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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435072	A. BUILDING _____ B. WING _____	05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN SISTERS LIVING CENTER	1201 HWY 71 SOUTH HOT SPRINGS, SD 57747

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 5/9/22 through 5/12/22. Seven Sisters Living Center was found not in compliance with the following requirements: F609, F657, F658, F679, F692, F742, F755, and F880.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 609		

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

[signature] | Administrator | 06-02-22

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 609	Continued From page 1 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, provider's incident review, and policy review, the provider failed to report to the South Dakota Department of Health (SD-DOH) an incident that required emergency medical treatment outside of the facility for one of one sampled resident (31). Findings include: 1. Interview on 5/9/22 at 4:02 p.m. with resident 31 revealed she: *Discharged from the facility to her home at the end of February 2022, fell at home, and required hospitalization after that fall. -Readmitted to the facility from the hospital for long-term care in early March 2022. *Had returned to the hospital since her readmission in early March 2022, but declined to discuss the nature of that hospital stay. Review of resident 31's care record revealed her diagnoses included: opioid abuse in remission, multiple sclerosis, chronic pain syndrome, fibromyalgia, major depressive order, anxiety disorder, and chronic obstructive pulmonary disease. Review of 3/7/22 interdisciplinary progress notes revealed: *At 9:45 a.m. she was found in bed by staff unresponsive. *At 9:50 a.m. a registered nurse assessment: -The resident's eyes would open intermittently and her pupils were pinpoint bilaterally. -She had no purposeful response to verbal or tactile stimuli. *She was transferred to an emergency	F 609	1. This is an isolated incident. No other Residents affected. The administrator, DON, and/or designee in consultation with the medical director will provide in-service training June 6, 2022 and June 7, 2022 on mandatory reporting state requirements with all facility staff. 2. All Staff re-educated on mandatory reporting by June 10, 2022. 3. ADON or designee will audit all Residents that transfer to higher level of care for any incident that requires mandatory reporting and audit that mandatory reporting was completed as required weekly x4, monthly x4 and quarterly x3. DON or designee will report audit results/findings to the QAPI committee monthly for further recommendations. 4. 6/10/2022	6/10/2022

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F 609	Continued From page 2 department for medical care. Review of resident 31's 3/8/22 Inpatient Discharge Summary revealed a discharge diagnosis list that included opiate overdose. Interview and review of the provider's 3/7/22 Incident Report/Investigative Report on 5/11/22 at 4:26 p.m. with director of nursing (DON) B revealed: *DON B stated someone had brought resident 31's purse from her home into the facility the morning of 3/7/22. *Oxycodone pills and amphetamine tablets had been found in that purse after she was transferred to the emergency room on 3/7/22. -Those were the same medications she had been discharged home with in February 2022. *The incident had not been reported to the SD-DOH but should have been. -That had been her responsibility. Review of the 3/1/17 Abuse policy revealed: *"g. Injuries of Unknown Origin: An injury should be classified as an injury of unknown source when both of the following conditions are met: -i. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident/patient; -ii. The injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incident of injuries over time." *Reporting and Response: -"It is the policy of this facility that "abuse" allegations (abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident/patient property) are reported per Federal and State	F 609		

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F 609	Continued From page 3 Law."	F 609		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure care plans were updated and revised to reflect residents current needs for one of fourteen sampled residents (31). Findings include:	F 657	1. IDT met with Resident 31 to review her care plan and spirituality needs, grief from the loss of her son, and current counseling needs. Care plan updated 5/30/2022 by IDT. Other Residents may have the potential to be affected. Activities will complete interviews by 6/3/2022 with all Residents asking about spirituality and counseling and will update care plans accordingly. 2. The administrator, DON, and/or designee in consultation with the medical director will provide in-service training June 6, 2022 and June 7, 2022 on care planning psych/social and spirituality needs to all facility staff. All staff will be re-educated by June 10, 2022. 3. ADON or designee will interview 31 and four Random Residents and audit their care plans for meeting psycho social and spirituality needs. ADON will complete audits weekly x4, monthly x4 and quarterly x3. DON or designee will report audit results/findings to the QAPI committee monthly for further recommendations. 4. 6/10/2022	6/10/2022

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F 657	Continued From page 4 1. Interviews on 5/9/22 at 4:02 p.m. and 5/10/22 at 10:45 a.m. with resident 31 revealed: *Spirituality was important to her. *She had tears in her eyes when she spoke about the death of her son. *She had a new roommate and they got along well. Review of resident 31's medical record revealed she: *Was found unresponsive in her room the morning of 3/7/22. -Was transferred to the emergency department, treated for an opioid overdose, and returned to the nursing home on 3/8/22. Review of resident 31's care plan last revised on 4/11/22 revealed: *That care plan had not been individualized and updated to reflect: -The unresolved grief she had related to her son's death. -Her heightened sense of sadness during the month of March when he died. -Her participation in individual therapy sessions related to her depression, anxiety, and complicated bereavement. -Her unique religion and how she maintains her connection with it through on line formats, individual practices, and through a current staff member who also shared those beliefs. -Her use of transcendental meditation to achieve inner peace. -The close relationship she has established with her current roommate. Interview on 5/11/22 at 4:26 p.m. with director of nursing (DON) B regarding resident 31's care	F 657		

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F 657	Continued From page 5 plan revealed she: *Agreed it had not identified specific interventions, supports, and strategies that resident utilized to help manage her depression, anxiety, and grief. -It was the responsibility of each interdisciplinary team member to have updated and revised that care plan as needed to ensure it was accurate and complete. *Knew the resident also enjoyed lifelike dolls she kept in her room, but that was not mentioned in the care plan either. Review of the providers 5/27/21 Care Planning Policy revealed: *"3. The Plan of Care will be individualized, based on the diagnoses and resident assessment. Each resident's comprehensive care plan is designed to: -Incorporate identified problem issues; -Incorporate risk factors associated with identified problems; -Build on the resident's strengths; -Reflect treatment goals, timetables and objectives in measurable outcomes; -Aid in preventing or reducing declines in resident's functional status and/or functional levels." *8. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: -When there has been a significant change in the resident's condition; -When the desired outcome is not met; -When the resident has been readmitted to the facility from a hospital stay; and -At least quarterly."	F 657		
F 658 SS=E	Services Provided Meet Professional Standards	F 658		

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F 658	Continued From page 6 CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure professional standards of practice were followed for: *Administration of as-needed medications by one of one unlicensed assistive personnel (UAP) (F) for one of one observed resident (23). *Eye drop administration by one of one UAP (J) for one of one observed resident (22). *Nasal spray administration by one of one UAP (J) for one of one observed resident (22). Findings include: 1. Observation, interview, and review of medication administration record (MAR) on 5/10/22 at 5:57 p.m. of registered nurse (RN) O for resident 23 revealed: *Resident 23 had complaints of back pain. *She had told the resident she would see if there was pain medication available. *The MAR had shown UAP F had administered a hydrocodone-acetaminophen 5/325 milligrams (mg) tablet at 4:47 p.m. *She indicated she had not directed UAP F to administer the medication. *Another nurse may have directed her to administer the medication but she was not sure. *UAPs were to ask a nurse before administering any as-needed medication to residents. Interview on 5/10/22 at 6:05 a.m. with UAP F	F 658	1. The administrator, DON, and/or designee in consultation with the medical director will review and update the standards of medication administration policy May 31, 2022 and DON will provide in-service training on updated policy to all staff that administer medications at staff in-service June 6, 2022 and June 7, 2022. All Residents had the potential to be affected. 2. All facility Staff that administer medications will be re-educated on standards of medication administration policy updates at staff in-services June 6, 2022 and June 7, 2022. All staff that administer medication will complete medication pass competency by June 10, 2022. 3. ADON or designee will audit med pass for UAP F, UAP J and three additional Random staff members auditing med administration of prn medications, nasal spray and eye drops for Res 23, Res 22 and three additional Random Residents weekly x4, monthly x4 and Quarterly x3. DON or designee will report audit results/findings to the QAPI committee monthly for further recommendations. 4. 6/10/2022	6/10/2022

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F 658	Continued From page 7 regarding the as-needed medication for resident 23 revealed she: *Did not ask a nurse before administering as needed medications to resident 23 because she asked for the pain medication every day around the same time. *Only asked a nurse if she could administer as needed medications if it was not a normal request for the resident. Review of resident 23's MAR and interdisciplinary progress notes revealed: *UAP F had administered: -Hydrocodone-acetaminophen 5/325 mg one tablet twenty times in April 2022 and nine times in May 2022. -Diphenhydramine 25 mg one capsule five times in April 2022 and one time in May 2022. *No progress notes that a nurse had been notified prior to administration. Interview on 5/11/22 at 5:24 p.m. with director of nursing B regarding UAPs administering as needed medications revealed: *She had expected UAPs to ask a nurse before administering as needed medication to any resident. *UAPs were educated to ask a nurse prior to administering any as needed medications. Review of UAP F's 7/7/21 Medication Aide Skills Competency revealed it had not addressed administration of as needed medications. Review of the provider's 7/12/18 Standard of Medication Administration policy revealed it had not addressed UAP's role in medication administration.	F 658		

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F 658	Continued From page 8 Review of the provider's October 2014 Medication Aide job description revealed the UAP should only administer as-needed medication under the direction of a nurse. 2. Observation and interview on 5/10/22 at 8:00 a.m. of UAP J administering three separate eye drop medications for resident 22 revealed: *All three medications were administered by UAP J into the inner most corner of the resident's eyes. *"An old nurse showed her" how to instill eye drops that way. *Had not known the accepted standard of practice for eye drop administration was to pull the center of the lower eyelid down and drop the medication into the mid lower eyelid. 3. Continued observation and interview on that same date and time with UAP J administering nasal spray for resident 22 revealed she: *Administered that spray without first having that resident clear her nasal passage by blowing her nose. -Knew she should have had her blow her nose before administering that spray, but she had not done that. Interview on 5/11/22 at 3:05 p.m. with DON B revealed she: *Confirmed professional standards of practice for eye drop and nasal spray administration had not been followed by UAP J. *UAP J's 7/9/21 medication aide skills competency checklist included medication administration observations for oral, topical, and inhaler routes. Review of the revised 7/12/18 Standards of	F 658		

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F 658	Continued From page 9 Medication Administration policy revealed: *Eye Drops: -"Gently pull the lower eyelid down. Instruct the resident to look up. -Drop the medication into the mid lower eyelid [fornix]." *Nasal Spray Administration: -"c. Ask Res [resident] to blow nose gently before using the spray."	F 658		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to update and implement an activity program for one of one resident (21) at risk for social isolation. Findings include: 1. Interview on 5/10/22 at 9:10 a.m. with resident 21 revealed: *She was afraid to leave her room because she needed to be near the bathroom. *She was unable to attend most group activities because of her fears related to her diagnoses. *She had pain to her rectum that had also	F 679		

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F 679	Continued From page 10 restricted her movement outside of her room. *She would have "loved someone to visit with her for even 10 minutes." *She felt the staff were too busy to take the time to just sit and listen to her. Review of resident 21's medical record revealed: *Her admission date was 3/19/21. *Her diagnoses included: atrial fibrillation, weakness, chronic obstructive pulmonary disease, congestive heart failure, anxiety disorder, pain, diarrhea, constipation, other specified diseases of the anus and rectum. Review of resident 21's 3/8/22 annual Minimum Data Set (MDS) assessment revealed: *She was cognitively intact. *She had important preferences for the following activities: -Books, newspapers, and magazines. -Music. -Animals. -News. -Fresh air. -Religion. *It was not at all important to do things with groups of people. *She was independent with activities of daily living. *She was occasionally incontinent of the bladder. *She was frequently incontinent of bowel. *She had pain almost constantly that had limited her day-to-day activities. Review of resident 21's 3/24/21 care plan revealed: *She was "dependent on staff for meeting physical, and social needs r/t [related to] physical limitations.	F 679	1. Res 21 care plan updated to offer 1:1 by DON 5/11/2022. DON completed follow up interview since 1:1 was added to care plan with Resident 21 on 5/30/2022 and reviewed Resident care plan with Resident. Res reported she is happy with current activities and care plan. There are 13 other Residents that have the potential to be affected. All 13 Residents will be interviewed for activity preferences and needs and care plan reviewed with Resident and updated by 6/3/2022. 2. The administrator, DON, and/or designee in consultation with the medical director will provide in-service training on June 6, 2022 and June 7, 2022 on identifying Residents at risk for social isolation and recommend staff stop by and visit with those Residents that frequently stay in their room check to see if they have any concerns and just visit with them a few minutes and encourage their involvement in facility activities. Notify activities of any activity concerns or requests. All staff will be re-educated by June 10, 2022. 3. ADON or designee will interview Res 21 and four Random Residents and audit their care plans for meeting activity needs. ADON will complete audits weekly x4, monthly x4 and quarterly x3. DON or designee will report audit results/findings to the QAPI committee monthly for further recommendations. 4. 6/10/2022	6/10/2022

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F 679	Continued From page 11 *The goal was that she would attend activities of choice. *Interventions included: -"Individual leisure interests include reading, watching television, and napping." -"Introduce Resident to Residents with similar background, interests and encourage/facilitate interaction." -"Invite/remind Resident of activities of choice." -"Resident enjoys getting her nails done, musical activities, games, Resident Council, and some special events or parties." -"Thank Resident for attendance at activity function." *It had not addressed her not wanting to do things with groups of people. *It had not addressed any 1:1 interaction. Review of resident 21's activity attendance logs from 4/12/22 through 5/11/22 revealed: *She had been invited to attend 24 group activities. *She had refused to attend nineteen of those activities. *Refer to above-mentioned preference of not wanting to join in group activities. *There was no documentation for one to one activities, pet visits, or outside activity. Review of resident 21's activity participation notes revealed: *For her quarterly MDS with look back dates of 12/3/21 through 12/9/21: -She had not participated in any activities. -"Resident participates in leisure opportunities with independent pursuits, small/large group interactions, and one on one interactions." -"Resident is social and enjoys visiting with others."	F 679		

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F 679	Continued From page 12 *For her annual MDS with look back dates of 3/2/22 through 3/8/22: -She had not participated in any activities. -"Resident participates in leisure opportunities with independent pursuits, small/large group interactions, and one on one interactions." -"Resident is social and enjoys visiting with others." Interview on 5/12/22 at 9:05 a.m. with unlicensed assistive personnel (UAP) Q revealed: *Resident spent a lot of time in her room alone and often slept a lot. *She would occasionally come out to visit with staff and walk in the hall. *Agreed she did have some bowel incontinence, and needed to stay near her bathroom. *She was not sure if she was offered one-to-one activities but had seen an activity staff person go into the room occasionally. Interview on 5/11/22 at 1:24 p.m. activity assistant P regarding resident 21 revealed: *Resident 21 was not offered one-to-one activities because she was not on the list. *It was the activity director who decided which resident was offered one-to-one activities. *The activity director was out of the facility on leave. *Tried to get resident 21 to attend group activities but she refuses because she is in pain and does not want to be away from the bathroom. *She had thought resident 21 was able to come out of her room and did not think she should need to be near her bathroom. *She was not aware resident 21 wanted people to come and spend time to listen to her. Interview on 5/11/22 at 5:29 p.m. with director of	F 679		

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	435072	A. BUILDING _____ B. WING _____	05/12/2022

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F 679	Continued From page 13 nursing B revealed: *Resident 21 preferred not to come out for group activities because of her pain and incontinence. *Did not know why resident was not receiving one-to-one activities. *Activity Director was out of the facility on leave. Review of the provider's 1/22/19 Activity Department policy revealed: *"It is the purpose of the Activities Department of Fall River Health Services to provide a program that will meet the physical, intellectual, social, spiritual and emotional needs of the residents/patients in much the same way that everyday life in the community provides challenges. *The Activities Department provides these needs in a planned and coordinated manner and in a way that is beneficial in overcoming specific problems. *"It is paramount and the objective to provide these activities in a "meaningful way" from the resident's/patient's view and abilities." *"The Activity Department will provide all residents/patients and necessary staff with a posted monthly calendar of scheduled activities and may ask nursing staff for assistance on the larger group activities (or special events) as needed to carry out those activities. *The Activity Director and assistant provide access to these events for residents/patients as well as one to one activities for those who require them."	F 679		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes,	F 692		

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F 692	Continued From page 14 both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and policy review, the provider failed to ensure one of one resident (3) who was at nutritional risk received ongoing monitoring of nutrition and revisions in care as her nutritional status changed. Findings include: 1. Observations on 5/9/22 at 3:56 p.m., on 5/10/22 at 8:04 a.m. and at 1:35 p.m. of resident 3 revealed she appeared thin and weak. Review of resident 3's medical record revealed: *An admission date of 10/2/15. *Her diagnosis included: chronic obstructive pulmonary disease, nutritional deficiencies, muscle weakness, osteoporosis, pain, dementia, depression, and post COVID-19 condition. *She was diagnosed with COVID-19 on 1/21/22.	F 692	1. Resident 3 is currently on Hospice. Dietician seen Resident 3 on 5/19/2022 and will continue to follow monthly. Res frequently refusing meals. Res ate 50% of each of the meals that were accepted by Resident. Res offered snacks by staff in the afternoon and hs. Resident does refuse snacks frequently. Daughter is bringing in additional snacks such as rice krispie bars and Resident eats 100% of snacks offered by daughter. Res enjoys sweets. Res current weight is 90 pounds and doctor has been notified. Staff will continue to offer and encourage meals TID, snacks in the afternoon and HS and offer boost with meals. All Residents assessed for weight loss 3 additional Residents noted to be at nutritional risk r/t weight loss. All Residents with unplanned weight loss noted care plans were reviewed by IDT team for interventions and care plan updated 6/1/2022 and dietician seen all Residents on 5/19/22 and doctor notified 6/1/2022. Residents considered at nutrititional risk r/t weight loss will continue to be seen by dietician monthly. 2. All facility Staff will be educated at staff in-service on June 6, 2022 and June 7, 2022 by DON, Administrator and Dietary Manager. Staff will be re-educated on documenting weights weekly and documenting all meal and snack intakes and documenting refusals. Dietary supervisor will review all residents weights weekly x4 then monthly and will notify dietician and physician of any Resident with significant weight loss. Dietician will be scheduled to see any Resident with weight loss monthly and facility will follow dietician recommendations. 3. ADON or designee will audit Resident 3 and four random Residents for weight loss, interventions, doctor notification and dietician visits. Audits completed weekly x4, monthly x4 and Quarterly x3. DON or designee will report to QAPI committee monthly for further recommendations. 4. 6/10/2022	6/10/2022

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F 692	Continued From page 15 *She had been admitted to hospice on 4/27/22 with an admission diagnosis of abnormal weight loss and dyspnea. *Her weight on: -1/4/22 was 117 pounds. -2/10/22 was 104.5 pounds. -2/15/22 was 108 pounds. -3/9/22 was 106 pounds. -3/17/22 was 103 pounds. -4/3/22 was 95.5 pounds. -4/21/22 was 89.5 pounds. -4/29/22 was 89.5 pounds. *She had lost 27.5 pounds which was 23.5% of her body weight in 4 four months. Review of resident 3's 2/1/22 quarterly Minimum Data Set (MDS) assessment revealed she had: *Short and long-term memory impairment. *Been able to feed herself with set-up assistance. *No problems swallowing. *Weight of 105 pounds. *Five percent or more weight loss not prescribed by a physician. Review of resident 3's dietary intakes revealed from 1/27/22 through 4/30/22: *1/27/22 through 2/9/22: -She had not eaten or refused 171 out of 282 meals. -33 meal intakes had not been documented. -She had not eaten or refused 82 bedtime snacks. -16 days of bedtime snacks had not been documented. -There was no documentation for an afternoon snack being offered. Review of resident 3's interdisciplinary progress notes revealed on:	F 692		

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F 692	Continued From page 16 *2/10/22 she had been seen by a physician. There was no note indicating if he was aware of the resident's weight loss. *2/10/22 a plan of care meeting was held and the resident's daughter had attended via phone. Her low mealtime intakes and weight loss had been discussed. No nutritional interventions had been discussed with the daughter. *2/18/2022 at 2:35 p.m. a dietary note indicated that she had weight loss in the last month. She had refused to drink Boost or Ensure supplement. It stated "[resident's name] will eat Nutty Buddys from the snack trays between meals." *4/28/22 at 10:38 a.m. a dietary note was entered by the registered dietician(RD) stating: "RD - Hospice care Wt [weight]: 89.5# [pound] (4/21/22) Diet order: regular, regular texture & consistency. Medical problems/history: COPD [chronic obstructive pulmonary disease], chronic right heart failure, NSTEMI MI [non-ST-elevation myocardial infarction], Alzheimer's disease, dementia, weakness. Assessment: Resident is hospice care. Resident has poor intake - she declines most meals. Of meals consumed she has 30% average of foods 232cc/ [cubic centimeter per]meal of fluids. No eating problems. No edema. Skin is intact, thin, fragile & [and] pale. She unintentionally lost 27.5# since 1/4/22 and 6# in the past 3 weeks. Continued wt loss is expected with poor intake. Nutrition interventions: Resident will be provided foods, fluids and supplements that she requests, enjoys and tolerates to provide comfort and maintain dignity during her passing." Review of resident 3's physician progress notes revealed on: *2/10/22 she had been seen for an annual exam with labs.	F 692		

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F 692	Continued From page 17 -Weight listed in the note was 117 pounds. -Weight loss was not addressed in the note. *4/14/22 she had been seen for a 60 day visit. -Weight listed in the note was 95.8 pounds. -Assessment/Plan included: --Diagnoses: dementia without behavioral disturbance, moderate depression, congestive heart failure, hypothyroidism, and long COVID. --"Patient continues to be bedridden, dementia appears to be getting worse. Staff reports that since patient had COVID that she had been deteriorating at a more rapid pace." Review of the provider's Nutrition/Skin Workgroup Minutes revealed they had met on: *2/15/22 and resident 3 was not discussed for her weight loss. *3/15/22 and resident 3's weight loss was discussed as new business. -The food service supervisor was listed as the process owner. -They did discuss that she did not care for supplements but did like Nutty Buddy bars and ice cream between meals. -For follow up they were going to continue to monitor. *4/19/22 and resident 3's weight loss was again discussed. -The food service supervisor was listed as the process owner. -Resident had agreed to adding Boost at meal times. -Stated she liked Nutty Buddy Bars. -For follow up they were going to continue to monitor. Review of resident 3's 2/12/21 care plan revealed: *The goals were:	F 692		

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F 692	Continued From page 18 -To eat 75 to 100 percent of her lunch and supper meals. *Interventions included: -Encouraging her to get up out of bed for lunch, or provide her a room tray. -"Avoid activities that involve bending, lifting. -"Avoid lying down for at least 1 hour after eating. Keep HOB [head of bed] elevated. Encourage to stand/sit upright after meals." -"If she is hungry at night there are Marie Callendar pot pies in the freezer in activities, or provide something from the HS [hour of sleep] snack tray." -"Provide Boost or ensure pudding at meals to aid in receiving extra protein when [resident's name] does not eat." --This had been added on 3/22/22. *It had not addressed weight loss. *It had not addressed offering snacks between meals. Interview on 05/11/22 at 4:51 p.m. with director of nursing (DON) B regarding resident 3's weight loss revealed: *Supplements were added to the care plan on 3/22/22. *The interdisciplinary team did not catch the weight loss timely. *The resident had COVID-19 in January and had a health decline. *Provider held monthly nutrition meetings. *Did not know how often the registered dietician reviewed and documented on each resident. Interview on 5/11/22 at 4:55 p.m. with food services supervisor D regarding resident 3's weight loss revealed: *She had tried to review all residents' weights weekly.	F 692		

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F 692	Continued From page 19 *She was responsible to update the registered dietician if a resident was having weight loss or nutritional concern. *Resident was on the snack list on the snack tray to receive a snack during the afternoon and evening snack pass. *Agreed she had not found the weight loss when it first started. *She had tried to offer resident 3 supplements prior to March 2022 but the resident had stated she did not want them. *She did not know she should have documented what interventions had been tried and residents refusals of those interventions. Continued interview on 5/12/22 at 8:45 a.m. with food services supervisor D revealed: *She was responsible to update nutrition care plans for all residents. *She did not update a care plan when a resident had weight loss. *Intake of nutritional supplements were not documented to monitor if a resident was drinking them. *She had stated the care plan should have been updated to reflect the residents' current needs. Phone interview on 5/12/22 at 10:45 a.m. with RD E regarding resident 3's weight loss revealed: *Resident 3 had just decided to quit eating. *The meal and snack intake records indicated she was refusing to eat. *She was in the facility one time a month. *She received a list of residents who needed to be reviewed each month from food services supervisor D. *She had been aware resident 3 was losing weight but she was not sure how long she had known about the weight loss.	F 692		

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F 692	Continued From page 20 *She thought there had been different interventions tried but did not know if they would have been documented. *"She knows it is not an excuse, but she [resident 3] just doesn't want to eat". *She had spoken with resident 3's daughter about the weight loss but had not documented the conversation. Interview on 5/12/22 at 11:01 a.m. with DON B, assistant director of nursing (ADON) C, and food services supervisor D regarding resident 3's weight loss revealed: *The ADON noticed the weight loss when doing MDS assessments in April 2022. *Food service supervisor did not notify RD E about the weight loss until the end of April 2022. *Did not have documentation of doctor, family, or RD notification of the weight loss. Review of the provider's July 2017 Resident at Nutritional Risk policy revealed: *"Policy: Residents at nutritional risk will be identified and provided nutritional care unless contrary to the resident's, their family's wishes, or Physician's orders." *"1. The CDM/DSM [certified dietary manager/dietary service manager] will keep a current list of those at nutritional risk. Information will be obtained from nursing, from attending care conference and other meetings, from personal observations, and the Registered Dietitian. All residents who meet the following criteria will be included:" -"a. Weight down - 5% [percent] in 1 month or 10% or more in 6 months unless resident is expected to have weight loss. -b. Resident is below Ideal Body Weight Range." *"3. Nursing will be asked to weigh the nutritional	F 692		

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F 692	Continued From page 21 "At Risk" resident weekly (all other residents monthly or more as requested), and will be asked to reweigh resident with a gain/loss of 5 pounds or more in a week's time. *4. Dietary will visit the resident to offer suggestions for food substitutions, nutritious snacks or supplements. The first choice of increasing intake will be offering regular foods and snacks whenever possible and appropriate...."	F 692		
F 742 SS=G	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, job description review, and policy review, the provider failed to: *Arrange for timely behavioral health follow-up after one of one sampled residents (31) hospitalization for an opioid overdose. *Identify, implement, and evaluate interventions for caregivers to follow for one of one sampled resident (31) who had: -Recently returned to the facility after a fall in her home and now required long term care. -A history of mental illness diagnoses and	F 742		

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F 742	Continued From page 22 unresolved grief issues. -Multiple medical diagnoses including chronic pain and progressive physical debility. Findings include: 1. Observation and interviews on 5/9/22 at 4:02 p.m. and 5/10/22 at 10:45 a.m. with resident 31 revealed she: *Had been in her room lying in her bed. -Was alert, oriented, and able to verbally engage in conversation. *Got along well with her roommate and they visited throughout the day. *Enjoyed books, watching television, and reading devotions to other residents. *Had been practicing Buddhism since she was nine or ten years old. -Used the strand of beads on her nightstand for meditation. -Used an online forum to connect with other Buddhists. *Practiced transcendental meditation. *Discharged home from the facility the end of February 2022, but had a subsequent fall at her home, required hospitalization, and returned to the facility for long term care in early March 2022. *Had been hospitalized since her return to the facility but declined to explain the reason why. *Stated two years ago in March her youngest son had died unexpectedly. -The month of March was an especially difficult time for her. -Had been meeting with a therapist since early April 2022 to help her manage unprocessed grief related to that death. *Had also been referred to a psychiatrist in early April 2022. -Felt no benefit from having seen that provider.	F 742	1. Res 31 interviewed and assessed by DON for psychosocial concerns and treatment needs on 5/31/2022. Care plan reviewed with Resident 31 and care plan updated 5/31/2022. Res currently seeing counselor at Fall River Health Services and reports she is happy with her current counselor and does not wish to see anyone else at this time. DON contacted counselor and reviewed Resident current care plan with counselor and discussed asked counselor if there are any additional interventions recommended. 2. The administrator, DON, and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for Timely behavioral health follow up and care planning psychosocial needs. All facility staff will be re-educated at staff in-service by DON or designee on June 6, 2022 and June 7, 2022. 3. ADON or designee will audit Resident 31 and four random Residents for timely behavioral health follow up and audit care plan for addressing psycho social needs, and audit progress notes for documentation mood behavior documentation and follow up. Audits will be completed weekly x4, monthly x4 and Quarterly x3. DON will report audit results to QAPI committee monthly for further recommendations. 4. 6/10/2022	6/10/2022

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F 742	Continued From page 23 Review of resident 31's care record revealed: *Admission Physician's Orders dated 3/3/22 included an order for psychiatry services. *Her diagnoses included: multiple sclerosis, chronic pain syndrome, fibromyalgia, major depressive order, anxiety disorder, chronic obstructive pulmonary disease, opioid abuse in remission. *She was hospitalized on 3/7/22 after an opioid overdose and readmitted to the facility on 3/8/22. *On 4/7/22 she had an initial consultation with a licensed clinical social worker (LCSW) T outside of the nursing home that specialized in behavioral health. -Had received counseling from that social worker regularly since that time. *On 4/12/22 she had a psychiatric evaluation completed. Interview on 5/11/22 at 3:15 p.m. with director of nursing (DON) B regarding behavioral health follow-up after resident 31's 3/8/22 hospital return revealed: *The resident had been referred to a behavioral health nurse practitioner in the clinic attached to the nursing home after her 3/3/22 admission, but the resident had requested to see a different provider. *DON B had contacted that same behavioral health clinic by e-mail on 3/8/22 and on 3/10/22 requesting a behavioral health appointment for the resident with a different provider. *On 3/22/22 the resident had indicated to DON B she was willing to see a behavioral health provider not affiliated with the attached behavioral health clinic. -No referrals outside of the attached behavioral health clinic had been made. *On 3/29/22 DON B sent an e-mail to the LCSW	F 742		

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F 742	Continued From page 24 in the attached behavioral health clinic requesting an appointment for the resident. -That appointment with the LCSW occurred on 4/7/2. *On 4/12/22 an appointment with a behavioral health physician in the attached clinic was made. *DON B expected resident 31 had not waited over a month to receive psychiatric follow-up after her 3/8/22 hospital return. -She was unable to explain why that appointment had been delayed. Interview on 5/12/22 at 9:30 a.m. with administrator A regarding behavioral health follow-up after resident 31's 3/8/22 hospital return revealed: *"We dropped the ball." -Struggles between medical and behavioral health providers within that facility's healthcare system had "stalled" the ability to get resident 31's behavioral health services sooner. *That was a process that the healthcare system was actively working on. *An appointment with a different behavioral health provider should have been arranged. 2. Review of resident 31's interdisciplinary progress notes between 3/8/22 and 3/31/22 revealed: *Repeated entries throughout that time regarding that resident's need for pain and anxiety medication. -No description of how that anxiety had manifested itself. *The first nurse documentation related to resident 31's mood state was on 3/13/22. -"Psych/Social: States that she likes to be a hermit but is quite social when out with others for activities or at meal times."	F 742		

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F 742	Continued From page 25 *One social service note on 3/15/22 stated: -"...she possibly attempted suicide one time here-that is why she ended up in the hospital so her Physician knows as well as Behavioral Health. No behaviors present." *Her 3/7/22 PHQ-9 (patient health questionnaire) depression scale score was 6 indicating mild depression. -Mood indicators included appearing depressed, tired, and feelings of letting herself down. *Her 3/13/22 PHQ-9 score was 4 indicating minimal depression. -Mood indicators included trouble staying asleep and feeling tired daily. *A 3/17/22 interdisciplinary care team meeting note. *None of the documentation referred to above had comprehensively described the status of resident 31's current or ongoing mood state since her 3/8/22 nursing home readmission. Review of resident 31's revised 4/11/22 care plan revealed mood interventions that included: *"Monitor/document/report as needed any signs or symptoms of depression including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing negative statements, repetitive anxious or health-related complaints, and tearfulness." *"The resident needs time to talk. Encourage the resident to express feelings." *A list of her preferred leisure activities that were last updated on 9/9/21 during a prior nursing home stay. *Inclusion of the anti-depressant and anti-anxiety medications she had taken along with their potential side effects. *That care plan had not been updated and revised to reflect:	F 742		

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F 742	Continued From page 26 -Her receipt of ongoing behavioral health services. -The association of the month of March as it related to her mood state. -The significance of the death of her son and the unresolved grief continued to experience. -The importance of her unique religious and spiritual beliefs and practices. -The strong relationship she had with her roommate. Interview on 5/11/22 at 10:22 a.m. with unlicensed assistive personnel (UAP) I regarding resident 31 revealed: *She had not been informed of any updates or changes to resident 31's plan of care after her 3/8/22 hospital return. *Mood documentation was completed on interdisciplinary progress notes or on a behavioral symptoms checklist. -Both were in the resident's electronic medical record. *She was unaware of any triggers that might negatively impact that resident's mood state. Interview and review of resident 31's 4/12/22 through 5/12/22 daily behavioral symptoms documentation on 5/12/22 at 9:05 a.m. with UAP R revealed: *Behaviors on that checklist included observed: repetitive movement, yelling/screaming, kicking/hitting, pushing, grabbing, pinching/scratching/spitting, biting, wandering, abusive language, threatening behavior, sexually inappropriate, and care rejection exhibited by the resident. -Frequent crying was the only mood symptom on that checklist. -She considered isolation and infrequent talking	F 742		

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F 742	Continued From page 27 as mood symptoms too. *Throughout the time referred to above the tool had been marked "none of the above" referring to those behavioral symptoms and the single mood indicator. Interview on 5/12/22 at 9:15 a.m. with licensed practical nurse (LPN) S regarding resident 31's care record documentation revealed: *Nurses' documentation that described the status of that resident's mood state after her 3/8/22 hospital return was minimal. -There was no indication any staff had regularly spoken with the resident about whether she felt her depression and anxiety had improved or worsened, what interventions she used to manage her symptoms of depression and anxiety, and if those interventions had been effective or not. *LPN S had been responsible for ensuring thorough and complete resident documentation was evidenced in that care record and that had not occurred. Interview on 5/11/22 at 2:20 p.m. with social services director (SSD) N regarding resident 31 revealed she: *Knew that resident was at risk for a decline in her psycho-social well-being related to her mental health history, medical diagnoses, recent hospitalization for an opioid overdose, new need for long term care, and unresolved grief issues related to the death of her son. *Stated monitoring and assessing that resident's mood state was her responsibility. -That was accomplished by reviewing behavioral symptom charting, reviewing interdisciplinary progress notes, resident, family, and staff interviews, updating the plan of care as needed	F 742		

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F 742	Continued From page 28 and ensuring staff understood that plan of care. *Had not reviewed and assessed resident 31's behavioral symptom charting since she returned to the facility on 3/8/22 but should have. -Had not realized that documentation tool had not accounted for mood symptoms that would have been pertinent to resident 31. *Had only documented one social services progress note since 3/8/22. -Thought she had spoken with the resident several times since her hospital return, but had not documented those encounters and should have. -Incorrectly documented resident 31 had attempted suicide. *Said the interdisciplinary team usually met daily throughout the week to discuss pertinent resident issues. -Had not made a point of bringing up that resident during those meetings to solicit team members' input that could have been used in assessing her psycho-social status. *Had not reassessed and updated the care plan to include mood triggers or individualized non-pharmacological approaches the resident used to manage her mood symptoms, but should have. *Felt most of her time was spent coordinating new resident admissions. Interview on 5/11/22 at 3:15 p.m. with DON B regarding the interdisciplinary team's response after resident 31's 3/8/22 hospital return revealed: *She expected regular and detailed interdisciplinary progress notes after the 3/8/22 hospitalization that demonstrated the resident's mental health status had been monitored, identified and addressed any new concerns, and described how she had been coping.	F 742		

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F 742	Continued From page 29 -That had not occurred. Refer to F609 5/11/22 at 4:46 p.m. continued interview with DON B. Interview on 5/12/22 at 9:30 a.m. with administrator A regarding the interdisciplinary team's response after resident 31's 3/8/22 hospital return revealed: *Care plan interventions had not been individualized or revised to identify the resident's coping mechanisms. *There was a lack of documentation and a lack of appropriate documentation that demonstrated ongoing monitoring and review of the resident's psycho-social well-being. -As a result, there had been no assessment of the resident's mood state to determine if plan of care changes had been indicated. -SSD N was the most appropriate person to assume ownership of that assessment process, but he was not sure she had the time to do that. Review of the undated Resident's Rights revealed: "As a resident of Seven Sisters Living Center, you have certain rights and protections under Federal law that help ensure you get the care and services you need." Review of the October 2014 Social Worker job description revealed: *Role Overview: -"The Social Worker provides the social services necessary to meet the psychosocial, mental, environmental, emotional and behavioral needs of the residents to maintain their optimum levels of wellness, serving as the resident advocate ad family liaison." *Essential Functions:	F 742		

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F 742	Continued From page 30 -"4. The position maintains progress notes and documentation on any changes in the resident's condition and other pertinent information and reviews similar documentation prepared by other caretakers." Review of the revised 5/26/21 Charting and Documentation policy revealed: *Policy: "-All services provided to the resident, or any changes in the resident's medical or mental condition, is to be documented in the resident's medical record."	F 742		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		

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F 755	Continued From page 31 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to implement a consistent process to document and safely dispose of unused medications for one of one observation. Findings include: 1. Observation on 5/11/22 of unlicensed assistive personnel (UAP) I passing medications revealed at: *7:44 a.m. she had given resident 48 her medications. -Resident had accidentally dropped her aspirin tablet and it fell into the crack in her recliner. -UAP I was unable to locate the aspirin. -She did not document the dropped dose or tell a nurse she had dropped the dose. *8:07 a.m. she had given resident 10 her medications. -Resident only wanted to take half tablet of the fiber supplement. -UAP I had taken the other half tablet and threw it into a sharps container sitting on top of her medication cart. -She did not document the disposal of the half tablet or inform the nurse. -The sharps container was not affixed to the medication cart, it was just sitting on top of it.	F 755	1. The administrator, DON, Pharmacist and/or designee in consultation with the medical director will create policy for medication destruction by June 6, 2022. All Residents had the potential to be affected. 2. All staff will be educated by Administrator and DON at in-services June 6, 2022 and June 7, 2022 reviewing the revised medication administration policy, documenting refusals and wastes, and medication destruction. 3. ADON or designee will audit UAP I and three random staff members passing medications. ADON or designee will audit the medication pass of Res 48 and three random residents. The ADON or designee will audit documentation of any refused medications, dropped medications, and the waste and destruction of those medications per policy. Audits will be completed weekly x4, monthly x4 and quarterly x3. DON or designee will report audit results to QAPI committee monthly for further recommendations. 4. 6/10/2022	6/10/2022

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F 755	Continued From page 32 Interview on 5/11/22 between 7:44 a.m. through 8:10 a.m. with UAP I revealed: *When she dropped a dose of medication she did not document that anywhere or tell a nurse. *When a resident refused a medication, she did not document where she put the refused medication or tell a nurse. *She would destroy the medication by putting it into a sharps container unless it was a controlled medication. *If the medication was a controlled medication then she had to tell and nurse and two people had to destroy the medication. Interview on 5/11/22 at 8:42 a.m. with director of nursing B regarding destroying medications revealed: *When a medication was destroyed a slip for the pharmacy should be filled out and the medication should be wasted in a sharps container. *If the medication was a controlled medication it was destroyed by two nurses. Sometimes it was put into a sharps container and sometimes is was put into the Omnicell [an automated dispensing system for medications] for the pharmacy to destroy. *She had expected the UAP to notify a nurse if a medication needed to be destroyed. *She agreed the sharps containers were not affixed to the medication carts. -They had been unable to order sharps containers that fit into the sharps container holders on the sides of the medication cart. Interview on 5/11/22 at 9:15 a.m. with registered nurse H regarding destruction of medications revealed: *Staff had not documented destruction of refused or dropped doses unless they were controlled	F 755		

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F 755	Continued From page 33 medications. *Controlled medications were to be wasted in the sharps containers. *She did not feel like it was safe to put the controlled medications into the sharps container so, she would put them down the sink drain. Interview on 5/11/22 at 2:40 p.m. with registered pharmacist (RPh) M revealed: *Staff were able to put all medications that needed to be destroyed into the Omnicell and then the pharmacy would have destroyed them. *Agreed staff put medications that were destroyed at the facility into a sharps container. Requested a policy medication destruction from director of nursing B on 5/11/22 at 10:30 a.m. Received a 2/8/19 Controlled Substances Distribution and Administration policy from RPh M on 5/12/22 at 10:00 a.m. that revealed: *Unused controlled substances could be returned to the Omnicell return bin. *It did not address where medications were to be wasted.	F 755		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		

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F 880	Continued From page 34 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed	F 880	Corrective Action: 1. For the identification of lack of: *Appropriate handling and storage of medications during active medication pass. *Appropriate cleaning and maintenance of mechanical lifts between residents. *Appropriate handling and cleaning of glucose meter between residents. *Appropriate hand hygiene and glove use by staff *Appropriate hand hygiene when serving meal trays and assisting in resident set-up. The administrator, DON, and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas. All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by Infection preventionist or designee at staff in-services 6-6-2022 and 6-7-2022. All staff will be re-educated by infection preventionist or designee by 6-10-2022. Identification of Others: 2. ALL residents and staff have the potential to be affected by lack of: *Appropriate resident care needs as noted in above identified care areas. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by infection preventionist or designee by June 10, 2022. System Changes:	6/10/2022

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F 880	Continued From page 35 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure infection prevention and control practices were maintained for: *Storage and handling of medications by one of one unlicensed assistive personnel (UAP) (J) during one of one observed medication pass for one of one observed resident (22). *Cleaning of mechanical lifts by three of three observed UAPs (K, L, and T) after use by two of two observed residents (24 and 40). *Handling and cleaning of a glucometer by one of one UAP (F) during use for two of two observed residents (4 and 23). *Hand hygiene by one of one UAP (F) performing blood sugar monitoring for two of two observed residents (4 and 23). *Hand hygiene by one of one UAP (G) while passing meal trays for four of five observed residents (10, 30, 36, and 48). Findings include: 1. Observation on 5/10/22 at 8:00 a.m. of UAP J	F 880	3. Root cause analysis conducted 5/31/2022 answered the 5 Whys: We discovered further education and re-education is needed for all staff for handwashing, glucometer handling and cleaning, storage of medications and handling of medications during active med pass, and cleaning the mechanical lifts. Also Sani-wipes need to be more accessible to staff for cleaning the lifts. The facility also needs to allocate time for the infection preventionist for proper oversight, training time and auditing time. Administrator, DON, medical director, and any others identified as necessary will ensure ALL facility staff responsible for the assigned tasks have received education/training with demonstrated competency and documentation. Director of Nursing contacted the South Dakota Quality Improvement Organization (QIN) on 5/31/2022 and discussed root cause analysis findings, further education needed for all staff and sani-wipes need to be more available to staff for cleaning equipment. Allocating time for infection preventionist for proper oversight, training and auditing discussed with QIN for monitoring and gaining sustained compliance. 6/1/2022 DON placed work order request for Maintenance to place baskets on all mechanical lifts to hold sani-wipes for cleaning equipment. Supply placed Order for baskets 6/1/22 and maintenance will place on lifts immediately upon arrival. Additional Nurses were hired and were in orientation during the survey. Now that the additional nurses are orientated more time can be allocated for the infection preventionist to complete infection control oversight, training and audits.	6/10/2022

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F 880	Continued From page 36 preparing to administer resident 22's medications revealed she: *Performed hand hygiene, opened the medication cart drawer, and removed her three bottles of eye drops and one nasal spray from a designated section of that cart. -An uncapped tube of antibiotic eye ointment also belonging to that resident was stored with those eye drops and nasal spray. *Placed the three eye drop bottles and nasal spray into her front smock pocket then entered the resident's room. -A ring of keys was also inside that pocket. *Reached in and out of that pocket to remove each bottle, administer that medication, then return that bottle to her pocket after use. Interview on 5/10/22 at 9:23 a.m. and 2:07 p.m. of UAP J regarding the above medication pass revealed: *Medication bottles should have been carried into the room with her clean hands and not placed inside her unclean smock pocket. *The antibiotic ointment had been without a cap for about a week. -It was administered daily during the evening shift. *That ointment should have been given to a nurse for destruction at the time its cap was noted to have been missing. *The contents of that tube had been compromised and posed a contamination risk to the resident. 2. Observation on 5/10/22 at 7:50 a.m. of UAPs K and T transferring resident 40 with a mechanical lift revealed: *After transferring that resident from a chair to her bed, UAP K removed that lift from the room, and	F 880	Monitoring: 4. Administrator, DON, Infection preventionist and/or designee will conduct auditing and monitoring 2 to 3 times weekly over all shifts to ensure identified and assigned tasks are being done as educated and trained. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. *Staff compliance in the above identified area. *Other areas as identified through root cause analysis exercise and process. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by administrator, DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee. 6/10/2022	6/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435072	A. BUILDING _____ B. WING _____	05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN SISTERS LIVING CENTER	1201 HWY 71 SOUTH HOT SPRINGS, SD 57747

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F 880	Continued From page 37 placed it in a common sitting area across the hallway from an activity/small dining area in the west hall living unit without cleaning it. Observation on 5/10/22 at 11:17 a.m. of UAP L revealed: *She exited resident 24's room with a mechanical lift after assisting her off the toilet. -Placed that lift in a common sitting area across the hallway from the activity/small dining area in the west hall living unit without cleaning it. Interview on 5/10/22 at 11:22 a.m. with UAPs K and L revealed: *Cleaning mechanical lifts after use was not a part of their usual routine. -Lifts were cleaned if they were visibly soiled. *Agreed lifts should also have been cleaned between resident use. Interview on 5/11/22 at 3:05 p.m. with director of nursing (DON) B revealed: *Resident medications were not expected to be transported inside staffs' unclean pockets. *The uncapped antibiotic ointment should have been immediately discarded when it was discovered that way and replaced with an unopened tube. *Mechanical lifts were expected to be cleaned between resident use and when visibly dirty. Review of the revised 7/12/18 Standards of Medication Administration policy revealed: *1. Oral Medication Administration: -"Place medications on the bedside table or tray" if necessary prior to administering that medication. *4. Instillation Administration Eye Ointment: -"Wipe off the tip of the ointment tube with a clean	F 880		

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F 880	Continued From page 38 gauze pad and replace the cap." A Cleaning of Critical and Non-Critical Medical Equipment policy was requested of DON B on 5/11/22 at 8:15 a.m., but she indicated there was none. The revised July 2021 Lifting/Transferring policy was provided instead. Review of that policy revealed no lift cleaning expectations. 3. Observation on 5/10/22 of UAP F performing blood sugar monitoring revealed: *At 4:40 p.m. she was in resident 23's room: -She had set the glucometer, glucose strips, and a white plastic container on the bedside table without a barrier under them. -With a pair of gloves on she obtained the blood sugar reading, removed her gloves, threw them away, and returned to the cart with the above supplies. -She set the glucose strips and the white container on the medication cart. -Went into the soiled utility room and retrieved a PDI Sani Cloth from a container on the edge of the sink, then walked back to her med cart. -She wiped the glucometer with a PDI Sani Cloth and set it on top of the medication cart. --She did not ensure the glucometer had stayed wet for two minutes. -She removed the keys from her shirt pocket and unlocked the medication cart. -She put the strips and the glucometer in the plastic container and set it into the top drawer of the med cart. -She used the hand sanitizer on the medication cart to sanitize her hands. *At 5:30 p.m. she entered resident 4's room: -She set the glucometer, glucose strips, and plastic container on the bedside table without a barrier under them.	F 880		

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F 880	Continued From page 39 -Put on a pair of gloves and obtained the blood sugar reading. -Removed the gloves, threw them away, collected the supplies from the bedside table, and walked out of the room without performing hand hygiene. -She entered the dirty utility room and retrieved a PDI Sani Cloth. -Put the cloth around the glucometer and set it on top of the medication cart. -Removed the keys from her shirt pocket and unlocked the medication cart. -She then sanitized her hands, removed the wipe from the glucometer, and put the supplies into the top drawer of the medication cart. --She did not ensure the glucometer had stayed wet for two minutes. Interview on 5/10/22 at 5:33 p.m. with UAP F regarding the above observations revealed she: *Did not know she should have used a barrier under the blood glucose supplies. *Agreed that the bedside tables in residents rooms could be contaminated. *Agreed after removing her gloves she should perform hand hygiene before touching other surfaces. *Was not aware of the contact time required for the PDI Sani Cloth. Interview on 5/11/22 at 8:42 a.m. with DON B revealed: *Staff had been expected to use a barrier under the blood sugar monitoring supplies. *When cleaning the glucometers with a PDI Sani Cloth the surface of the glucometer needed to stay wet for two minutes. -The staff either needed to wipe the glucometer the entire two minutes or wrap the glucometer in the wipe for two minutes.	F 880		

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

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	435072	A. BUILDING _____ B. WING _____	05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN SISTERS LIVING CENTER	1201 HWY 71 SOUTH HOT SPRINGS, SD 57747

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F 880	Continued From page 40 Review of the provider's 5/27/21 Glucose Monitoring/Glucometer Cleaning policy revealed: *Staff should wash hand after removing their gloves. *The glucometer should be cleaned with a PDI Sani Cloth. -One cloth was to be used to remove any heavy soil and a second cloth was to be used to wet the surface. *The surface of the glucometer was to remain wet for 2 minutes. 4. Observation on 5/9/22 at 5:17 p.m. of UAP G passing meal trays to residents 10, 30, 36, and 48 revealed she had a cart with meal trays on it in the hallway and she: *Entered, set down meal tray, exited, and shut doors of residents 10, 30, 36, and 48's rooms. *Pushed cart back down hall to dining room, set down resident 35's meal tray, assisted her with set up and then returned to medication cart. *UAP G did not perform hand hygiene during any of the above observations. Interview on 5/9/22 at 5:42 p.m. with UAP G revealed she should have sanitized her hands when going in and out of resident rooms. Interview on 5/12/22 at 8:42 a.m. with DON B revealed staff should be performing hand hygiene when entering and exiting resident rooms. Review of the provider's 6/24/21 Hand Hygiene policy revealed: *All employees would wash hands before preparing food. *All employees would wash hands after handling equipment.	F 880		

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SEVEN SISTERS LIVING CENTER	1201 HWY 71 SOUTH HOT SPRINGS, SD 57747

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F 880	Continued From page 41 *It had not addressed hand hygiene after touching potentially contaminated surfaces.	F 880		

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

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 5/9/22 through 5/12/22. Seven Sisters Living Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: DKleinsasser | TITLE: Administrator | (X6) DATE: 6/2/22

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435072	A. BUILDING **03 - SEVEN SISTERS** B. WING _____	**05/12/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN SISTERS LIVING CENTER	**1201 HWY 71 SOUTH HOT SPRINGS, SD 57747**

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 5/12/22. Seven Sisters Living Center was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

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

Administrator 6/2/22

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	10630	A. BUILDING: _____ B. WING _____	05/12/2022

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 5/9/22 through 5/12/22. Seven Sisters Living Center was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 5/9/22 through 5/12/22. Seven Sisters Living Center was found in compliance.	S 000		

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

TITLE: Administrator

(X6) DATE: 6/2/22

STATE FORM 6899 R4VQ11 If continuation sheet 1 of 1