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
	435114	A. BUILDING _____ B. WING _____	R 07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND CARE CENTER	901 N MAIN AVE BRIDGEWATER, SD 57319

(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 An onsite revisit survey was conducted on 7/25/24 for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities for all previous deficiencies cited on 6/21/24. Diamond Care Center was found not in compliance with the following requirements: F657, F658, and F700.	{F 000}		
{F 657} SS=E	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.	{F 657}	This deficiency has the potential to impact all residents. Care plans for resident 8 and 9 have been audited by Director of Nursing on 7/27/24. Corrections made to resident 8 care plan; focuses IV antibiotics and PICC line monitoring resolved from care plan, interventions resident not safe to administer medications, staff to observe for difficulties and staff to give medications have been removed, physician's orders for CeraVe cream, Preparation H, and Tinactin have been updated to reflect self-administration. New Self-administration assessment completed with the following medications identified: Biofreeze, Biotene, CeraVe cream, Fluticasone Propionate, Olopatadine, Systane, Tinactin, and Volarten as safe to self-administer. Corrections made to residents 9 care plan; Self administration care plan updated to reflect self-administration of Halls Vitamin C drops, Saline Nasal Spray, Vicks vapor rub, Desenex powder, Refresh tears, Ketoconazole cream, Polyethylene Glycol powder, and bio freeze. Self-administration assessment updated to reflect the following medications identified: Halls Vitamin C drops, Saline Nasal Spray, Vicks vapor rub, Desenex powder, refresh tears, Ketoconazole cream, Polyethylene Glycol powder, and bio freeze as safe to self-administer. Outdated order from 12/27/2018 that stated "may keep topical pain scripts at bedside with the exception of Voltaren" has been discontinues as it is no longer accurate.	08/12/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brianna Morris
TITLE: Administrator
(X6) DATE: 08/12/2024

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 This REQUIREMENT is not met as evidenced by: Based on plan of correction (POC) review from the 6/21/24 survey with a completion date of 7/23/24, record review, interview and policy review, the provider failed to provide evidence that the POC was followed for the previously cited F657 for having failed to ensure care plans reflected residents' (8 and 9) current needs relating to antibiotic use and self-administration of medications. Findings include: 1. Review of the provider's 7/23/24 PoC for F657 Care Plan Timing and Revision revealed: *"The deficiency has the potential to impact all residents." *"Care Plans found to be inaccurate have been corrected." 2. Review of resident 8's medical record revealed: *Her 7/25/24 care plan included: -A 7/26/23 initiated focus area indicated there was a wound infection to her left hip incision. --She was currently on an IV antibiotic through a "PICC [peripherally inserted central catheter] Line in Right Upper Arm." --Staff were to monitor the PICC Line site every shift for signs and symptoms of infection and to ensure the line and dressing remained intact. -A 7/26/23 revised focus area indicated she was able to self-administer medications and keep them at her bedside. --Staff were to administer medications as she was not safe to independently administer medications. --Staff were to observe her for difficulties in self-administering medications. --Staff were to "Give medications as ordered."	{F 657}	Orders for Halls Vitamin C drops, Saline Nasal Spray, Vicks Vapor rub, Desenex powder have been updated to reflect self-administration. Audit and update of all residents care plans completed by DON on 7/27/24, 7/28/24 and 7/29/24. Audit included the following updated baseline to include all GGs, updated behaviors and ISPs to current care in place, removed resolved focuses. Self-administration Assessment were compared to care plans and order to ensure all medications that are self-administed are documented appropriately. Weekly care plan meetings with IDT team to review residents with ARDs due that week began and will continue weekly. Care plans are to be reviewed and updated during this time. Policy and expectations review completed with IDT team. Care Plan audits will be completed by Director of Nursing with each residents ARD x 3 months, two residents will be randomly audited each month x 3 months, PRN following. Results will be reported to QAPI. If desired outcome is not achieved/maintained, individual staff education to be completed as indicated and review of process will be completed.	

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{F 657}	Continued From page 2 *Her physician's orders included: -Biofreeze Gel "May keep at bedside". -Biotene Moisturizing Mouth "may keep at bedside." -CeraVe Cream "May keep at bedside". -Fluticasone Propionate Suspension "unsupervised self-administration" "may keep at bedside" -Olopatadine "May keep at bedside and self-administer per order 3/7/24". -Preparation H Cream "May keep at bedside". -Systane Ultra Solution "May keep at bedside and self-administer per order 3/7/24" -Tinactin Aerosol Powder "May keep in room, nursing to administer". -Voltaren Gel "May Keep at bedside." -There was no order for an IV antibiotic. *Her 7/11/24 self-administration assessment indicated: -She was able to self-administer medications independently. -That assessment did not indicate which medications she was able to self-administer. 3. Review of resident 9's medical record revealed: *Her 7/25/24 resident care plan included: *A 3/21/23 initiated focus area indicated that she was able to self-administer Miralax, eye drops, and topical medications. -Staff were to "set up medications and resident can self administer [self-administer]". *A 7/11/24 initiated intervention indicated she was safe to self-administer medications after they were set up. -Those medications included Refresh tears, polyethylene glycol power, and Biofreeze. -They were to be kept at her bedside. *Her physician orders included:	{F 657}		

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{F 657}	Continued From page 3 -A 12/27/18 order indicated "May keep topical pain scripts at bedside with the exception of Voltaren." -A 12/27/18 order for "Halls Defense Vitamin C Drops" "may keep at bedside and may self administer". -A 1/8/20 order for "Saline Nasal Spray Solution" "May keep at bedside per MD [medical doctor]". -A 5/10/20 order for "Vicks VapoRub Ointment" "May keep at bedside per MD". -A 12/3/20 order for "Desenex Powder" "may keep at bedside". -A 2/22/21 order for "Refresh Tears Solution" "Ok to keep at bedside and self administer". -A 2/22/21 order indicated "Ok to self administer medication after set up by nurse". -A 4/2/21 order for "Ketoconazole Cream" "May keep at bedside". -A 3/21/23 order for "Polyethylene Glycol Powder" "May store in room and self administer". -A 7/11/24 order for "Biofreeze Gel" "may keep at bedside and self administer". *Her 7/24/24 self-administration assessment indicated the following medications were assessed for self-administration: -Biofreeze Gel. -Refresh Tears Solution. -Polyethylene Glycol Powder. --That assessment also included that her care plan was "Up-To-Date". 4. Interview on 7/25/24 at 1:51 p.m. with director of nursing B and administrator A regarding residents' care plans revealed: *They confirmed: -Resident 8 and 9's care plans did not accurately reflect their current care needs. -Residents care plans were to be updated with new care needs.	{F 657}		

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{F 657}	Continued From page 4 -Residents care plans were not revised to remove care needs that were no longer provided. *They had expected care plans to accurately reflect the care residents required. Interview on 7/25/24 at 3:09 p.m. with administrator A regarding care plans revealed: *The interdisciplinary team that participated in the care plan development for each resident included the activity director, the social worker, the dietary manager who was in the learning process, and the Minimum Data Set (MDS) nurse. -The MDS nurse was the primary person responsible for completion of residents' care plans. 5. Review of the provider's undated Care Plan Policy revealed: *"All residents of [provider name] must have a person-centered care plan that is reflective of the residents' goals and involvement in its development and updated at regular intervals. The care plan serves as the action plan for all care management activities and should be reflective of care team involvement." *"All members of the resident's care team should participate in the development of each resident's care plan. The documentation and review of the care plan is the responsibility of the Interdisciplinary Team. *"Each resident must have a care plan stored within the [provider name] electronic chart and updated as resident's needs are reported/identified, no later than 7 days from admission but updated no less often than quarterly."	{F 657}		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		

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F 658	Continued From page 5 §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 plan of correction review for survey date 6/21/24, staff member listing, record review and interview, the provider failed to ensure the plan of correction (PoC) review from the 6/21/24 with a completion date of 7/23/24, staff member listing review, record review, and interview, the provider failed to ensure the PoC was followed regarding staff education for the previously cited following citations: F554, F686, F761, and F880. Findings include: 1. Review of the provider's PoC for the above citations revealed education related to F554, F686, F761, and F880 was to be provided to staff with a completion date of 7/23/24. The provider's 7/25/24 staff listing indicated there were a total of 47 staff members. -Of those, 25 were nursing staff members. -An agency registered nurse (RN) was not listed. Review of the provider's documented staff education as stated in the provider's PoC for the above citations revealed: *The provider's PoC for citation F554, Resident Self-Administration of Medications, indicated, "All nursing staff are required to complete medication education with post test. All new hired nurses/CMAs [certified medication aides] will be required to complete medication storage training." -There were 17 employees who had completed	F 658	Individuals that did not complete required education from annual survey have been contacted and sent links from AHA slides or paper copies for the education required to be completed. A log for each employee will be created for training to be put into place, staff members that do not complete the required education in time will be individually contacted and possible disciplinary action to be filed in their employee file will take place. Executive Director or Director of Nursing will maintain logs fro training to be completed to be kept in an education binder/file for reference. Expectations for education completed will be explained to each new employee upon hire. Executive Director will audit logs for completion of education within one week after in-service or implementation of training to ensure employees are completing these within the time frame set or before their next shift.	08/12/2024

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F 658	Continued From page 6	F 658		

the training.
--Those staff included seven nursing staff members, four dietary staff members, two housekeeping staff members, one laundry staff member, one maintenance staff member, one activity staff member, and the administrator.

*The provider's PoC for citation F686, Treatment/Services to Prevent/Heal Pressure Ulcer, indicated, "Education on repositioning and offloading including techniques to prevent pressure injuries implement for nursing staff on 7/5/24. Education to be reviewed and quiz to be completed for Nurses, CMAS [medication aides] and CNA's [Certified Nurse Aides]. New hires for nursing staff will be required to complete the quiz as part of the new hire orientation."
-There were 19 staff members who had completed the training.
--Those staff included one dietary staff member and 18 were nursing staff members.

*The provider's PoC for citation F761, Label/Store Drugs and Biologicals, indicated, "All nursing staff are required to complete medication storage education with a post test. All new hire nurses/CMA's [CMAs] will be required to complete medication storage training."
-There were 11 staff members who had completed the training.
--Those staff included one dietary staff member, one RN, three licensed practical nurses (LPN's), and six CNA's.

*The provider's PoC for citation F880, Infection Prevention and Control, indicated, "Nursing staff are required to complete hand hygiene education with post test. All new hires will be required to complete hand hygiene training."

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F 658	Continued From page 7 -The provider's staff member listing indicated there were 25 nursing staff that included RN's, LPN's, and CNA's. --There was one agency nurse not listed. -There were 17 nursing staff members who had completed the hand hygiene training, which included the agency nurse. Interview on 7/25/24 at 12:10 p.m. with director of nursing (DON) B regarding education for staff members revealed: -She created a PowerPoint presentation, staff reviewed the presentation, and signed electronically that they had completed the training. -Staff members who had not completed that education would have been educated on a one-to-one basis. Interview on 7/25/24 at 3:09 p.m. with administrator A and DON B confirmed the PoC education was not completed by 7/23/24 as stated in the PoC's.	F 658		
{F 700} SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of	{F 700}		

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{F 700}	Continued From page 8 bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on plan of correction (POC) review from the 6/21/24 survey with a completion date of 7/23/24, interview, observation, record review, and policy review, the provider failed to provide evidence that the POC was followed for the previously cited F700 for having failed to ensure bed rail assessments were accurately completed for two of two sampled residents (2 and 8). Findings include: 1. Review of the provider's PoC for F700 revealed, "Assessments and consent forms have been completed for all residents with bed rails." 2. Interview and observation on 7/25/24 at 11:15 a.m. with resident 8 regarding her bed rail use revealed: *She was in her room, seated in an electric wheelchair. *Her bed had one-fourth size bed rails attached to the upper half of her bed frame. -The rails were in the up position. *She used the rails to hold herself in position while in bed when staff had assisted her. Review of resident 8's medical record revealed: *A 7/11/24 Physical Device Evaluation indicated	{F 700}	This deficiency has the potential to impact all residents. Assistive device assessments have been updated for resident 8 and 2. Resident 8 assistive device care plan has been updated to reflect 1/4 bed rails bilaterally, this was compared to residents 8's assistive device assessment and physician orders to ensure documentation is correct. Resident 2's assessment has been updated to reflect u-shaped grab bar to right upper side of bed. Care plan confirmed to match u-shaped grab bar. New orders obtained for u-shaped grab bar to right side of bed. Audit was completed of bed rail types, assessments, care plans and order for residents with bed rails updated to reflect the current bed rails in use. Process for bed rail/assistive devise installment updated to: requests for assistive devices will be reported to Director of Nursing of MDS coordinator utilizing the request form to ensure proper documentation is in place. Nursing management will fax orders, complete assessments, update care plan, and place work order for maintenance to install. Schedule for residents' assessments due quarterly, biannually, and annually has been created for IDT team to follow to ensure they are completed in a timely manner. Updated process and policy reviewed with IDT. Assessment audits will be completed by Director of Nursing with each residents ARD x 3 months, two residents will be randomly audited each month x 3 months and PRN following. Maintenance supervisor to keep a log of bedrails in place and complete monthly audits to ensure safety of bedrails and confirm the placement of correct assistive device. If desired outcome is not achieved/ maintained individual staff education to be completed as indicated and review and process will be completed.	08/12/2024

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{F 700}	Continued From page 9	{F 700}		

she had one-half size bed rails on both sides of her bed.
*A 6/12/20 physician order for "1/4 side rail/grab bar for assist with bed mobility and turning."

3. Observation on 7/25/24 at 11:25 a.m. of resident 2 revealed:
*He was lying in his bed with his eyes closed.
*There was a one-fourth size bed rail in the up position attached to the right side of the frame of the bed.

Review of resident 2's medical record revealed:
*A 7/18/24 Assistive Device Assessment indicated he used a "Bed Assist Bar".
-That assessment had not identified the placement or size of the bed rail bar.
*A 1/18/24 physician order for "U-shaped grab or 1/4 Side to bed on right side to assist resident in maintaining independence and assist in repositioning self."

4. Interview on 7/25/24 at 2:01 p.m. with director of nursing B regarding bed rail assessments revealed:
*She confirmed resident 8 used one-quarter size bed rails and that the 7/11/24 Physical Device Evaluation that indicated she had 1/2 size bed rails was not accurate.
*She confirmed all completed bed rail assessments for residents who used them should have identified the placement and size of the side bed rails.
*She would have expected all assessments to be completed accurately.

Review of the provider's Bed Rails policy revealed:
*"Upon admission, readmission or change of

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{F 700}	Continued From page 10 condition, residents will be screened to determine:" -"Assess the need for special equipment or accessories (e.g. bed rails)". -"Assess the resident for risk of entrapment from bed rails prior to installation."	{F 700}		