

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

PRINTED: 10/03/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/26/2023
NAME OF PROVIDER OR SUPPLIER ALCESTER CARE AND REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 101 CHURCH STREET ALCESTER, SD 57001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 9/26/23. Areas surveyed included dialysis, professional standards related to falls and residents individualized care, and care planning. Alcester Care and Rehab Center, Inc was found not in compliance with the following requirements: F657, F658, and F698.	F 000		
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	F 657	Resident 1's care plan will be updated to include the discontinuation of fluid restriction, information regarding dialysis, interventions for missed dialysis days, and direct care needs regarding activities of daily living by 10/20/2023.* Administrator or designee will re-educate CNA D and all licensed personnel on proper techniques when caring for incontinent residents. DON and interdisciplinary team will review and revise, as necessary, the policy and procedure ensuring complete and accurate care plans. DON, or designee, will provide education to all staff responsible for creation, review, and revision of resident care plans on 10/13/2023 and 10/20/2023. Including, but not limited to, active and historical diagnoses, goals, and or/expected outcomes, and specific nursing interventions.** DON or designee will perform audits on care plans to reflect current care practices for residents once per week for four weeks and once per month for two more months. *All residents care plans will be updated with current care needs.	11/10/2023

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

TITLE

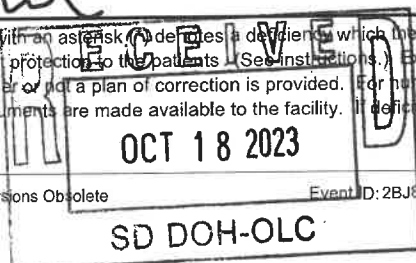
(X6) DATE

Tim M

Administrator

10/13/2023

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 657	Continued From page 1 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (1) had an updated care plan that reflected the following: *Interventions for missed dialysis treatments. *Current individualized care needs regarding activities of daily living and how to appropriately care for the resident. Findings include: 1. Observation and interview on 9/26/23 at 9:00 a.m. in resident 1's room with certified nursing assistant (CNA) D and another unidentified CNA indicated they were just finishing up care provided to the resident. The resident was lying in bed on his back. 2. Observation on 9/26/23 at 10:00 a.m. the resident was lying on his back in his bed. 3. Interview on 9/26/23 at 10:15 a.m. with LPN B nurse manager and LPN C regarding resident care plans revealed: *There were staffing concerns. *The updating of resident care plans were not completed. *Many of the management staff had to work on the floor due to staff shortages. 4. Interview on 9/26/23 at 10:30 a.m. with administrator A revealed the MDS (Minimum Data Set) coordinator worked approximately 12 hours per week. She was the one responsible for updating the resident care plans.	F 657	DON, or designee, will present findings from these audits at the monthly QAPI meetings for review until the QAPI committee advises to discontinue monitoring. **DON/MDS, Skins Nurse, Infection Control Nurse, and Nurse Manager, are all responsible for updating resident care plans.	

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F 657	<p>Continued From page 2</p> <p>5. Observation and interview with resident 1 at 11:00 a.m. revealed: *He ate all meals in his room. *He was in the same position in bed as previously observed. *There had been no staff that had entered his room since the 9:00 a.m. observation. *He stated that he usually got his noon meal around 11:00 a.m.</p> <p>6. Observation and interview with resident 1 at 11:30 a.m. revealed he: *Was sitting on the edge of the bed eating his noon meal. *Stated staff had assisted him to a sitting position at the edge of the bed. *Stated no staff had assisted him with his incontinent brief or asked if he had to use the restroom.</p> <p>7. Interview and observation on 9/26/23 at 1:00 p.m. with CNA D regarding resident 1 and the above observations revealed: *Staff were supposed to check and change residents who were incontinent every two hours. *She confirmed she had not completed the checking and changing of resident 1 since 9:00 a.m. *She stated, "I need to get in there." *When asked how she knows what care to provide to residents, she provided a piece of paper with the names of the residents and their room numbers but no other indicant information related to each residents individual care needs.</p> <p>8. Interview and observation with travel CNA E on 9/26/23 at 1:15 p.m. regarding care provided to the residents revealed: *She was a traveling CNA.</p>	F 657			

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F 657	<p>Continued From page 3</p> <p>*She stated she used the provided "cheat sheet" that had the residents name, room number, and minimal information related to the individual care needs of the residents.</p> <p>9. Review of the provider's "cheat sheet" related to resident 1 revealed: *There was no date on the "cheat sheet" and no title on the form. *The only information on the form for resident 1 was the following: -His name. -The room number. -1-2 staff assist. -Wheelchair. -Eats meals in room. -"Needs Hoyer sling under him when goes to dialysis (M,W,F [Monday, Wednesday, Friday])." -"L[large]/XL[extra large] brief." *There was a lack of information for direct care staff related to toileting, bathing, mobility, transfers, personal grooming, communication, hygiene, and any assistance required for eating.</p> <p>10. Review of resident 1's comprehensive care plan revealed: *There was no information related to the discontinuation of his 1800 fluid restriction. *There was minimal information related to his dialysis. *Encourage resident to go to the scheduled dialysis appointments. *There was no information related to interventions when the resident missed the scheduled dialysis treatments. *There was no information related to assessments and monitoring of the residents condition when those dialysis treatments were missed.</p>	F 657		

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F 657	Continued From page 4 *There was no information regarding the residents care needs for direct care staff to have followed to provide the appropriate care. Refer to F698, finding 2 11. Review of the provider's reviewed 5/5/23 Care Plan Policy and Procedure revealed: *It was the basic responsibility of the MDS or designee. *Care plans should have been developed by an interdisciplinary team with participation of the resident, family, and or representative. *Care plans should include "active and historical diagnoses, goals, and/or expected outcomes, specific nursing interventions so that any nursing staff member was able to quickly identify a resident's individual needs and to decrease he risk of incomplete, incorrect, or inaccurate care and to enhance continuity of nursing care". *Care plans should have been reviewed quarterly, annually, and with any significant change in the residents condition. *Care plans were written "by exception from the Residents Centered Care Plan Facility Standards and Short Term Care Plans."	F 657		
F 658 SS=D	Services Provided Meet Professional Standards 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 record review, interview, and policy review, the provider failed to ensure one of one sampled resident (1) who had a witnessed fall	F 658	Administrator, DON, and interdisciplinary team will review and revise, as necessary, the policy and procedure for documenting falls. RN will be re-educated on fall documentation policy on 10/20/2023. DON or designee will provide education to licensed personnel responsible for documenting falls on 10/13/2023 and 10/20/2023. DON or designee will perform audits on all fall documentation two times weekly for four weeks and monthly for two more months.	11/10/2023

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F 658	<p>Continued From page 5</p> <p>had the following completed:</p> <ul style="list-style-type: none"> *A thorough head to toe assessment completed by the nurse at the time of the fall. *A fall assessment. *Vital signs obtained every shift for 72 hours after the fall. *Physician and family notification of the fall. *An update to the care plan to include new interventions to prevent another fall. <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of resident 1's electronic medical record (EMR) revealed: <ul style="list-style-type: none"> *He had a witnessed fall on 8/23/23 at 3:55 a.m. -The resident had called to use the restroom; the registered nurse (RN) on the night shift was assisting him. -The resident was using his walker and there was a gait belt used by the RN. -The resident was having difficulty turning himself and the residents legs had become tired. -The nurse lowered the resident to the floor. -There were no injuries documented. -The staff transferred the resident back to his bed with a Hoyer lift. *On 8/25/23 at 11:36 p.m. were the only set of vital signs that were found in EMR. *There was no documentation the following had been completed by the RN: <ul style="list-style-type: none"> -A full head-to-toe assessment. -No vital signs. -No physician notification. -No notification to the family. *There was no indication that the residents care plan was reviewed or revised related to the residents fall that should have included interventions to prevent another fall. <p>Interview on 9/26/23 at 12:20 p.m. with</p>	F 658	DON or designee will present findings from these audits at the monthly QAPI meetings for review until the QAPI committee advises to discontinue monitoring.	

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F 658	Continued From page 6 administrator A confirmed that she was unable to find the above information in resident 1's EMR related to the fall on 8/23/23. Review of the provider's undated Fall policy revealed: *The purpose of the policy was to have provided a safe living environment for the residents and to protect them from injury. *The policy was to ensure that a resident who had sustained a fall would have been thoroughly assessed by an RN or an LPN [licensed practical nurse]. *Thoroughly assess the resident by completing a head-to-toe assessment. *Notify the physician and the family of the fall and the residents condition as soon as possible. *Document in the nurses notes the following: -Date and time of the fall. -Residents activity prior to the fall. -Condition of the resident. -Date and time the physician was notified. -Date and time the family was notified. *A licensed nurse would update the care plan to reflect interventions instituted to prevent further falls. *Completed vital signs would have been placed in the residents medical record.	F 658			
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced	F 698	Unable to correct noncompliance for failure to notify physician, assessments for missed dialysis treatments, and appropriate transportation arrangements. Administrator, DON, and interdisciplinary team will review and revise as necessary the dialysis and fistula Intervention policy and procedure to include, but not limited to, notifying the physician, assessments, and transportation arrangements in refusals of dialysis.	11/10/2023	

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F 698	<p>Continued From page 7</p> <p>by:</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (1) who required dialysis three times a week at an off-site contracted end stage renal disease facility:</p> <p>*Had the appropriate transportation arrangements set up to ensure dialysis was completed as ordered by the physician.</p> <p>*Had ongoing assessments and monitoring of the residents condition for complications related to missed dialysis treatments.</p> <p>*Physician was notified of the missed dialysis treatments.</p> <p>1. Observation and interview on 9/26/23 at 9:00 a.m. with resident 1 in his room revealed:</p> <p>*He was lying in bed on his back.</p> <p>*The CNA D and an unidentified CNA had just performed peri care due to a bowel movement.</p> <p>*There was a 16 ounce can of beer with a straw, a can of soda with a straw, and a clear plastic mug of water that was on his bedside table.</p> <p>*He stated he would drink two cans of beer a day, and soda pop.</p> <p>*He was aware of the date and his whereabouts but was slow to answer.</p> <p>*When asked about his dialysis he stated he had not gone to dialysis on Monday, September 25, 2023 because there was no transportation available.</p> <p>*He stated he felt fine. No complaints of pain or shortness of breath.</p> <p>*He would eat meals in his room.</p> <p>*He had a central line in the upper left chest area that was used for dialysis and there was a transparent dressing secured to the site.</p> <p>*The dialysis staff was responsible for the care of that central line.</p>	F 698	<p>DON or designee will provide education to all licensed personnel responsible for dialysis residents on 10/13/2023 and 10/20/2023.</p> <p>DON or designee will perform audits on proper dialysis procedures weekly for four weeks and monthly for two more months.</p> <p>DON or designee will present findings from these audits at the monthly QAPI meetings for review until the QAPI committee advises to discontinue monitoring.</p>	

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F 698	Continued From page 8 2. Interview with licensed practical nurse (LPN) B who was the nurse manager and LPN C regarding resident 1 revealed: *He had been hospitalized until September 23, 2023 when he returned to the facility. *The resident missed dialysis on Monday, September 25, 2023 due to no transportation was available. *The resident refused dialysis treatments at times. *The physician was not notified of the missed dialysis treatment. *They thought the family had been notified. *There had been no assessments or monitoring of the residents condition when dialysis treatments were missed. *The fluid restriction had been discontinued by dialysis. *The only fluids the residents drank was beer and soda pop. He never drank water. *The dialysis access site was a central line and the staff at the dialysis treatment center were the only ones that cared for the site. *LPN B nurse manager stated the nursing staff would not do anything with that dialysis access site. 3. Interview with administrator A regarding resident 1's missed dialysis treatments: *The resident had refused to go to dialysis quite frequently. *He was his own power of attorney and made all his medical decisions. *The family had been notified of the missed dialysis treatment on Monday, September, 25, 2023. *There had been no assessment or monitoring of the residents condition when missing dialysis	F 698		

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F 698	<p>Continued From page 9</p> <p>treatments.</p> <p>*She stated that she could have let the family take the facility van to transport the resident to dialysis but that thought never crossed her mind.</p> <p>*There was no extra staff that day that could have transported the resident to dialysis.</p> <p>4. Review of the resident 1's electronic medical record revealed:</p> <p>*He was admitted on 7/13/22.</p> <p>*He was 73 years of age.</p> <p>*His diagnoses included the following:</p> <ul style="list-style-type: none"> -Displaced right shoulder fracture of the coracoid process (the anterior portion of the scapula that stabilizes the shoulder joint). -Type II diabetes. -Cerebral infarct. -End stage renal disease. <p>*He had an order for dialysis three times a week (Monday, Wednesday, and Friday).</p> <p>*He was usually cognizant but had times of confusion.</p> <p>*There was no documentation related to assessments or monitoring of the residents condition due to missed dialysis treatments.</p> <p>*There was no documentation that the physician had been notified when the resident refused to go to dialysis or missed due to transpiration issues.</p> <p>5. Telephone interview on 9/26/23 at 11:15 a.m. with lead driver G from Rural Office of Community Services (ROC) regarding the transpiration service for resident 1 revealed:</p> <p>*The hours of operation were 7:30 a.m. to 4:30 p.m. Monday through Friday.</p> <p>*A facsimile had been sent by the provider on 9/23/23 regarding resident 1's return from the hospital.</p> <p>*The facsimile must have come in after hours on</p>	F 698		

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F 698	<p>Continued From page 10 Friday, September 23, 2023. *They could not provide transpiration for resident 1 due to multiple transfers scheduled for that day.</p> <p>6. Review of resident's 1 comprehensive care plan with an initiated date of 7/29/22 revealed: *Check and change dressing daily at access site as needed. *Encourage resident to go to the scheduled dialysis appointments. *Monitor vital signs before dialysis. Notify MD (medical doctor) of significant abnormalities. *There was no information related to interventions when the resident missed the scheduled dialysis treatments. *There was no information related to assessments and monitoring of the residents condition when those dialysis treatments were missed.</p> <p>7. Interview on 9/26/23 at 1:30 p.m. with LPN B nurse manager regarding the above care plan inconsistencies indicated due to the staffing challenges care plans were not updated to reflect the current resident care needs.</p> <p>8. Review of the provider's 5/5/23 Dialysis and Fistula Intervention policy and procedure revealed there was no documentation related to missed dialysis treatments and interventions that should have been put in place when a resident missed a scheduled dialysis treatment.</p>	F 698			

