

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

PRINTED: 01/04/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/21/2021
NAME OF PROVIDER OR SUPPLIER  DIAMOND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 N MAIN AVE BRIDGEWATER, SD 57319	
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F 000	INITIAL COMMENTS  Surveyor: 41088 A recertification survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 12/19/21 through 12/21/21. Diamond Care Center was found not in compliance with F636, F657, F686, F710, F801, F812, F838, and F865.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii)  §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit.	F 636	The deficiency has been corrected for resident 174 by submitting MDS on 12/21/21. It as accepted on 12/21/21. IDT is short for interdisciplinary team which is our morning meeting, all department head attend. The Director of Nursing and MDS Coordinator each reviewed the RAI manual - Chapter 2: the Assessment Schedule for the RAI and the CMS - Long Term Care Regulations and Guidance power point with specific attention paid to slides 7,8,9,10. Information was reviewed on 12/29/2021. Director of Nursing services will report monthly to QAPI. The information to be included will be the # of MDS due for the month, the # completed by due date, the # submitted by due date, care plan reviews completed by due date, # of late MDS's. If any late MDS noted - QAPI committee will discuss why, what changes are needed and will monitor the next month. All backlogged MDS have been completed and submitted. In the future, Director of Nursing Services will assist in completion of MDS to ensure they are completed by due date.	

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

TITLE

(X6) DATE

*Brianne Mauer*

*Executive Director*

*1/14/22*

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

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F 636	<p>Continued From page 1</p> <p>(xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.</p> <p>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.</p> <p>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii) Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Surveyor: 43021 Based on record review, interview, and resident assessment instrument (RAI) manual review, the provider failed to complete Minimum Data Set (MDS) comprehensive resident assessment within 14 days for 1 of 12 sampled residents (174). Findings include:</p>	F 636	<p>Objective: All assessments and minimum data sets (MDS) will be completed in the allotted time frame as outlined by CMS.</p> <p>Direction: DNS and MDS Coordinator will monitor through IDT process and weekly audits of the current upcoming, new admission, and/or sig change assessments/MDS to ensure completed and transmitted within the allotted time frame. A flow sheet has been designed to be completed and reviewed by DNS and MDS Coordinator as the MDS process progresses. Audits will be completed weekly for 3 months. Audit results will be discussed monthly at facility QAPI meeting. Re-education was provided to DNS and MDS Coordinator regarding comprehensive assessments and timing.</p>	1/19/2022	

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F 636	Continued From page 2  1. Review of resident 174's electronic medical record (EMR) and MDS assessments as of 12/20/21 revealed: *His 11/30/21 entry MDS date was his admit date. *A 12/6/21 admission MDS was in progress. -The provider's MDS software system generated the following notes: --"Complete by: 12/13/2021." --"7 days overdue." -The care area assessments had not been completed. *He had a 12/17/2021 Significant Change MDS in progress. *By not having a complete assessment and comprehensive care plan in place, the resident's needs would not be adequately identified and taken care of by all staff.  Interview on 12/20/21 at 9:15 a.m. with licensed practical nurse (LPN)/MDS Coordinator C regarding resident 174 revealed and confirmed: *The admission MDS was incomplete. *She had to get that done as it needed to be transmitted by tomorrow. *He also had a significant change MDS as of 12/17/21 that was due to be completed.  Further interview on 12/21/21 at 8:20 a.m. with LPN/MDS Coordinator C revealed: *She worked full-time "and then some". *She was currently pulled to work "on the floor" to cover nursing shifts for resident care at least once a week. *The provider had an increased number of resident and staff COVID-19 infections the last two weeks of October through the beginning two weeks of November 2021 that caused her to work full-time "on the floor," covering nursing shifts for	F 636		

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F 636	<p>Continued From page 3</p> <p>resident care.</p> <p>*During that time, they had an increased number of MDS assessments due to significant changes in resident status.</p> <p>*She had been "playing catch up since then."</p> <p>*She was also the provider's social service designee which included completing resident admissions.</p> <p>-The provider had between one and three resident admissions a week.</p> <p>-One admission took "the whole day" for her to complete.</p> <p>*She also completed the dietary components of the RAI process because the provider's dietary manager position was currently open.</p> <p>*She kept in communication with her supervisor and the director of nursing (DON) B and informed them verbally or with "constant text messages" regarding the resident MDS assessment status.</p> <p>Interview on 12/21/21 at 2:47 p.m. with administrator A and director of nursing B revealed they were aware of the backlog of MDS assessments that were overdue and needed to be completed.</p> <p>Review of the October 2019 Long-Term Care Facility RAI 3.0 User's Manual Version 1.17.1 regarding completion of the RAI revealed and confirmed:</p> <p>*The RAI process is the basis for the accurate assessment of each resident.</p> <p>*All comprehensive RAIs must include at least the MDS Version 3.0, use of the Care Area Assessment (CAA) process, and the CAA Summary.</p> <p>*The primary purpose of the MDS was as an assessment tool is to identify resident care problems that are addressed in an individualized</p>	F 636			

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F 636	Continued From page 4 care plan. *The MDS was to be completed for all residents in Medicare or Medicaid certified nursing homes. *The Admission assessment was a comprehensive assessment for a new resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day one.	F 636	Objective: Following Diamond Care Center policy and CMS §483.21(b)(2)(i), A Comprehensive Care Plan will be developed for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental, psychosocial problems, needs, and/or strengths that are identified in the comprehensive Assessment. The Comprehensive Care Plan must be developed within SEVEN days after completion of the comprehensive assessment/MDS. Each care plan shall identify individualized problems/needs/strengths for each resident.  The deficiency for resident 174 was corrected by review residents chart. It was noted the Admission Assessment was not "locked" on admission which is the reason the care plan was not generated. The Admission Assessment was locked with care plan generated and personalized. At the end of Nursing Admission Assessment there are tabs for the user to "save & Sign" " Save", "Save & Exit", Save & Sign & Lock & Exit", "Cancel", or "Clear"	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)  §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		

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F 657	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 43021</p> <p>Based on observation, interview, record review, and policy review, the provider failed to develop a care plan for one of one newly admitted sampled resident (174) that was individualized and reflected his current needs. Findings include:</p> <p>1. Observation on 12/19/21 at 3:15 p.m. of resident 174 revealed: *A welcome poster on the opened door to his room. *He was in his room lying on a pressure reducing alternating air mattress on a bed frame with his eyes closed and a blanket over him. *His bed was in a low position with a thick cushioned fall mat alongside his bed and a lift sling was on the chair.</p> <p>Review of resident 174's electronic medical record (EMR) on 12/20/21 at 8:53 a.m. revealed: *His admission date was 11/30/21. *An incomplete nursing admission assessment created on 11/30/2021 at 4:15 p.m. *An incomplete admission Minimum Data Set (MDS) assessment. *He had a 12/17/2021 Significant Change MDS in progress. *A comprehensive care plan had not been initiated.</p> <p>Interview on 12/20/21 at 9:15 a.m. with LPN/MDS Coordinator C regarding resident 174 revealed and confirmed: *The resident had no care plan. *His 12/6/21 admission MDS was incomplete. -That assessment was due today and had to be transmitted by the next day.</p>	F 657	<p>In order for the care plan to be generated the "Save &amp; Sign &amp; Lock &amp; Exit" must be clicked. This step has been added to the New Admission/Readmission checklist that the Charge Nurse uses to ensure all new or readmission requirements are met. The Director of Nursing or designee will complete audits on new or readmission within 24 hours for 3 months. Nursing has been given the updated check list and Director of Nursing has explained the guidelines for use. This will be on ongoing training with nursing and will be reviewed with each admission or readmission. DNS will report audit revisits to QAPI in the following categories - Assessments locked, care plan generated for new &amp; readmissions monthly.</p> <p>All charts were reviewed to ensure care plans were in place. A generic care plan has been developed for emergent situations, such as computer malfunction and can be placed in resident chart until malfunction is corrected. DNS will ensure care plan has been generated in resident chart within 24 hours of resolution of computer issues.</p>	1/19/22	

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F 657	<p>Continued From page 6</p> <p>*He had a Significant Change MDS as of 12/17/21 that she needed to complete.</p> <p>Review of resident 174's electronic medical record (EMR) on 12/20/21 at 10:15 a.m. revealed: *A care plan had been initiated on 12/20/21 with five focus areas: -Limited physical mobility with fall risk. --No goal had been identified. -Incontinence with a goal of remaining free of moisture associated skin alterations. -Altered cardiovascular status with potential for bleeding and bruising related to his anticoagulant medication. --No goal had been identified. -A discharge plan with a goal to return to community. -Impairment to skin integrity with a goal to remain free from skin alteration or injury. *The care plan was not individualized and needed details added to the interventions.</p> <p>Review of resident 174's care plan printed by the provider on 12/21/21 revealed: *12/21/21 was day 22 of resident 174's admission on 11/30/21. *The care plan that had been initiated on 12/20/21 with ten focus areas including: -Limited physical mobility with fall risk did not specify which mechanical aid (full body lift or sit to stand) to use or the number of staff needed when assisting the resident to transfer. -Difficulty sleeping was not individualized and a goal had not been specified for hours of sleep needed with specifics needing to be added to interventions. -Incontinence was not individualized and had not specified what the incontinence was related to. -Altered cardiovascular status with potential for</p>	F 657		

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F 657	Continued From page 7 bleeding and bruising related to anticoagulant medication was not individualized and had no goal. -Nutritional problem was not individualized or identified what it was related to. -Pain problem was not individualized or specific with no interventions or disciplines identified. -Impairment to skin integrity was not individualized.  Review of the provider's undated Care Plans policy revealed: *Policy: -"A Comprehensive Care Plan will be developed for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial problems, needs, and/or strengths that are identified in the Comprehensive Assessment." -"The Comprehensive Care Plan must be developed within seven days after the completion of the Comprehensive Assessment/MDS." *Procedures: -"The initial Comprehensive Care Plan Conference is held within seven days of the completion of the Comprehensive Assessment/MDS, and within 21 days of admission." -"Care Plan elements must include specific problems/needs/strengths, specific goals and interdisciplinary approaches/ interventions incorporating frequency and timetables, and identified disciplines." -"Each care plan shall identify individualized problems/needs/strengths for each resident."	F 657			
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686			



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F 686	<p>Continued From page 8</p> <p>§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Surveyor: 43021</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure three of three sampled residents (14, 23, and 174) who had developed pressure ulcers had been assessed, received care, on-going assessments, and interventions to prevent new ulcers from developing or prevent wounds from worsening. Findings include:</p> <p>1. Observation and interview on 12/20/21 at 8:07 a.m. with resident 174 revealed:</p> <p>*He was lying on a pressure-reducing alternating air mattress in his room.</p> <p>*When asked if he had any skin problems, he replied he had "scores" on his bottom.</p> <p>Review of resident 174's electronic medical record (EMR) revealed:</p> <p>*He had been admitted to the facility on 11/30/21.</p> <p>*His diagnoses included:</p> <p>-Cerebral infarction.</p> <p>-Unspecified disturbances of skin sensation.</p>	F 686	<p>Objective: Following Diamond Care Center's policy and procedure on Pressure Ulcer Prevention, DNS or designee will ensure that the Pressure Ulcer Prevention Policy is being followed and documentation and physician notification is being completed.</p> <p>Deficiencies have been corrected immediately following State Survey Exit. DNS completed wound documentation on residents 14, 23, &amp; 174. A weekly wound assessment has been designed and DNS has completed documentation weekly. DNS is keeping a calendar and completing audits to ensure documentation is completed for these residents and any new skin issues.</p> <p>In-services has been provided to nursing staff, nurses, CNA's, bath aids, and med aides by DNS on skin and wound management policy and procedure. Education is ongoing. DNS or designee will report to the monthly QAPI meetings. Each skin issue will be identified by its type, charting completed per policy and physician notification. Interventions in place for residents with or at risk: Nutrition consult by dietician, addition of protein supplement(s), repositioning program, toileting program if needed, positioning devices in bed and/or chair, air mattress</p>	1/19/22

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F 686	Continued From page 9 -Other Reduced Mobility. *An 11/30/21 nursing admission assessment indicated no pressure ulcer was present. *A 12/6/21 comprehensive skin and positioning evaluation did not identify a pressure ulcer. -No other skin evaluation had been completed. -The evaluation was locked and signed on 12/20/21 at 10:01 a.m. *A 12/6/21 Braden scale assessment revealed he was at moderate risk for skin breakdown. *A 12/11/21 Nursing Order identified an open area to coccyx [tail bone] measuring 9 centimeters (cm) by 8 cm. -Order summary for "every day and night shift monitor every shift for dressing, drainage, wound bed, periwound area, pain, and status." *A progress note to the above order entered on 12/14/21 at 11:26 p.m. by licensed practical nurse (LPN) D "clean, dry and intact." *A fax information sheet dated 12/16/21 at 2:49 p.m. to resident 14's physician. -"Information: Resident has had a decline in overall function, he has developed an unstageable pressure wound to his coccyx, he has started to complain of more pain, and his wife feels like he is giving up. Wife and I discussed a hospice consult and she would like to proceed." -"Request: OK to consult [hospice provider]." -It had been signed by director of nursing (DON) B. -"Physician's Response: OK for Hospice." --It was signed by medical doctor (MD) on 12/17/21. *A Braden scale assessment dated for 12/17/21 had not been started. *A "Fax Order Request - hospice in LTC [Long Term Care] standing orders." -He had been admitted to hospice on 12/17/21. -"Skin care products/interventions of choice to	F 686	The Executive Director or designee will be completing weekly audits of weekly wound assessment completion. Education provided to staff at monthly in-service and at shift change report. Education will be ongoing. Continue to review pressure ulcer prevention policy, skin & wound,, management policy & wound care policy. Audit results will be reported at QAPI by DNS after being received by Executive Director. The DNS will be the individual completing weekly wound documentation and has a calendar set up to document on correct. Will review resident charts weekly if has a Braden Scale below 12 for any new skin concerns. Interventions in place for residents at risk for pressure ulcer - repositioning - documentation of resident being reposition every 2 hours in Point of Care, nursing signs off on any intervention worn by resident, such as heel boots and documents refusal Audits will be completed by DNS or designee weekly to ensure interventions are being implemented and appropriate documentation.	1/19/22	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/21/2021
NAME OF PROVIDER OR SUPPLIER  DIAMOND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 N MAIN AVE BRIDGEWATER, SD 57319	
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F 686	<p>Continued From page 10</p> <p>prevent or treat skin care problems." -"MD Signature" was signed on 12/20/21. *Active physician orders as of 12/21/21 had no treatment order for his pressure ulcer. *No initial skin wound assessment was found. *No weekly skin or wound assessments were found.</p> <p>Review of resident 174's treatment administration records (TAR) revealed: *There had been many gaps with treatments related to the resident's 9 cm by 8 cm pressure wound since the identified start date of 12/11/21 at 6:00 p.m. *A current treatment plan for care was not identified.</p> <p>Interview with on 12/20/21 at 2:04 p.m. with DON B revealed: *She had worked for the provider for five years and had been in the DON position for the past two years. *She had monitored resident skin/wounds every week, but stated, "I don't always get the paperwork done." *Resident 174's pressure ulcer was first noticed on 12/11/21 with his complaint of pain. -"It had appeared suddenly." *She confirmed the 12/11/21 order was a nursing order.</p> <p>Interview on 12/21/21 at 8:27 a.m. with LPN D revealed: *The current treatment plan for resident 174's pressure ulcer was an Opti foam dressing. -It was part of "out standing orders." *Resident 174's pressure ulcer was not healing but getting worse. *She was not sure if his physician was aware of</p>	F 686		

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F 686	<p>Continued From page 11 his pressure ulcer.</p> <p>Interview with administrator A and DON B on 12/21/21 at 2:47 p.m. revealed and confirmed: *DON B was the provider's wound care nurse. -Resident 174 did not have weekly skin assessments documented. -She had not been able to get to the weekly wound/skin assessments. -The nurse(s) working the floor was to communicate resident conditions to the residents' primary physician. *She could not confirm if resident 174's physician had been notified of his pressure ulcer. *Resident 174 did not have an initial wound assessment. -His pressure ulcer was not on his care plan.</p> <p>2. Observation and interview on 12/20/21 at 9:59 a.m. with resident 14 in her room revealed: *She was sitting in her wheelchair in her room. *When asked if she had any skin problems, she replied she had a "sore" on her bottom that "hurts a little at times." -The staff told her, "it was getting better."</p> <p>Review of resident 14's electronic medical record (EMR) revealed: *She had been admitted to the facility on 6/14/21 on hospice care. *Her diagnoses included: -Cerebral Vascular Accident -Osteoporosis -Immobility/Contractures -Urinary incontinence *A 6/20/21 comprehensive skin and positioning evaluation did not identify a pressure ulcer. -The Braden scale assessment revealed she was</p>	F 686		

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F 686	<p>Continued From page 12</p> <p>at risk for skin breakdown.</p> <p>*An 8/30/21 comprehensive skin and positioning evaluation identified a pressure ulcer.</p> <p>- Stage 1 or greater.</p> <p>-The Braden scale assessment revealed she continued at risk for skin breakdown.</p> <p>*A Braden scale assessment dated 11/18/21 revealed she was at high risk.</p> <p>*A 12/11/21 nursing order identified a "red/open area to the coccyx."</p> <p>-Red area measured 7 cm by 7 cm.</p> <p>-Open area to the center measured 4 cm by 4 cm.</p> <p>-Order summary for "every day and night shift Monitor every shift for dressing, drainage, wound bed, periwound area, pain, and status."</p> <p>*A 12/12/21 skin/wound progress note by LPN F revealed:</p> <p>-"Resident has open area to coccyx."</p> <p>-"Dressing is soiled with yellow/tan drainage."</p> <p>-"Wound measures 1.5 cm X 1 cm sacrum dressing applied."</p> <p>*A 12/14/21 Hospice communication at 6:30 p.m. by hospice registered nurse (RN) H revealed:</p> <p>-Pressure ulcer "area to coccyx is now stage 2, shallow, deep purple around edges."</p> <p>-LPN D "states they will start using medihoney and continue to cover with mepilex dressing."</p> <p>-Wound measured 1 cm by 1 cm.</p> <p>*A 12/17/21 hospice communication at 4:17 p.m. by hospice RN H revealed:</p> <p>-"Cleansed coccyx wound with sterile saline, did not have wound cleanser, applied medihoney and covered with Mepilex."</p> <p>-Wound measured 1.5 cm by 0.8 cm, oblong shape.</p> <p>*Active physician orders as of 12/21/21 had no treatment order for his pressure ulcer.</p> <p>*No initial wound assessment was found.</p>	F 686			

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F 686	<p>Continued From page 13</p> <p>*No weekly skin or wound assessments were found.</p> <p>Review of resident 14's TAR revealed: *There were three shifts with no documented treatments related to the resident's red/open area to coccyx since the start date of 12/11/21 at 6:00 p.m. *A current treatment plan was not identified. Surveyor: 41088 3. Interview on 12/19/21 at 4:51 p.m. with resident 23 revealed: *She had a history of pressure "sores." *She tended to get sores on the back of her legs. *She currently had a sore on the back side of her right thigh that was caused by rubbing against a metal piece on her wheelchair. *She could not remember when the area had opened, but thought that it had been sometime in September 2021. *The provider had added padding and adjusted her wheelchair to eliminate further issues. *Nursing put bandages on the area every day. *The facility had recommended she get a new wheelchair but she wanted to keep the one she had.</p> <p>Review of resident 23's medical record revealed: *An admission date of 12/27/18. *Her diagnosis included: multiple sclerosis, edema, anemia, reduced mobility, muscle weakness, and bladder dysfunction. *She had a Brief Interview Mental Status (BIMS) score of fifteen indicating her cognition was intact. *A 12/1/21 Braden Scale assessment score of 14 which put her at moderate risk of skin integrity issues. *A 12/10/21 MDS nursing summary had not identified the open area on her thigh.</p>	F 686		

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F 686	<p>Continued From page 14</p> <p>*A 12/16/21 care conference review note that mentioned she had an open area on the back of her right thigh.</p> <p>*There had been no documentation to support: -Her physician had been notified of the pressure ulcer she had developed. -When that pressure ulcer had been discovered or by whom.</p> <p>Review of resident 23's 12/1/21 Minimum Data Set (MDS) assessment revealed: *She had been at risk for developing pressure ulcers. *No pressure ulcers had been identified.</p> <p>Review of resident 23's 12/10/21 revised care plan revealed: *A focus area for skin impairment potential due to immobility and diagnosis of multiple sclerosis. *Interventions for: *4 inch x 4 inch hydrocellular dressings placement to bilateral thighs where the wheelchair meets thighs at her request to provide cushioning. *Observe skin during cares. Report any changes to nurse.</p> <p>Surveyor 45383 4. Observation on 12/21/21 at 10:41 a.m. with certified nurse practitioner (CNP) G assessing resident 23's skin revealed: *CNP G had been nearby and able to come to the facility if the need to assess a resident came up and the primary physician was not available. *This had been the first time she had been made aware of the need to assess resident 23 for a pressure ulcer. *The resident had an open area on the back side of her right thigh that measured 2 centimeters in</p>	F 686		

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F 686	<p>Continued From page 15</p> <p>length through the epidermis (outer layer of skin) .</p> <p>Interview on 12/21/21 at 1:33 p.m. with bath aide H regarding resident skin assessment with bathing revealed she: *Had just returned from a three week absence. *Was the person that had completed most of the baths for the residents. *Checked the residents closely for any skin concerns. *Reported any skin concerns to the nursing staff. *Had not been required to document any skin findings. *Was not sure when resident 23's "sore" had opened up but it had been there prior to her absence.</p> <p>Interview on 12/21/21 at 2:00 p.m. with licensed practical nurse (LPN) C and LPN D regarding skin documentation revealed: *They had been aware of the above resident skin concerns. *Due to scope of practice concerns they had not assessed the wounds. *They had reported any resident skin concerns to DON B for further assessment. *Confirmed they had not documented skin findings.</p> <p>Surveyor 41088 Interview on 12/21/21 at 2:48 p.m. with DON B and administrator A regarding resident skin and wound assessment revealed: *DON B stated she: -Had been responsible for the wound care for all residents. -Had not ensured weekly skin assessments or wound assessments for the above residents had taken place.</p>	F 686		



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F 686	<p>Continued From page 16</p> <p>-Had not considered resident 23's wound to be a pressure ulcer.</p> <p>-Thought her skin injury had been cause by sheering and not pressure at the time.</p> <p>-Agreed that rubbing from a metal piece on her wheelchair had caused the injury.</p> <p>-Would expect:</p> <p>--Newly admitted residents to have a comprehensive skin assessment and then on a quarterly basis.</p> <p>--All residents' skin was to be assessed during weekly bathing by the bath aide.</p> <p>--Any concerns discovered by the bath aide were to be reported to the nurses.</p> <p>--The nurses would report any skin concerns to the resident's primary physician for further instruction.</p> <p>--Agreed that documentation had been lacking regarding weekly skin assessments and wound assessments.</p> <p>--Confirmed they had not followed their policy for skin and wound care.</p> <p>*This surveyor asked for any documentation that would support skin assessment or wound assessments had taken place for resident 23. No further documentation had been provided prior to the survey exit.</p> <p>Review of the provider's 10/15/21 Pressure Ulcer Prevention policy revealed: "It is the policy of [facillty name] to prevent a resident who enters the facility without pressure sores from developing pressure sores unless the individual's clinical condition demonstrates that they were unavoidable and to provide necessary treatment and services to a resident having pressure sores to promote healing, prevent infection and prevent new sores from developing. Procedure:</p>	F 686			

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F 686	Continued From page 17 1. Skin checks/assessments to be completed weekly (likely following bath schedule) for each resident within the skilled nursing facility. Initial skin assessment to be completed and documented upon admission, with skin assessments continuing weekly thereafter. 2. Any identified new skin injury/wound shall be reported to the charge nurse on duty. Nursing will then complete an evaluation of the injury inclusive of wound measurements. Nursing staff will report the skin injury/wound to the designated wound nurse. An initial wound assessment (UDA) [user defined assessment] will be started in [name of facility computer program] under the assessment tab by the wound nurse (charge nurse to complete if wound nurse unavailable) and continue weekly until healed. A nurse progress note should accompany each wound UDA completed. 3. Charge nurse will notify the physician of skin injury/wound when discovered and obtain any treatment orders recommended. The skin injury/wound will be treated according to physician orders. If there is no order, the skin injury/wound will be placed on the ETAR [electronic treatment administration record] to be monitored daily until healed. 4. If the cause of the skin injury is unknown at the time of the occurrence, an incident report (risk management) shall be completed by the nurse completing the skin assessment. Nursing management or DNS [director of nursing services] will complete an investigation within facility to determine the cause of the skin injury. If the cause of the skin injury is not determined, the proper course of action will be taken by guidelines of Reporting of Injuries of Unknown Source and Reasonable Suspicion of a Crime form.	F 686		

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F 686	Continued From page 18 5. Document in the nurse's notes the following information: *Mechanism of skin injury/wound if known or applicable [if determined after investigation, complete a follow up note with unknown cause found]. *Size of injury. *Treatment if applicable. *Notification of family and physician. 6. Include new skin injury in daily nursing report."	F 686		
F 710 SS=E	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2)  §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs.  §483.30(a) Physician Supervision. The facility must ensure that-  §483.30(a)(1) The medical care of each resident is supervised by a physician;	F 710	Objective: Following Diamond Care Center's policy and procedure on Pressure Ulcer Prevention, DON or designee will ensure that the Pressure Ulcer Preventions Policy is being followed and documentation and physician notification is being completed.  Resident 174's doctor had been notified of pressure ulcer written in a fax request to doctor. The fax note was then filed under telephone order tab. Resident 23 was evaluated by nurse practitioner on 12/20/21 for pressure ulcers.	

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F 710	<p>Continued From page 19</p> <p>§483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by:</p> <p>Surveyor: 43021</p> <p>Based on observation, interview, and record review, the provider failed to ensure physician notification and involvement had occurred in a timely manner for two of three sampled residents (174 and 23) with facility acquired pressure injuries. Findings include:</p> <p>1. Observation and interview on 12/20/21 at 8:07 a.m. with resident 174 revealed: *He was lying on a pressure-reducing alternating air mattress in his room. *When asked if he had any skin problems, he replied he had "sores" on his bottom.</p> <p>Refer to F686, findings 1 and 5. Surveyor: 41088</p> <p>2. Review of resident 23's medical record revealed: *Her admission date of 8/16/21. *Her diagnosis included: multiple sclerosis, edema, anemia, reduced mobility, muscle weakness, and bladder dysfunction. *She: -Had a Brief Interview Mental Status (BIMS) score of fifteen which indicated her cognition was intact. -Had developed a pressure ulcer on the back of her left thigh. *There had been no documentation to support: -Her physician had been notified of the pressure ulcer she had developed. -When the pressure ulcer had been discovered or by whom.</p>	F 710	<p>Now weekly updates will be made to residents provider when completing weekly wound assessment. The form to be used is "provider notification/update of skin issues" form. The weekly wound assessment has a place to document provider notification. The form requires provider signature and order. All faxes sent to provider go in a pending file until signed fax is received back. Executive Director or designee will audit weekly that provider notification has been completed. Executive Director will provide audit results to DNS to report to monthly QAPI meeting. Results will be reviewed and discussed.</p>	1/19/22	

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F 710	Continued From page 20 -What had been done to treat it by nursing staff.  Interview on 12/21/21 at 3:20 p.m. with administrator A and director of nursing B revealed: *They agreed their documentation had not supported resident 23's physician being contacted of her pressure ulcer. *They should have contacted the physician, documented it. *They had not followed their policy but should have.	F 710		
F 801 SS=F	Refer to F686, findings 3, 4, and 5 . Qualified Dietary Staff CFR(s): 483.60(a)(1)(2)  §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e)  This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by	F 801	Advertisement for a Dietary Manager is posted on multiple sites. Once hired, if not licensed, will have qualified Dietician help new hire with process to become licensed. At this time, will continue to consult with the dietician regarding diets, meals, training, and nutritional consults.  Contact with dietician will be weekly by email and if needed by phone.	1/19/22

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F 801	<p>Continued From page 21</p> <p>an appropriate national accreditation organization recognized for this purpose.</p> <p>(i) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.</p> <p>(ii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.</p> <p>(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.</p> <p>§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-</p> <p>(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:</p> <p>(A) A certified dietary manager; or</p> <p>(B) A certified food service manager; or</p> <p>(C) Has similar national certification for food service management and safety from a national certifying body; or</p> <p>(D) Has an associate's or higher degree in food service management or in hospitality, if the</p>	F 801			

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PRINTED: 01/04/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  12/21/2021
NAME OF PROVIDER OR SUPPLIER  DIAMOND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 801	<p>Continued From page 22</p> <p>course study includes food service or restaurant management, from an accredited institution of higher learning; and</p> <p>(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and</p> <p>(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Surveyor: 43021</p> <p>Based on observation, interview, and job description review the provider failed to employ a full-time qualified registered dietitian or dietary manager who met the requirements to serve as the director of food and nutrition services.</p> <p>Findings include:</p> <p>1. Observation and interview on 12/19/21 at 11:11 a.m. of the provider's kitchen revealed cook E was in the kitchen preparing the noon meal, and she</p> <ul style="list-style-type: none"> <li>*Was ServSafe certified.</li> <li>*Was not a certified dietary manager (CDM).</li> <li>*The provider did not currently have a dietary manager.</li> </ul> <p>Interview on 12/21/21 at 10:15 a.m. with administrator A revealed and confirmed:</p> <ul style="list-style-type: none"> <li>*They did not had a current dietary manager (DM).</li> <li>*In the absence of a DM, she oversaw the dietary department.</li> <li>-She was not a CDM.</li> <li>-She completed the food order every week.</li> <li>*The consultant registered dietitian (RD) was not full-time.</li> </ul>	F 801			

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F 801	Continued From page 23 -The RD visited once a month.  Review of the provider's undated dietary manager job description revealed: **Assures that the dietary department is in compliance with all state, federal and local regulations." *Qualifications: -"Dietary Manager's Certificate. If not certified upon hire, must enroll in course within 90 days of hire and complete course within 18 months of hire."	F 801			
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)  §483.60(i) Food safety requirements. The facility must -  §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.  §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Surveyor: 43021 Based on observation, and interview, the provider	F 812	1. Glove use and Hand Hygiene will be performed per facility handwashing policy. 2. All dietary staff will be re-educated to the handwashing policy and procedure including competencies. To be completed by Dietary Supervisor or designee. 3. Re-education will completed by 1/17/22. 4. Handwashing audits, including meal service will be completed by the Dietary Supervisor or designee 3 times per week for one month.  Competencies will be completed for all dietary staff annually.	1/19/22	



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F 812	Continued From page 24 failed to ensure one of one dietary cook (E) had followed appropriate hand hygiene and glove use to prevent contamination in the handling of foods during one of one observed meal service. Findings include:  1. Observation of the 12/19/21 noon meal revealed: *At 11:46 a.m. cook E left the kitchen with gloved hands pushing a food cart for the assisted living center. *At 11:48 a.m. cook E returned to the kitchen, removed the gloves from her hands, and donned another pair of gloves without washing her hands. *From 12:19 p.m. to 12:51 p.m. cook E kept the same pair of gloves on while completing the following food preparation tasks: -Handled nine trays, lining them on the top counter over the steam table. -Dished pie onto dessert plates, touched pie crust with her gloved hands on seven servings. -Brought out another pie and cut it into slices with gloved hands that touched the rim of the pie crust. -Handled tongs, slotted serving spoon, and gravy ladle with her gloved hands. -Wiped gravy from a resident's plated food with her gloved hand. -Touched buttered bread to remove bread off pork loin on resident's plated food to another spot on the plate. -Touched two separate servings of pork loin with her gloved left hand to cut with the rotary cutter in her right hand. -Laid rotary cutter down on serving board surface in front of the steam table on numerous occasions, without a clean barrier. -Touched three more separate servings of pork loin with her gloved left hand to cut with the rotary	F 812	Education was provided to dietary cook E on proper hand hygiene and glove use on 1/11/2022	

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F 812	Continued From page 25 cutter in her right hand. -Touched pieces of pork loin with her gloved hand to wipe off blade onto resident's plate. -Touched three more separate servings of pork loin with her gloved left hand to cut with the rotary cutter in her right hand.  Interview on 12/19/21 at 12:55 p.m. with cook E regarding the above observations confirmed she had touched individual portions of pork loin with her gloved hands to cut the meat after touching multiple other surfaces with the same gloved hands.  Interview on 12/21/21 at 10:15 a.m. with administrator A confirmed: *They had no current dietary manager. *Cook E should not have touched food with her gloved hands after touching other surfaces with those same gloved hands. *Cook E should have used tongs to hold the meat. *Cook E should have placed the rotary cutter on a plate and not directly on the serving board surface.	F 812			
F 838 SS=E	Facility Assessment CFR(s): 483.70(e)(1)-(3)  §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the	F 838	Facility Assessment completed on 1/13/2022 QAPI committee has reviewed the assessment and signed off on the facility assessment 1/17/2022. Facility Assessment will be reviewed and signed off annually by QAPI committee. Assessment will be ensured to be completed by facilities fiscal year in January.	1/19/2022	

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F 838	Continued From page 26 facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:  §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.  §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding,	F 838		

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F 838	<p>Continued From page 27</p> <p>or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.</p> <p>§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Surveyor: 41088</p> <p>Based on interview, and facility assessment review, the provider failed to review and update their facility assessment at least annually and include the coronavirus pandemic. Findings include:</p> <p>1. Review of the provider's June 2020 Facility Assessment revealed:</p> <ul style="list-style-type: none"> <li>*There were no other dates on the assessment to indicate it had been reviewed or updated after June 2020.</li> <li>*The assessment had not included COVID-19 as a possible concern.</li> <li>*The provider had experienced a COVID-19 outbreak in September 2021 that continued into November 2021.</li> </ul> <p>interview on 12/21/21 at 2:05 p.m. with administrator A confirmed:</p> <ul style="list-style-type: none"> <li>*The facility assessment had not been updated since June 2020.</li> <li>*She was aware it was to be reviewed annually and should have included information regarding the COVID-19 pandemic.</li> </ul>	F 838		

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F 865 F 865 SS=E	Continued From page 28 QAPI Prgm/Plan, Disclosure/Good Faith Atmpt CFR(s): 483.75(a)(2)(h)(i)  §483.75(a) Quality assurance and performance improvement (QAPI) program.  §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;  §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.  §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Surveyor: 43021 Based on record review and interview, the provider failed to ensure performance improvement projects (PIP) had been thoroughly examined and resolved with an effective quality assurance performance improvement (QAPI) process. Findings include:  1. Interview on 12/21/21 at 3:11 p.m. with administrator A and director of nursing (DON) B revealed: *The provider's management team met monthly for a QAPI meeting. *The provider's medical director and pharmacy consultant attended quarterly either in person, by phone, or FaceTime.	F 865 F 865	PIP has been implemented starting January 1, 2022 regarding weekly wound documentation with PCP notification. The PIP will be monitored weekly for 3 months, then monthly for 3 months by completing weekly audits assessing wound documentation assessment, resident progress notes, and physician notification and updates. Audit forms to be used are from survey tag F 686 Part B and F 710. Audit information will be reviewed monthly at QAPI committee.  PIP has been updated to include weekly skin assessments on any resident with a Braden score below 12. Executive Director will be provided a monthly list of all residents with a Braden below 12 to be able to perform audits of weekly skin assessments. Our PIP was designed to focus on the weak areas of weekly wound and skin assessments as identified by our survey. Assessments will be audited by ED to ensure documentation is completed. PIP monthly results will be discussed at QAPI by ED and improvements will be made based on discussions.	1/19/22

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F 865	<p>Continued From page 29</p> <p>-Participants had signed in to register their attendance for the meeting.</p> <p>-In the last six months:</p> <p>--The pharmacy consultant attended the 8/26/21 and 9/8/21 QAPI meetings.</p> <p>--The medical director attended the 7/28/21 QAPI meeting.</p> <p>*The QAPI team worked on audits with Great Plains Quality Improvement Organization.</p> <p>*The QAPI team had no PIPs in place.</p> <p>-"They were not working on anything."</p> <p>*The provider's 10/1/19 QAPI plan identified the following:</p> <p>-"On at least an annual basis, or as needed, the QAPI Self Assessment will be conducted."</p> <p>-"We will also conduct an annual facility assessment to identify gaps in care and service delivery in order to provide necessary services. These items will be considered in the development and implementation of the QAPI plan."</p> <p>-"Revising your QAPI Plan:</p> <p>--The QAPI Committee will review and submit proposed revisions to Administration, Governing Body, or Management Firm for approval on an annual and/or as needed basis."</p> <p>*Administrator A acknowledged and confirmed not updating the current QAPI plan.</p> <p>Refer to F636, F657, F686, and F838.</p>	F 865			

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E 000	Initial Comments  Surveyor: 41088 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 12/19/21 through 12/21/21. Diamond Care Center was found in compliance.	E 000		

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

TITLE

(X6) DATE

*Brianne Morris*

*Executive Director*

*1/14/22*

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





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K 000	INITIAL COMMENTS  Surveyor: 40506 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 12/20/21. Diamond Care Center was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities.  The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K255 and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 241 SS=D	Number of Exits - Story and Compartment CFR(s): NFPA 101  Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation the provider failed to maintain at least two conforming exits from each floor of the building. The hazardous boiler space (basement) did not have two conforming exits. Findings include:  1. Observation on 12/20/21 at 12:00 p.m. revealed there was only one exit provided from	K 241	Stairs were placed in boiler room on 1/9/2022	1/9/2022

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

TITLE

(X6) DATE

*L. M. Mowin*

*Executive Director*

*1-14-2022*

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K 241	Continued From page 1 the basement boiler room. A second door accessing the building interior corridor is available, however, the stairs to the door have been demolished and will be rebuilt. The lumber has been purchased for construction by a board member.  That deficiency would only affect maintenance personnel if in the basement during a fire emergency.	K 241		
K 712 SS=E	Fire Drills CFR(s): NFPA 101  Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation, and interview, the provider failed to ensure staff were familiar with the provider's fire drill requirements and documentation requirements for the fire drills. Findings include:  1. Record review on 12/20/21 at 3:25 p.m. revealed the fire drill documentation lacked documentation of fire drills for September 2021 and for two of four required night shift drills for the	K 712	1. Fire drills will be performed per facility's policy and procedure. 2. All staff will be reeducated to the fire policy and procedure by the executive director or designee. 3. Re-education will be completed by 1/17/2022.	1/17/2022

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K 712	Continued From page 2 one year period.  2. Record review on 12/20/21 at 3:25 p.m. revealed the fire drill sign off sheets for staff did not include documentation of fire alarm signal receipt at the monitoring agency.  3. Interview on 12/20/21 at 4 p.m. with the director of nursing and the administrator confirmed the findings from the record review. They explained the maintenance person did not spend much time in the facility, and was not well aware of procedures.  The deficiency had the potential to affect 100% of the building occupants.	K 712			



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  10597	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/21/2021
NAME OF PROVIDER OR SUPPLIER  DIAMOND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 901 N MAIN AVENUE 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) COMPLETE DATE
S 000	Compliance/Noncompliance Statement  Surveyor: 40506 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 12/19/21 through 12/21/21. Diamond Care Center was found not in compliance with the following requirement(s): S157.	S 000		
S 157	44:73:02:13 Ventilation  Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system.  This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to maintain exhaust ventilation in three randomly observed rooms (soiled storage room in laundry, soiled utility room on 200 wing, and salon). Findings include:  1. Observation on 12/20/21 at 11:45 a.m. revealed the soiled storage room in the laundry had no exhaust ventilation. Interview with the maintenance man at the time of the observation confirmed that finding.  2. Observation on 12/20/21 at 12:10 p.m. revealed the revealed the soiled utility room on the 200 wing had a hopper but no exhaust ventilation. Interview with the maintenance man at the time of the observation confirmed that finding.  3. Observation on 12/20/21 at 3:40 p.m. revealed the revealed the salon had no exhaust ventilation.	S 157	Contractor Complete	1/19/22

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

TITLE

(X6) DATE

*Brianna Moses*

Executive Director

1-14-22

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10597</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/21/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>DIAMOND CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>901 N MAIN AVENUE BRIDGEWATER, SD 57319</b>
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(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 157	Continued From page 1  Interview with the Director of Nursing at the time of the observation confirmed that finding.	S 157		
S 000	Compliance/Noncompliance Statement  Surveyor: 41088 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 12/19/21 through 12/21/21. Diamond Care Center was found in compliance.	S 000		