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
	10745	A. BUILDING: _____ B. WING _____	C 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE INN ON WESTPORT	4000 S. WESTPORT AVENUE SIOUX FALLS, SD 57103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance Statement A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers was conducted from 4/8/24 through 4/9/24. Areas surveyed included nursing services, medication administration, medication errors, physician and family notification, and resident safety. The Inn on Westport was found not in compliance with the following requirements: S337, S601, and S800.	S 000		
S 337	44:70:04:11 Care Policies Each facility shall establish and maintain policies, procedures, and practices that follow accepted standards of professional practice to govern care, and related medical or other services necessary to meet the residents' needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on the South Dakota Department of Health (SD DOH) event report review, interview, record review, policy review, and job description review, the provider failed to ensure medications were administered as ordered for one of one sampled resident (2) by one of one certified medication aide (CMA) J. Findings include: 1. Review of the SD DOH event report received on 2/26/24 revealed: *On 2/11/24, resident 2 was given another resident's medications. *Those wrong medications administered were melatonin (a sleep aid), lorazepam (a sedative), mirtazapine (an antidepressant with side effects of sleepiness), and Senna (a stool softener).	S 337	Care Policies * All residents receiving medication administration services have the potential to be impacted by the deficient practice * To ensure the deficient practice does not recur, the DON or designee will educate all nurses and medication aides on the following: * Medication Administration - Electronic Documentation Policy * Medication Errors Policy * Medication Aide Clinical Skills Checklist * Education will be completed no later than May 24th, 2024 * To monitor performance and ongoing compliance, the DON or designee will conduct weekly medication audits for three weeks. Audits will include all medication errors and that policy/procedure were followed. The results of the weekly audits will be utilized to confirm system processes are achieved and desired outcomes met or if adjustments/ additional training is necessary. The audit will continue monthly for three months. * The results of the audit findings will be brought to Quality committee by the DON or designee for review of compliance for 3 months. The Quality committee will review the results of the audits and recommend further action as necessary. * The Assisted Living Administrator is responsible.	May 24, 2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jim Dykstra — TITLE: Executive Director/Administrator — (X6) DATE: 4-26-24

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*Resident 2 was found on the floor on the morning of 2/12/24 and staff had a difficult time waking her.
*She fell again on 2/12/24 around 12:30 p.m.
*She was taken to the emergency room on recommendation from her physician.

2. Interview on 4/9/24 at 1:15 p.m. with CMA J regarding the medication error on 2/11/24 revealed she:
*Recalled the event because it was Super Bowl Sunday, and she did not feel well.
*Prepared medications for resident 2 and another resident at the same time, placed each resident's medications in separate medication cups and placed them on the medication cart.
*Administered medications to resident 2.
*Realized she had administered another resident's medications to resident 2 when she returned to the medication cart and noticed resident 2's medications were still there.
-That happened around 7:00 p.m.
*Withheld resident 2's medications as she did not know if they would have reacted with the other medications she had given her in error.
*Did not receive approval from the resident's physician to withhold the medications.
*Did not contact the physician or nursing management.
*Informed the oncoming CMA (H) about the medication error at around 8:30 p.m. and left the building.
*Confirmed she should not have prepared two different resident's medications at the same time.
*Confirmed she should have contacted the director of nursing (DON) about the medication error.
-Decided she would follow-up with resident 2 the next day.
*Was aware the facility policy regarding

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medication errors indicated to contact the DON.

3. Interview on 4/9/24 at 1:40 p.m. with licensed practical nurse/resident care coordinator (LPN/RCC) F regarding the medication error revealed:
*She was the current RCC for the first and second floors.
*At the time of the medication errors, a different RCC was employed and covered the first floor.
-Resident 2 resided on the first floor.
*She did not know what the policy indicated regarding medication errors and follow-up actions.

4. Interview on 4/9/24 at 1:57 p.m. with DON B regarding medication errors revealed:
*CMA H notified her of the medication error around 5:00 a.m. on 2/12/24.
*She confirmed that it was not in CMA J's scope of practice to decide to withhold a resident's medications.

5. Interview on 4/9/24 at 2:26 p.m. with executive director A regarding medication errors revealed she:
*Expected staff to follow the medication administration and medication error policies.
*Confirmed staff had not followed those policies.

6. Review of resident 2's electronic medical record revealed:
*Orders for the following medications to be administered at bedtime:
-One aspirin 81 mg (milligrams) tablet.
-One calcium/vitamin D supplement 500 mg-200 U (units) tablet.
-One Eliquis 2.5 mg tablet.
-One metoprolol succinate 25 mg extended-release tablet.

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-One pravastatin 80 mg tablet.
*Her 2/11/24 medication administration record indicated those medications were "Held due to med error."
*A 2/12/24 progress note at 9:00 a.m. that read:
-"This am [a.m.] it was reported to this nurse that this resident was given another [resident's] medications, resident was given the resident in room [room number redacted] medication which includes Senna, [Mirtazapine], Melatonin & Lorazepam. [This] error occurred around 7:00PM on 02/11/2024. The DON was notified. BP [Blood pressure] was 155/60, P [Pulse]-84. Last time resident was seen was on 02/11/2024 at 10:30 PM, was seen sitting on a chair after she had showered. No abnormal behavior noted, resident has been more confused lately. Dosages of medication are: 1 mg of Lorazepam, 3mg Melatonin, 15 mg [Mirtazapine], Senna-Plus 8.6-50mg tablet. Spoke to [physician's] nurse this [a.m.] at [10:30 a.m.] as well."
*She went to the emergency room on 2/12/24 due to two separate falls and increased drowsiness.

7. Review of the provider's 8/8/23 Medication Administration - Electronic Documentation policy revealed, "Medications are administered in accordance with Physicians' orders. Administration and/or refusal of medication is documented in the electronic medication record."

8. Review of the provider's 8/1/23 Medication Errors policy revealed:
*"The facility will ensure that it is free of medication error rates of five percent or greater and that residents are free of significant medication errors. A significant medication error in defined as an error that causes the resident discomfort or jeopardizes the resident's health or safety ... When a medication error occurs it will

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S 337	Continued From page 4 be reported to the attending physician and the responsible party, documented in the medical record, and a facility incident/error report completed." *"Procedure: 1. A medication error is a discrepancy or a departure from what is usual or expected and that occurs through the pharmacy or in the administration of medications or treatments. 2. A medication error may consist of the following: a. Wrong medication administered ...g. Wrong resident given the medication h. Unauthorized medication given (medication administered without a physician's order) i. Omission of medication ordered, unless omission is justified due to resident's condition and information regarding the omission and justification is documented 3. Measures to ensure the resident's safety shall [be] implemented immediately following discovery of a medication error. When a medication error results in the resident actually receiving the wrong medication ...the physician should be notified promptly and nursing interventions corresponding to the medication administered should be implemented immediately. Physician's orders should be acted upon accordingly. 4. Monitor the resident for as long as needed. It may be necessary to contact the pharmacy or poison control center to determine the effects of the medication and the length of time for excretion of medication from the body. 5. The responsible party shall be notified following a medication error ... ...8. The incident/error will be reported to the Charge Nurse or other appropriate facility management and action to correct the error and will be implemented. A plan to prevent future errors should be implemented."	S 337		

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S 337	Continued From page 5 9. Review of the provider's revised 11/3/16 job description for certified medication assistants revealed: *"Purpose: the primary purpose of this position is to provide each of your assigned residents with routine daily nursing care and services accordance with the resident's assessment and care plan, and as may be directed by your supervisors." *"Essential Job Functions Duties and Responsibilities ...Nursing Department Functions 1. Prepare and administer medications according to health care provider instructions and within the scope of the license. ...4. Inform the nurse of any changes in the resident's condition (e.g. vitals, reports of pain, etc.) so that appropriate information can be acted upon." *"Required Knowledge, Skills and Abilities ...Licensing/Certifications -Must be a licensed Certified Nursing Assistant and a licensed Medication Assistant in accordance with laws of this state."	S 337		
S 601	44:70:07:01(2) Policies And Procedures Each facility shall establish and implement written policies and procedures for medication control that include: (2) Provisions for proper storage of prescribed medications so that the medications are inaccessible to residents and visitors, with requirements for: (a) Separate storage of poisons, topical medications, and oral medications; (b) Each resident's medication to be stored in the container in which it was originally received and not transferred to another container; and	S 601	Policies and Procedures * All residents receiving medication administration services have the potential to be impacted by the deficient practice. * To ensure the deficient practice does not recur, the DON or designee will educate all nurses and medication aides on the following: * Medication Administration - Electronic Documentation Policy * Medication Errors Policy * Medication Aide Clinical Skills Checklist * Education will be completed no later than May 24, 2024 * To monitor performance and ongoing compliance, the DON or designee will conduct weekly medication audits for three weeks. Audit will include all medication errors and that policy/procedure were followed. The results of the weekly audits will be utilized to confirm system processes are achieved and desired outcomes met or if adjustments/ additional training is necessary. The audits will continue monthly for three months. * The results of audit findings will be brought to Quality Committee by the DON or designee for review of compliance for 3 months. The Quality committee will review the results of the audits and recommend further action as necessary. * The Assisted Living Administrator is responsible	May 24, 2024

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S 601	Continued From page 6 (c) A medication prescribed for one resident not to be administered to any other resident; This Administrative Rule of South Dakota is not met as evidenced by: Based on the South Dakota Department of Health (SD DOH) event report review, interview, record review, and policy review, the provider failed to follow their policy when two of two certified medication aides (E and J) administered the wrong medications to one of one sampled resident (2) on two separate occasions. Findings include: 1. Review of the SD DOH event report received on 2/26/24 revealed: *Resident 2 was given another resident's medications on the morning of 2/9/24 and the evening of 2/11/24. *On 2/9/24, she was given another resident's trospium chloride (a medication for an overactive bladder) by certified medication aide (CMA) E. *On 2/11/24, she was administered the wrong medications that included melatonin (a sleep aid), lorazepam (a sedative), mirtazapine (an antidepressant with side effects of sleepiness), and Senna (a stool softener) by CMA J. *Resident 2 was found on the floor the morning of 2/12/24 and staff had a difficult time waking her up. *She fell again on 2/12/24 around 12:30 p.m. *She was taken to the emergency room on recommendation from her physician. 2. Interviews were attempted with CMA E,	S 601		

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however she was unavailable during the survey.

3. Refer to S337, finding 2.

4. Interview on 4/9/24 at 1:57 p.m. with director of nursing B regarding medication administration errors revealed she:
*Was aware of the medication errors.
*Expected staff to administer medications as ordered.

5. Interview on 4/9/24 at 2:26 p.m. with executive director A regarding medication administration errors revealed she:
*Confirmed CMA E and CMA J had administered the wrong medications to resident 2.
*Expected staff to follow the medication administration and medication error policies.
*Indicated CMA J should have contacted a nurse manager immediately following the medication error.
*Confirmed staff did not follow the policies.

6. Review of resident 2's paper and electronic medical record revealed:
*Refer to S337, finding 6.
*2/9/24 progress note at 1:23 p.m. that read:
-"Staff member was asking about if we had received a medication on another resident as could not find the am [a.m.] dosage pack for Trospium CL tab 20 mg. ...This writer went to each cart with the other [resident's] names & found the am [a.m.] dosage package of Trospium CL tablets 20 mg's in [resident 2's] medications. Upon looking at the package it was noted that the [a.m.] February, 9 dosage was punched out meaning to this writer that it was given along with her other medications. Spoke to [CMA E] who passed meds & she said she did not realize the medication was for another resident & did give

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S 601	Continued From page 8 the medication, 1 dosage to this resident ..." *After she had been given the wrong medication on the evening of 2/11/24, resident 2 experienced increased confusion, excessive sedation, and three falls: -She was found on the floor in her apartment on 2/12/24 around 5:10 a.m. -She was found lying on her side on the floor at the base of her bed on 2/12/24 around 1:35 p.m. --She was last seen at 1:15 p.m. sitting on her bed. -The resident's family brought her to the emergency room around 2:00 p.m., and returned around 10:00 p.m. 7. Refer to S337, findings 8 and 9.	S 601		
S 800	44:70:09:04 Notification When Resident's Condition Change A facility shall immediately inform the resident, consult with the resident's physician, physician assistant, or nurse practitioner, and, if known, notify the resident's legal representative or interested family member when any of the following occurs: (1) An accident involving the resident that results in injury or has the potential for requiring intervention by a physician, physician assistant, or nurse practitioner; (2) A significant change in the resident's physical, mental, or psychosocial status; (3) A need to alter treatment significantly; or (4) A decision to transfer or discharge the resident from the facility This Administrative Rule of South Dakota is not	S 800	Notification When Resident's Condition Change * All residents have the potential to be impacted by the deficient practice * To ensure the deficient practice does not recur, the DON or designee will educate all nurses and medication aides on the following: * Medication Administration - Electronic Documentation Policy * Medication Errors Policy * Incident Report Policy * Education will be completed no later than May 24, 2024 * To monitor performance and ongoing compliance, the DON or designee will conduct weekly audits for three weeks of all resident incidents that meet the criteria for medication errors. The audit will ensure that appropriate notification were completed within the timelines outlined in the Incident Report Policy. The results of the weekly audits will be utilized to confirm system processess are achieved and desired outcomes net or if adjustments/additional training is necessary. The audits will continue monthly for three months. * The results of the audit findings will be brought to Quality committee by the DON or designee for review of compliance for 3 months. The Quality committee will review the results of the audits and recommend further action as necessary. * The Assisted Living Administrator is responsible.	May 24, 2024

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met as evidenced by:
Based on the South Dakota Department of Health (SD DOH) event report review, interview, record review, and policy review, the provider failed to ensure notification to the physician and family had occurred timely for one of one sampled resident (2) related to a medication error.
Findings include:

1. Review of the SD DOH event report received on 2/26/24 revealed:
*Resident 2 was given another resident's medications on the evening of 2/11/24.
*The wrong medications administered were melatonin (a sleep aid), lorazepam (a sedative), mirtazapine (an antidepressant with side effects of sleepiness), and Senna (a stool softener).
*Resident 2 was found on the floor the morning of 2/12/24 and staff had a difficult time waking her up.
*She fell again on 2/12/24 around 12:30 p.m.
*She was taken to the emergency room (ER) on recommendation from her physician.

2. Refer to S337, finding 2.

3. Interview on 4/9/24 at 1:40 p.m. with licensed practical nurse (LPN) F revealed:
*She was the resident care coordinator (RCC) for the first and second floors.
*At the time of the medication errors, a different RCC was employed and covered the first floor.
*It was her expectation that CMAs contact the on-call nurse or the DON immediately following a medication error for further direction.
*It was the responsibility of the RCC or the DON to contact the resident's physician, family, and pharmacy.
*She did not know what exactly the policy indicated regarding medication errors and

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S 800	Continued From page 10 follow-up actions. 4. Interview on 4/9/24 at 1:57 p.m. with DON B revealed: *She was aware of the medication errors that certified medication aide (CMA) J had made on 2/11/24. *It was her expectation that staff contact her immediately following a medication error for further direction. *CMA H notified her of the medication error around 5:00 a.m. on 2/12/24. *She confirmed that resident 2 had experienced increased confusion and sleepiness, and had two falls prior to being sent to the ER. *She confirmed resident 2's physician was not notified until around 10:30 a.m. on 2/12/24. 5. Refer to S601, finding 5. 6. Review of resident 2's paper and electronic medical record revealed: *Refer to S337, finding 6. *Refer to S601, finding 6. *There was a Physician Notification sheet from 2/12/24 at 10:45 a.m. that summarized the medication errors made on 2/11/24, the resident's confusion, and fall. -The physician responded with "Please bring patient to ER, unwitnessed fall + confusion." *There was a progress note entered on 2/12/24 at 1:06 p.m. that read: -"[Resident's] daughter here, an additional set of vitals were taken within normal limits. Resident does appear to be more sedated or groggy ... Spoke to [advanced practice registered nurse] and instead of going into physician office this afternoon will go to the ER, spoke to [resident 2's daughter] on information received back, she will come get resident & take her to the ER for	S 800		

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evaluation."
*The resident had another unwitnessed fall around 1:35 p.m.
*Resident 2 was not brought to the ER until around 2:00 p.m.

7. Review of the provider's 8/1/23 Incident Report policy revealed:
*"POLICY: Any incident to a resident ...needs to be reported to the Assisted Living Facility management. An incident report form should be completed to document what happened."
*"PROCEDURE: In the event of an accident, injury [or] damage to the property an incident report form must be turned in to the Supervisor or Assisted Living Director."
-"If a resident is involved in any incident, their responsible person must be notified to let them know of the occurrence."
-"If the incident happens outside of business hours, the person completing the incident report must notify the responsible person and then notify the RN [registered nurse] on-call and the Assisted Living Director, as appropriate."

8. Review of the provider's 8/8/23 Medication Administration - Electronic Documentation policy revealed:
*"Policy: Medications are administered in accordance with Physicians' orders. Administration and/or refusal of medication is documented in the electronic medication record."
*"Procedure:"
-"F. Report unusual reactions and/or significant changes in resident's health or behavior to resident's health care provider immediately and document in resident's record."

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE INN ON WESTPORT	4000 S. WESTPORT AVENUE SIOUX FALLS, SD 57103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S 000}	Compliance Statement A 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 5/29/24 for deficiencies cited on 4/9/24. All deficiencies have been corrected, and no new noncompliance was found. The Inn on Westport is in compliance with all regulations surveyed.	{S 000}		

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