics per physician orders. Interview on 4/30/24 at 4:30 p.m. with executive director (ED) A regarding the above interview revealed: *She was unaware resident 1 was out of his antibiotics. *She confirmed resident 1 had not received his full dose of antibiotics per physician orders. *The expectation was for staff to notify the registered nurse (RN) or herelf when medications were not available. Review of the providers undated Medication Refills policy revealed: "Medications refills will be obtained in a timely manner to ensure residents have all physicians ordered medication available." "3. Medications are never allowed to run out unless directed to by the physician."	S 680		
S 681	44:70:07:08 Medication Records And Administration Medication errors and drug reactions must be reported to the resident's physician, physician assistant, or nurse practitioner and an entry made in the resident's care record. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview and policy review, the provider failed to ensure two of thirteen medication errors involving one of one sampled resident (1) were reported to the	S 681	S681 1. Resident #1 unable to correct noncompliance. 2. All residents have the potential to be affected by this deficiency. 3. Medication Management Policy has been reviewed. 4. DON or designee will educate clinical staff on proper medication administration including review of the Medication Error Policy referencing: "The community will report all medication errors as soon as the error is discovered. 1. Medication and treatment errors must be reported to the DON immediately or as soon as the error is discovered. 2. DON or licensed Nurse wi telephone physician regarding error for any immediate interventions (including call the pharmacist.) This communication and resulting guidance received from the physician will be document in the resident's medical record. 3. The team member who makes or discovers the error must complete the medication/treatment error report. 4. The DON will be responsible for completing their portion of documentation and submit to Executive Director for review." 5. An audit of three medication administration events will be completed by the DON/Designee weekly times 4 weeks, then monthly times 3 months then monthly thereafter until substantial compliance is continuously met. 6. An audit of three MAR's to monitor for availability of medications and proper administration will be completed by DON/Designee weekly times 4 weeks, then monthly times 3 months then monthly thereafter until substantial compliance is continuously met. 7. The results of these audits will be brought to the QA committee monthly for their review and advisement until substantial compliance is met for 3 consecutive months.	6.14.2024

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S 681	Continued From page 3 physician. Findings included: 1. Review of resident 1's Medication Administration Record (MAR) revealed: *On 4/9/24 he started on Amoxicillin-Potassium Clavulanate Oral Tablet 1 tablet by mouth two times a day for infection Lead for 60 administrations. *On 4/24/24 his Amoxicillian-Potassium Clavulanate Oral Tablet was marked as not available and continued as not available through 4/30/24. -On dates 4/25/24 at 2100 and 4/27/24 at 0700 his medication had been marked as administered. Review of resident 1's progress notes revealed: *On 4/23/24 a note referenced "Amoxicillin-Potassium Clavulanate Oral Tablet medicine given at the time was the last one in the bottle." *On 4/24/24 a note referenced "Amoxicillin-Potassium Clavulanate Oral Tablet medicine not available will notify nursing." -There was no documentation indicating a nurse was notified that the medication was not available. *There was no documentation was in the resident electronic medical record (EMR) indicating there was communication to the physician regarding the medication errors on 4/25/24 and 4/27/24. Interview on 4/30/24 at 4:45 p.m. with executive director (ED) A regarding the above record review revealed: *She was unaware resident 1 was out of his antibiotics. *The expectation was for staff to notify the registered nurse (RN) or herself when medications were not available.	S 681		

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S 681	Continued From page 4 *The expectation was for staff not to mark a medication as administered if it had not been administered. *The director of nursing (DON) B would assist the MT that made the medication errors in completing the medication error report and call the physician. Review of the providers 2023 Medication Errors policy revealed: "The community will report all medications errors as soon as the error is discovered." "1. Medication and treatment errors must be reported to the DON immediately or as soon as the error is discovered." "2. DON will instruct the medication assistant to telephone physician regarding error for any immediate interventions(including call the pharmacist). This communication and resulting guidance received from the physicians will be documented in the residents medical record." "3. The team member who makes or discovers the error must complete the medication/treatment error report." "4. The DON will be responsible for completing their portion of documentation and submit to Executive Director for review."	S 681		
S 838	44:70:09:09(4) Quality Of Life A facility shall provide care and an environment that contributes to the resident's quality of life, including: 4) Freedom from verbal, sexual, physical, and mental abuse and from involuntary seclusion, neglect, or exploitation imposed by anyone, and theft of personal property;	S 838	S838 1. Resident #1 unable to correct noncompliance. 2. All residents have the potential to be affected by this deficiency. 3. Change of Condition Policy has been reviewed. 4. DON or designee will educate clinical staff on Change of Condition Policy and Allowable Health Condition Policy. 5. DON and ED will audit 3 resident care service plans weekly for 4 weeks to ensure appropriate ancillary service referrals are in place. Then monthly audits of 3 residents for 3 months and then monthly thereafter until significant compliance is met. 6. The results of these audits will be brought to the QA committee monthly for their review and advisement until continued substantial compliance is met for 3 consecutive months.	6.14.2024

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S 838	Continued From page 5 This Administrative Rule of South Dakota is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) event report review, record review, interview, and policy review, the provider failed to ensure one of one sampled resident (1) received care that contributed to his quality of life and resulted resulted in surgery. Finding included: 1. Review of SD DOH event report for resident 1 indicated on 4/2/24 he was sent to the urgent care to have his fingernails clipped but was referred to the emergency room (ER). Review of the provider's SD DOH event report for resident 1 indicated: *He approached the medication technician (MT) on the above date to get his morning medications when the MT noticed dried blood. She asked resident 1 if he was ok and he responded no. MT attempted to open his left hand which had contractures and noted his fingernails embedded into the palm of his hand. *He was taken to urgent care at 2 p.m. and then transported to ER at 4:30 p.m. Review of Resident 1's electronic medical record (EMR) revealed: *He was admitted to the facility on 2/9/23. *His diagnoses were paranoid schizophrenia, mental disorder, alcohol dependence, seizures, fracture of the right and left humerus and dysphagia. *Guardianship was an Advocacy Group. *The Mini Mental examination was a 28 indicating normal cognition. *The health and Functional Assessment was completed on 3/13/23. -The was no documentation of a contracture to	S 838		

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S 838	Continued From page 6 his left hand. *The resident evaluation was started on 6/28/23 but was not completed. *The resident evaluation was completed on 11/27/23 indicating he needed assistance with nail care and foot care. *The first skin assessment noted in his EMR was on 2/1/24. Review of Resident 1's progress notes revealed: *On 7/29/23 a note was entered stating, "On {resident's name} left hand, there is a start of an infection, it has a bad odor, the skin is dry and scaley, but yet seems moist. His nails were quite long and difficult to trim, due to his fingers being curled inward." *On 7/31/2023 a note was entered stating, "Washed {resident's name} left hand with Antibacterial soap and dried well, he has very dry skin on his hand and some flaking as well. I put a rolled up wash cloth in his hand, his fingers are difficult to move or uncurl, but I was able to place the wash cloth." *There was no other documentation was entered into the EMR regarding his fingernails until 4/2/24. Review of Resident 1's 4/2/24 hospital stay revealed: *He had an infection of the left hand due to the puncturing of his fingernails through the skin of his palm. -He had a chronic contracture of his left hand. *He had surgery for a contracture tendon release and debridement of the left-hand palmar wounds. *He had cellulitis myositis(the area was becoming necrotic(dead tissue). *Infectious disease was consulted and recommended six weeks of oral Augmentin. *Orthopedic recommended physical therapy (PT) and occupational therapy (OT).	S 838		

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S 838	Continued From page 7 *He was discharged from the hospital on 4/9/24 and returned to the assisted living facility (ALF). Interview on 4/30/24 at 9:40 a.m. with MT E regarding resident 1 revealed: *He came to the facility over a year ago. *He came in with the contracture to his left hand. *He would refuse to let anyone help him stretch his fingers out due to the pain. -It would hurt even when he would try to move his fingers. *She had not seen orders for PT or OT for resident 1 now or before the left-hand issue happened. Interview on 4/30/24 at 10:00 a.m. with resident 1 revealed he: *Had felt better since they released the tendon. *Had been hurting for a few months. *Had not asked the staff to cut his fingernails. -Had not remembered being asked by staff to cut his fingernails. *Would have agreed to have someone stretch out his fingers. Interview on 4/30/24 at 4:05 with executive director (ED) A revealed: *She remembered he had come to the facility with the contracture of the left hand. *She was unaware of the progress notes from the end of July. -She not aware about his fingernails until he was sent to the ED. *She had stated that the veterans affairs (VA) had talked about the contracture tendon release before. -Confirmed there was no documentation in his EMR regarding communication with the VA regarding the contracture tendon release. *Confirmed the skin assessments had not been	S 838		

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S 838	Continued From page 8 getting completed by the previous director of nursing (DON). *The current DON had been emailing the Advocacy Group regarding his current PT and OT orders. Review of the provider's undated Abuse, Fraud and Wrongdoing policy revealed: "The community takes all reasonable steps to prevent resident abuse and neglect." "The Administrator will investigate any reports of abuse, fraud or other wrongdoing." "3. If a report of abuse, fraud, or other wrongdoing is received: a. The Administrator is notified immediately b. Any urgent medical or safety issues are addressed immediately c. The Administrator or other designated representative initiates and investigation. d. The resident's responsible party is notified." "4. If the suspected abuse, fraud, or other wrongdoing is substantiated a written report is made to the appropriate licensing/regulatory agency, the responsible party, the Ombudsman, and Adult Protective Services." Refer to S680 and S681	S 838		

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{S 000}	Compliance Statement An onsite revisit survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers was conducted on 6/24/24 for deficiencies cited on 4/30/24. All deficiencies have been corrected, and no new noncompliance was found. Fairmont Grand Senior Care is in compliance with all regulations surveyed.	{S 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE