South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10760	A. BUILDING: ____ B. WING ____	C 04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRMONT GRAND SENIOR CARE	**409 E FAIRLANE DRIVE** **RAPID CITY, SD 57701**

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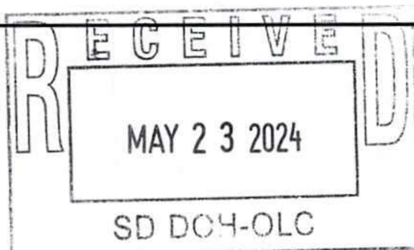
S 000	Compliance Statement A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 4/29/24 through 4/30/24. Areas surveyed included misappropriation of resident property and accidents. Fairmont Grand Senior Care was found not in compliance with the following requirements: S030, S681, S701, and S838.	S 000		6.14.2024
S 030	44:70:01:07 Reports To The Department Each facility shall report the following events to the department through the department's online reporting system within twenty-four hours of the discovery of the event: (1) An attempted suicide; (2) Any cause to suspect abuse or neglect of a resident; (3) Any death resulting from other than natural causes that originated on facility property; (4) A missing resident; (5) A fire in the facility; (6) Any loss of utilities, emergency generator, fire alarm, sprinklers, and other critical equipment necessary for operation of the facility for more than twenty-four hours; or (7) Any unsafe drinking water samples, or samples from pools or spas. The facility shall conduct an internal investigation for the event and report the results to the department no later than five working days after the event. The department may request additional information from the facility and investigate any reported event.	S 030	S030 1. Resident #1 unable to correct noncompliance. 2. All residents have the potential to be affected by this deficiency. 3. Abuse and Neglect Policy has been reviewed. 4. DON or designee will educate clinical staff on definition of abuse and neglect, misappropriation of property, and fraud. Education will also be provided on the reviewed Abuse and Neglect Policy. 5. Education provided to DON on appropriate steps to take when allegations are brought forth. 6. Abuse Allegation Tracking log has been created to assure appropriate steps are taken to address and investigate allegations. 7. DON will review and note all Care Refusal Forms, Incident Reports, and Grievances to assure monitoring and bring concerns to ED as soon as possible. Weekly meeting between DON and ED to also assure accurate monitoring has been done.Weekly meetings will be held monthly for 3 months until substantial compliance is obtained.	6.14.2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa Maciejewski

TITLE: Executive Director — Lisa Maciejewski

(X6) DATE: 5/23/2024



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S 030	Continued From page 1 This Administrative Rule of South Dakota is not met as evidenced by: Based on a review of the South Dakota Department of Health (SD DOH) complaint intake form, record review, interview, and policy review, the provider failed to investigate and report the following to the SD DOH: *An alleged personal theft reported by one of one sampled resident (1). *A fall with a serious injury and a second fall with limb entrapment for one of one sampled resident (2). Findings include: 1. Review of the 3/21/24 SD DOH complaint intake form revealed: *Resident 1 reported to a medical provider $150.00 was stolen from his room between 3/11/24 at 6:30 a.m. and 3/12/24 at 8:00 a.m. -He reported the same allegation to an unidentified facility staff person. *The resident thought the theft happened during an overnight shift and he identified the first name of a staff person he thought was responsible. -A similar incident occurred about a year ago and the resident was reimbursed by the facility for that money. *Resident 1 and his medical provider notified Adult Protection Services (APS) of the incident. -The APS worker submitted the complaint intake form to the SD DOH for follow-up. Review of resident 1's electronic medical record (EMR) revealed: *His admission date was 3/15/23 and his diagnoses included schizophrenia, dry eye syndrome, and disc degeneration. *His 12/1/23 Mini-Mental Status Examination	S 030		

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score was 29 indicating he had minimal cognitive impairment.
*His 2/3/24 revised care plan indicated he managed his own financial affairs without assistance.
*A 3/13/24 progress note: "[Resident 1] was very verbal and angry when pca [personal care assistant] went in his room to toilet him, stated 'he doesn't want anyone in there because of money being stolen. Told her to leave and not come back in."

Interview on 4/30/24 at 2:30 p.m. with executive director A regarding the 3/21/24 complaint revealed:
*Resident 1 managed his own money and kept various amounts of cash in his room.
-He gambled weekly in a nearby community with a friend.
*It was not the first time the resident reported missing money.
-He was discouraged from keeping more than $25.00 cash on hand and encouraged to obtain a locked box if he chose to keep more than that.
*Executive director A thought former director of nursing C completed and documented an investigation of that allegation and notified the SD DOH of that incident.
-She was unable to locate any documentation to support that notification occurred.
*Former director of nursing C was no longer employed by the facility.

2. Review of resident 2's closed electronic medical record (EMR) revealed:
*She was admitted on 6/30/23 and her diagnoses included atrial fibrillation and flutter, essential hypertension, age-related osteoporosis without current pathological fracture, dizziness and giddiness, major depressive disorder, and

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Parkinson's disease.
*Her 9/30/23 fall risk assessment was 80, indicating she was at a high risk for falling.
*Her last revised 11/30/23 care plan indicated she was to ambulate with the assistance of a two-wheeled walker, was encouraged to stand up slow and ensure she was steady before walking, and had to be reminded to ask for staff assistance.
*Her 6/28/23 Mini-Mental Status Examination score was 16, indicating she had moderate cognitive impairment.
*The resident had fallen on 12/15/23 and again on 12/28/23. EMR documentation revealed the following:
-A 12/15/23 progress note indicating she had been out of the facility at an urgent care visit. There was no prior documentation for the reason for the visit.
-A 12/15/23 emergency room (ER) summary revealed the resident had sustained a distal radius fracture in her left wrist from a fall, and either a cast or a splint was applied after the bone was re-aligned.
-A 12/28/23 progress note at 9:22 a.m. stating the resident was found "...on the floor sitting with her back against her bed and left arm was stuck between mattress and her bed rail. Vitals were taken, daughter and son in law took her to get checked out."
-A 12/28/23 consultation note revealed she was seen by a medical provider for acute left wrist pain following a fall.
-On 12/28/23 at 10:51 a.m. DON C documented, "Resident seen by provider for L [left] shoulder pain and L Colle's [wrist] fracture. Orders received to continue Tylenol as previously prescribed, continue elevating L arm, apply ice and heat to shoulder for 20 minute intervals, and topical Voltaren [pain relieving gel] 4x [times]/day

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PRN [as needed]."

Review of the provider's 12/15/23 internal incident report for resident 2 revealed:
*She had an unobserved fall in her room at 3:46 p.m. causing her left wrist to become "very swollen and instantly bruised."
*DON C was notified of the fall by a text message from a staff member.
*There was no documentation of when that notification had occurred or what was discussed.
*The resident was taken to the ER by a family member for an evaluation.

Interview on 4/30/24 at 9:40 a.m. with administrative supervisor H revealed all administrative staff were notified of all the resident's falls.

Interview on 4/30/24 at 3:30 p.m. with ED A regarding the above findings revealed:
*DON C was no longer employed.
*DON C was the one responsible for conducting fall investigations and completing reports to the SD DOH.
*It was her expectation that DON C would have informed her of any serious incidents, and that she would have investigated and reported those incidents to the SD DOH.
-She was unable to locate any documentation supporting an investigation occurred.
*The staff had notified DON C of the falls, but she was not notified.

Review of the provider's 9/28/21 Director of Nursing job description revealed:
*"A. Responsible to: The DON reports directly to the facility Administrator on all medically related matters which pertain to staff or to residents and on all documentation regarding that care in

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S 030	Continued From page 5 accordance with federal and state regulations." *"8. Communicates regularly with the facility Administrator regarding any changes in a resident's level of care." Review of ED A's signed 12/28/23 Executive Director job description revealed one of her responsibilities were to ensure compliance with all federal, state, and local regulations. A reporting policy was requested on 4/30/24 at 11:30 a.m. and ED A stated it was included in the undated "Abuse, Fraud, and Wrongdoing" policy. That policy revealed: *The administrator, or other designated representative, would initiate and investigate any reports of abuse, fraud, or other wrongdoing. *All staff were to have received annual training on reporting requirements. *Any urgent medical or safety issues were to have been addressed immediately. *All appropriate parties were to have been notified of the outcome of the investigation.	S 030		
S 681	44:70:07:08 Medication Records And Administration Medication errors and drug reactions must be reported to the resident's physician, physician assistant, or nurse practitioner and an entry made in the resident's care record. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure a medication	S 681	S681 1. Resident #1 unable to correct noncompliance. 2. All residents have the potential to be affected by this deficiency. 3. Medication Management Policy has been reviewed. 4. DON or designee will educate clinical staff on proper medication administration including review of the Medication Error Policy referencing: "The community will report all medication errors as soon as the error is discovered. 1. Medication and treatment errors must be reported to the DON immediately or as soon as the error is discovered. 2. DON or licensed Nurse will telephone physician regarding error for any immediate interventions (including call the pharmacist.) This communication and resulting guidance received from the physician will be document in the resident's medical record. 3. The team member who makes or discovers the error must complete the medication/treatment error report. 4. The DON will be responsible for completing their portion of documentation and submit to Executive Director for review." 5. An audit of three medication administration events will be completed by the DON/Designee weekly times 4 weeks, then monthly times 3 months then monthly thereafter until substantial compliance is continuously met. 6. An audit of three MAR's to monitor for availability of medications and proper administration will be completed by DON/Designee weekly times 4 weeks, then monthly times 3 months then monthly thereafter until substantial compliance is continuously met. 7. The results of these audits will be brought to the QA committee monthly for their review and advisement until substantial compliance is met for 3 consecutive months. 8. Lab tracking form has been created to track labs and results.	6.14.2024

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error involving a high-risk medication for one of one sampled resident (2) was investigated and reported to the physician.
Findings include:

1. Review of resident 2's closed electronic medical record (EMR) revealed:
*An order from a heart and vascular physician was received by fax on 3/1/24 at 11:01 a.m. which stated, "Today only 3/1/24 NO warfarin [blood thinning medication] then continue warfarin 5 mg [milligrams] Mon [Monday] Fri [Friday] and 2.5 mg all other days of the week. Recheck INR [international normalized ratio: determines coagulation rate of the blood][on] 3/4/24..."
-This order was dated and initialed as received by DON C on 3/1/24 and a progress note regarding the change was entered at 1:28 p.m.

Review of resident 2's March 2023 Medication Administration Record (MAR) revealed:
*On 3/1/24 at 5:00 p.m., a dose of warfarin sodium 5 mg was administered to the resident by medication technician (MT) J.
*There was no documentation in the EMR that identified a high-risk medication error occurred or that the physician was notified.

Further review of resident 2's EMR following the medication error showed a PT/INR lab result on 3/4/24 revealing a PT (prothrombin time) of 35.2 seconds (H-high) and an INR of 3.3 (H-high). The standard INR for a person receiving blood thinning medication was 2.0-3.0.

On 4/29/24 at 5:00 p.m. a medication error report for March 2024 was requested from executive director A. She indicated there were no medication errors reported in March 2024.

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Interview was attempted on 4/30/24 at 2:44 p.m. with MT J as she was scheduled for the 2:00 p.m. to 10:00 p.m. shift. She was not currently in the facility and was unavailable for an interview.

Interview on 4/30/24 at 3:30 p.m. with executive director (ED) A regarding the above medication error revealed:
*DON C was no longer employed.
*The nurses were responsible for entering physician orders into the EMR and ensuring the correct medications were in the medication cart.
-Stated, "She [DON C] noted the [3/1/24] order, but didn't do anything about it."
*It was her expectation for the person who made the medication error to fill out a medication error sheet and notify administration and the physician.
*No medication error sheet was found regarding the 3/1/24 incorrect warfarin administration.
-She was not aware that a medication error had occurred.

Review of the undated Hold orders policy revealed, "Hold medications were to be held from use by the resident as instructed by the physician."

Review of the August 2023 Medication Errors policy revealed:
*"1. Medication and treatment errors must be reported to the Wellness Director/Director of Nursing immediately or as soon as the error is discovered."
-"3. The Team Member who makes or discovers the error must complete the Medication/Treatment Error Report."
*The physician and the pharmacist were to have been immediately notified and medication error reports were to have been submitted to the executive director.

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S 701	44:70:08:01(1-6) Record Service The resident care records shall include the following: (1) Admission and discharge data including disposition of unused medications; (2) Report of the physician's, physician assistant's, or nurse practitioner's admission physical evaluation for resident; (3) Physician, physician assistant, or nurse practitioner orders; (4) Medication entries; (5) Observations by personnel, resident physician, physician assistant, nurse practitioner, or other persons authorized to care for the resident; and (6) Documentation that assures the individual needs of residents are identified and addressed. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure a discharge summary was completed for one of one sampled resident (2's) closed record. Findings include: 1. Review of resident 2's closed electronic medical record (EMR) revealed: *She was admitted on 6/30/23 and transferred to a hospital on 3/18/24. -She was discharged on 3/18/24 following that transfer. -Her progress notes documented her as "out of	S 701	S701 1. Resident #1 unable to correct noncompliance. 2. All residents have the potential to be affected by this deficiency. 3. Move Out Policy has been reviewed. 4. DON/Designee will provide education on placing a discharge note to include: a. Departure time, method of transportation and who accompanied resident b. Where the resident is transferring to c. Paperwork sent with resident or faxed d. Medications released and to whom e. PCP and Pharmacy notified and method of notification f. Was room cleaned of furniture or not 5. Education provided that DON or floor staff are able to complete the discharge note. 6. DON and ED will audit every discharge to assure accuracy on a weekly basis for 4 weeks, monthly for 3 months, and monthly thereafter until significant compliance has been met. 7. The results of these audits will be brought to the QA committee monthly for their review and advisement until continued substantial compliance is met for 3 consecutive months.	6.14.2024

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the facility" from 3/18/24 until 4/12/24.
*On 4/12/24 there was a progress note from a sister facility's staff member (K).
-That progress note stated, "Resident went from Hospital to Hospice house and passed away."
*There were no further progress notes or a discharge summary found in the resident's EMR.

Interview on 4/30/24 at 3:30 p.m. with executive director (ED) A and director of nursing (DON) B revealed:
*DON C's employment ended on 4/5/24.
*DON B had only been employed for approximately ten days.
*ED A was not aware of the progress note entered on 4/12/24 by the sister facility's staff member K.
-She was unsure as to the reason that staff member would have made that progress note.
*Stated former DON C should have entered and completed a discharge summary form in Point Click Care (PCC) following her discharge on 3/18/24.
*It was her expectation for the DON to complete a discharge summary for all discharged residents.

Review of the 9/28/21 'Director of Nursing' job description revealed:
*"10. Ensures personal and medical data is entered into the electronic medical record of each resident in the facility."
*The policy did not specify the completion of a discharge summary following a resident's discharge.

A discharge policy was requested on 4/30/24. ED A provided a Move-Out policy and stated it was the discharge policy. Review of the undated Move-Out policy revealed:
*"A move-out of the community [discharge] is

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S 701	Continued From page 10 conducted in a dignified manner to limit transfer trauma and to ensure that resident needs are met." -"8. A resident move-out summary is completed in the resident's record." *There were no instructions on when, how, or who was responsible for the completion of the discharge summaries.	S 701		
S 838	44:70:09:09(4) Quality Of Life A facility shall provide care and an environment that contributes to the resident's quality of life, including: 4) Freedom from verbal, sexual, physical, and mental abuse and from involuntary seclusion, neglect, or exploitation imposed by anyone, and theft of personal property; This Administrative Rule of South Dakota is not met as evidenced by: A. Based on closed record review, a South Dakota Department of Health (SD DOH) complaint report review, a facility-reported incident (FRI) review, incident report review, interview, and policy review, the provider failed to ensure one of one sampled resident (2) who: *Had falls that resulted in serious bodily injury was adequately monitored by a licensed nurse. *Was receiving a high-risk blood thinning medication was adequately monitored for medication-related complications. Findings include: 1. Review of resident 2's closed electronic medical record (EMR) revealed:	S 838	S838 1. Resident #1 unable to correct noncompliance. 2. All residents have the potential to be affected by this deficiency. 3. Change of Condition Policy has been reviewed. 4. DON or designee will educate clinical staff on Change of Condition Policy and Allowable Health Condition Policy. 5. DON and ED will audit 3 resident care service plans weekly for 4 weeks to ensure appropriate ancillary service referrals are in place. Then monthly audits of 3 residents for 3 months and then monthly thereafter until significant compliance is met. 6. The results of these audits will be brought to the QA committee monthly for their review and advisement until continued substantial compliance is met for 3 consecutive months.	6.14.2024

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*She was admitted on 6/30/23 and her diagnoses included atrial fibrillation and flutter, essential hypertension, age-related osteoporosis without current pathological fracture, dizziness and giddiness, major depressive disorder, and Parkinson's disease.
*Her 9/30/23 fall risk assessment was 80, indicating she was at a high risk for falling.
*Her last revised 11/30/23 care plan indicated she was to ambulate with the assistance of a two-wheeled walker, was encouraged to stand up slow and ensure she was steady before walking, and had to be reminded to ask for staff assistance.
*Her 6/28/23 Mini-Mental Status Examination score was 16, indicating she had moderate cognitive impairment.

Review of the 3/25/24 South Dakota Department of Health (SD DOH) complaint report and the 3/19/24 FRI regarding resident 2 revealed:
*The resident had a witnessed fall in her room on 3/17/24 at 11:30 p.m.
-The investigation of the fall indicated the resident had not hit her head, the staff monitored her hourly through the night, and she was last observed as alert and ambulatory on 3/18/24 at 5:00 a.m.
*The resident was found unresponsive on 3/18/24 at 9:00 a.m.
-She was taken to the hospital by emergency personnel where it was determined she had a subdural hematoma (bleeding in the space between the brain and the skull). She immediately underwent a left-sided craniotomy (removal of a piece of skull bone to relieve pressure by draining accumulated blood) on 3/18/24.

Review of the provider's 3/17/24 internal Incident

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRMONT GRAND SENIOR CARE	409 E FAIRLANE DRIVE RAPID CITY, SD 57701

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Report regarding resident 2's fall revealed:
*The resident had "fell back into a table pretty hard" as she was being assisted into her bathroom.
-She sustained a skin tear on her right hand that was "bleeding excessively" and a small bruise on her left index finger.
-That incident report did not indicate if she had hit her head.
*DON C was contacted at 11:50 p.m. on 3/17/24 regarding the 11:30 p.m. fall.
*The physician was not contacted.

Review of resident 2's EMR regarding the 3/17/24 fall revealed:
*There was no documentation to support the FRI's claim the resident was monitored hourly through the night and was last observed as alert and ambulatory at 5:00 a.m. on 3/18/24.
*There were no progress notes regarding the 3/17/24 fall, who provided the wound treatment to the right-hand skin tear, or if a licensed nurse assessed the resident's condition following that fall.
*The only nurse's progress note related to the fall was by DON C on 3/18/24 at 10:13 a.m., stating the resident was found lying in her bed and was unresponsive to voice, touch, and painful stimulation. The family arrived at the bedside and the resident was transferred by emergency medical services (EMS) to the hospital.
-There was no documentation indicating the resident's physician was notified of the fall.
*The progress notes indicated the resident was "out of the facility (OOF)" from 3/18/24 until a final note dated 4/12/24 stating the resident, "Was discharged from the hospital to hospice care and died."
*There was no discharge summary found in the resident's EMR.

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Further review resident 2's EMR progress notes revealed:
*A 12/28/23 progress note at 9:22 a.m. from medication technician (MT) D stating the resident was found "...on the floor sitting with her back against her bed and left arm was stuck between mattress and her bed rail. Vitals were taken, daughter and son in law took her to get checked out."
-A 12/28/23 consultation note revealed she was seen by a medical provider for acute left wrist pain following a fall.
-There was no documentation that indicated an investigation was completed for the fall or if an assessment was completed for side rail safety.

On 4/29/24 and again on 4/30/24, a request for information regarding the incident report and investigation related to the above 12/28/23 fall was requested from executive director (ED) A. That incident report was not provided by the end of survey.

Review of resident 2's 12/15/23 incident report and corresponding EMR revealed:
*The resident had a fall on 12/15/23 at 3:46 p.m. in her room, where her left wrist was severely injured requiring an emergency room visit. It was determined she had a left wrist fracture and a cast was applied to her left forearm and wrist.
-The report indicated DON C was notified of the fall by a text message from staff.
-There was no documentation in the nurse's progress note regarding the fall or of the resident's condition upon return to the facility.
-A fall-related vitals sheet, unsigned by staff, showed the resident's vitals were taken six times in a 48-hour period. The resident's pulse ranged from 117 beats per minute to 147 beats per

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minute (normal heartbeat range per minute was 60 to 100). There was no documentation a nurse or physician was notified of the elevated pulse rate.
*There was no nurse documentation regarding the resident's left-hand circulation and sensation following the 12/15/23 application of her cast.
*On 2/7/24 there was an order on the residents Medication Administration Record (MAR) for daily dressing changes every six hours as needed (PRN) to a pressure ulcer on her left wrist.
-There was no documentation located in the EMR to support when the cast was removed.
*There was one wound care note dated 2/9/24 by DON C indicating the pressure ulcer was from "orthopedic cast rubbing on bony prominence."
*There was no nursing skin assessment completed in February 2024 that indicated a pressure ulcer had formed to her left wrist that required daily monitoring and dressing changes.

2. Review of resident 2's closed EMR regarding her anticoagulant medication warfarin (high-risk blood thinning medication) revealed:
*A 1/24/24 physician's order from an anticoagulation clinic stating, "Received INR (clotting rate of the blood) from 1/10/24 today [on] 1/24 since this INR is already 2 weeks old, please get INR tomorrow 1/25/24..."
-That lab draw had not been obtained until 1/29/24 and it revealed a slightly elevated INR of 2.8 (H-high). The standard INR for a person receiving an anticoagulant was 2.0-3.0.
-There were no changes to the daily dose of warfarin 5 mg (milligrams) on Monday and Friday and 2.5 mg on all other days of the week.
-There was no nurse's note indicating the reason for the delay in obtaining that lab or when the next lab was due.
*A 2/29/24 ER (emergency room) visit summary

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S 838	Continued From page 15 stating the resident was seen for complaints of weakness. A PT/INR lab was drawn and she was discharged back to the facility that same day. -There were no nursing progress notes or a PT/INR lab result found for the 2/29/24 ER visit. *On 3/1/24 there was an anticoagulation clinic order for her warfarin 5 mg dose to be held for that day and a PT/INR lab to be drawn again on 3/4/24. -That warfarin 5 mg dose was administered to the resident and no medication error report was completed and there was no nurse documentation that the physician was notified of the error. *On 3/4/24 an INR lab revealed her INR was further elevated at 3.3 (H-high). -Her warfarin dose was decreased to 5 mg on Friday only and 2.5 mg on all other days of the week. -The physician's 3/4/24 After Visit Summary indicated the provider's warfarin dose on hand was a 5 mg tablet and it was to be cut in half to administer the 2.5 mg dose. -The resident's MAR stated, "Warfarin 2.5 mg tab 1..." *On 3/6/24 an INR lab revealed her INR had further increased to 3.9 (H). -That meant she was at a high-risk for excessive bleeding. -That lab result was dated and initialed as received by DON C on 3/6/24. -There were no nurse's progress notes that addressed the increased INR lab or if the physician or anticoagulation clinic was notified it had increased. -There was no nursing documentation that indicated there was monitoring for the increased risk of bruising or bleeding. *There were no further progress notes found in her EMR regarding her warfarin dose and	S 838		

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elevated INR labs up until her 3/18/24 transfer to the hospital and subsequent diagnosis of a subdural hematoma.

B. Based on electronic medical record (EMR) review, interview, and policy review, the provider failed to ensure education and oversight was provided from a licensed nurse for two of two medication technicians (MTs) (D and E) who had completed dressing changes on one of one sampled resident (2).
Findings include:

1. Review of resident 2's EMR and February and March 2024 medication administration record (MAR) revealed:
*The resident had a fractured left wrist with an acquired pressure ulcer on her left anterior lateral wrist bony prominence.
-A 2/7/24 physician order for daily dressing changes that included a wet-to-dry dressing with a wet gauze wound overlay and a dry gauze cover followed with an elastic bandage wrap and application of a wrist brace.
-That order was changed on 3/9/24 to a twice daily soap and water wash with an application of a Xeroform (specialized petrolatum infused dressing) gauze dressing then a taped bandage and gauze wrap for comfort.
-All dressing changes were completed by the MTs and not a licensed nurse.

Interview on 4/30/24 at 9:15 a.m. with MT E regarding resident 2's wound care and dressing changes revealed:
*She had been employed as a MT since November of 2022.
-Stated the MTs provided minor wound care and dressing changes.
-If it was a complicated dressing change, the

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resident went to a wound care clinic.
*The pressure ulcer on resident 2's left wrist was found after her cast was removed.
*She had performed the resident's wound care and dressing changes.
-Stated all the MTs performed her dressing changes and wound care.
*She was educated on how to perform wound care and dressing changes when she was first hired by a past DON.
-She was not educated on how to perform resident 2's wound care or dressing changes by a licensed nurse.

Interview on 4/30/24 at 9:30 a.m. with resident care aides (RCAs) F and G regarding resident 2's 3/17/24 fall, cast, and dressing changes revealed:
*They had been assigned to resident 2's care for the morning of 3/18/24.
-During the morning report, the night shift staff informed them of the resident's fall the prior evening.
*The staff member who had been with the resident when she fell was no longer employed.
*They could not recall if they were informed when the resident was last observed alert and awake.
-Stated they observed the resident sleeping in bed and did not attempt to awaken her at 6:00 a.m. and again at 7:00 a.m.
-At 8:00 a.m. they were unable to awaken the resident.
-DON C was summoned by the medication technician (MT) to assess the resident.
*Regarding the cast and pressure ulcer to resident 2's left arm revealed:
-There was a pressure ulcer on her anterior lateral bone of her wrist. It was found when the cast had been removed sometime in February 2024.
-The resident had a Velcro wrist brace after the

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cast was removed.
-The MTs were providing the daily dressing changes.

Interview on 4/30/24 at 9:40 a.m. with administrative supervisor H revealed:
*Residents were usually seen by a third party for wound care.
*Stated wound care orders needed to state if a MT could perform the wound care.
-Stated that in-house wound care should have been completed by the nurse.

Interview on 4/30/24 at 9:45 a.m. with MT D regarding resident 2's wound care and dressing changes revealed:
*She had been employed for nearly one year, but had a total of about five years working for the provider.
*She performed the resident's wound care and dressing changes.
-Stated all the MTs perform the wound care and dressing changes unless the resident went to a wound care clinic.
*She had not received any training or education on wound care or dressing changes in the last four to five years.
-Stated she had "Never seen any nurses perform wound care here."
*Confirmed none of the nurses had ever observed her perform wound care on resident 2.

Interview on 4/30/24 at 3:30 p.m. with executive director (ED) A and DON B regarding resident 2's falls with injury, warfarin medication error, PT/INR lab draws, and the wound care provided by MTs revealed:
*DON C was no longer employed.
*ED A expected all falls with injury to have been investigated, documented, and reported.

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*Regarding the above warfarin medication error and INR labs:
-ED A stated :
-She had, "No knowledge of any of this."
-If a lab was ordered, the contracted lab was available to come any day of the week and if it had been ordered on the weekend, they would transport the resident to the lab.
-It was the expectation for lab orders to have been obtained according to the physician's order and for elevated labs and medication errors to have been addressed with the physician.
-ED A stated, "She (DON C) just didn't do it, I have no explanation. She never asked me for assistance."
*Regarding the above dressing changes provided by the MTs:
-ED A stated, "Serious dressing changes were referred to a wound care clinic."
-Stated MTs could perform uncomplicated dressings such as applications of adhesive bandages.
-MTs could perform other dressing changes if the nurse first demonstrated the dressing change to them and felt comfortable delegating that task to the MTs.
-DON B stated her expectation was for the MTs to have been trained and educated on individual dressing changes or she would do it herself.
*They were unaware the MTs had not been educated by a nurse on how to complete resident 2's dressing changes.

A wound care policy or job description was requested on 4/29/24 at 5:00 p.m. ED A stated wound care was "outsourced" and no policy or job description was provided.

Review of the provider's April 2015 'Certified Medication Aide' (also referred to as MTs) job

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S 838	Continued From page 20 description revealed it had not listed wound care or dressing changes as a part of their job description.	S 838		

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

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