STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING ______ B. WING ______	C 02/12/2024

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DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

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F 000	INITIAL COMMENTS An extended recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/6/24 through 2/8/24 and on 2/12/24. Dells Nursing and Rehab Center Inc was found not in compliance with the following requirements: F582, F657, F658, F689, F812, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/6/24 through 2/8/24 and on 2/12/24. Areas surveyed included antibiotic treatment for infections, resident neglect, and accidents. Dells Nursing and Rehab Center Inc was found in compliance. On 2/8/24 at 1:30 p.m., immediate jeopardy was identified related to monitoring and managing residents at risk for elopement at F689. On 2/8/24 at 3:17 p.m., notice of immediate jeopardy was provided verbally and in writing to administrator A, director of nursing B, and nurse manager C. An immediate jeopardy removal plan was requested at that time. On 2/12/24 at 7:31 a.m. administrator A provided their final plan for the removal of the immediate jeopardy. On 2/12/24 at 8:35 a.m. the provider's removal plan was accepted by the survey team. On 2/12/24 at 11:30 a.m. the survey team reviewed the provider's documentation for the removal of the immediate jeopardy and determined the immediacy was removed. The resident census was 40.	F 000		
F 582	Medicaid/Medicare Coverage/Liability Notice	F 582		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Calyn Weiss
TITLE: Administrator
(X6) DATE: 3/6/24

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 582 SS=D	Continued From page 1 CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident	F 582	Unable to correct noncompliance for lack of correct SNF ABN and NONMC forms provided. SSD or designee will ensure residents received updated/correct forms going forward. Administrator, DON, and interdisciplinary team will review and revise policies and procedures as necessary. SSD educated on any updated policies and procedures by 3/8/24. SSD or designee will audit correct forms are given weekly for 4 weeks and monthly for 2 months. SSD or designee will present findings from these audits at monthly QAPI committee for reviews until QAPI committee advised to discontinue.	3/8/24

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F 582	Continued From page 2 representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and interview the provider failed to ensure Medicare notices were completed and provided for two of three sampled residents (25 and 28) before their discharge from skilled services. Findings include: 1. Review of resident 25's CMS (Centers for Medicare and Medicaid Services) SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review form provided by social service designee (SSD) E on 2/7/24 at 11:00 a.m. revealed the Medicare Part A Skilled Services Episode start date was 8/16/23 and the last covered date was on 10/6/23. Review of resident 25's electronic medical record (EMR) revealed: *He was admitted on 1/28/23. *He was re-admitted on 8/16/23 for a skilled stay covered by Medicare Part A. *His 12/17/23 cognitive assessment revealed he was severely impaired.	F 582		

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F 582	Continued From page 3	F 582		

*After his skilled stay, he had skilled covered days remaining and continued to reside in the facility.
*There was no record that a Notice of Medicare Non-coverage (NOMNC) was given to the resident or his representative before the end of his skilled stay.
*His Advance Beneficiary Notice of Noncoverage (ABN) CMS-R-131 form was signed by his cousin/guardian on 10/4/23.
-SNFs issue that notice for items/services expected to be denied under Medicare Part B only.
-That standardized notice was not the correct SNF ABN, CMS-10055, form used for Medicare Part A services that were ending.

Interview on 2/12/24 at 9:20 a.m. with SSD E revealed she:
*Worked the past one and a half years as the social service designee.
*Was responsible for issuing the Medicare notices to the residents.
*Agreed she had not given resident 25's representative the NOMNC notice before the end of his skilled stay.
*Was not aware she had given the wrong form that provided notice of his Medicare Part A services ending.

2. Review of resident 28's CMS SNF Beneficiary Protection Notification Review form provided by SSD E on 2/7/24 at 11:00 a.m. revealed the Medicare Part A Skilled Services Episode start date was 11/29/23 and the last covered date was on 12/15/23.

Review of resident 28's EMR revealed:
*She was admitted on 11/29/23 for a skilled stay covered by Medicare Part A.

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F 582	Continued From page 4	F 582		

*Her 12/1/23 Brief Interview for Mental Status (BIMS) was a 7 indicating severe cognitive impairment.
*After her skilled stay, she had skilled covered days remaining and continued to reside in the facility.
*Her NOMNC form had the resident's Medicare number in the space provided for the "Patient Number" and was signed on 12/13/23 by her sister/power of attorney.
*Her ABN, CMS-R-131, form was signed on 12/13/23 by her sister/power of attorney.
-That notice was for items/services expected to be denied under Medicare Part B only.
-That standardized notice was not the correct SNF ABN form used for Medicare Part A services that was ending.

3. Interview on 2/12/24 at 10:49 a.m. with SSD E revealed:
*Regarding the provider's Medicare meeting held every Friday:
-She attended along with the following staff:
--Director of nursing/minimum data set coordinator B.
--Nurse manager C.
--The director of rehab services.
-The meeting reviewed residents receiving services covered by Medicare Part A or Part B.
-That meeting provided her with plenty of time to complete and give the required Medicare notices.
*She had received training on the required Medicare notices with the social service designee at another facility in their corporation and she had in her office the NOMNC forms, ABN forms (CMS-R-131), and "Form Instructions for the Advance Beneficiary Notice of Non-coverage (ABN)" that she had been trained to use.
*She did not have the following forms:

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F 582	Continued From page 5 --Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123. --SNF ABN forms (CMS-10055). --Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) Form CMS-10055 (2018). *She agreed she had: *Not used the correct SNF ABN form (CMS-10055) to notify residents of their Medicare Part A services ending. Interview on 2/12/24 at 12:45 p.m. with administrator A revealed the provider had no policy on the required Medicare notices. Administrator A agreed with the findings above and that the correct forms should have been given to residents.	F 582		
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	F 657	Resident 39's care plan has been updated to match current interventions. All other necessary resident's care plan have been updated to match current care needs and interventions. DON or designee will ensure going forward that resident's care plans are updated regularly to match ongoing interventions. Administrator, DON, and interdisciplinary team will review and revise policies and procedures as necessary. Administrator or designee will educate all necessary staff on updating care plans by 3/8/24. DON or designee will audit resident care plans weekly for 4 weeks and monthly for 2 months. DON or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue.	3/8/24

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F 657	Continued From page 6	F 657		

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.
This REQUIREMENT is not met as evidenced by:
Based on record review, interview, observation, and policy review, the provider failed to review and revise one of one sampled resident (39) care plan with effective interventions to prevent the resident from eloping. Findings include:

1. Refer to F689, findings 2 and 12.

2. Interview on 2/8/24 at 3:13 p.m. with administrator A revealed she updated resident 39's care plan after each elopement.

3. Review of the resident's care plan on 2/8/24 revealed:
*The elopement occurred on 1/3/24 and was not on the resident's care plan.
*The interventions remained the same for all elopements:
-She had at least three recorded elopements.
-Resident 39 was wearing the Tile tracker.
-She was placed on either 10-minute or 15-minute checks for 24 hours, 30-minute checks for the next 24 hours, then went back to 60-minute checks.
*There was no indication that anything else was trialed to prevent her from eloping.

4. Review of the provider's 8/31/23 "Care

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F 657	Continued From page 7 Planning Process" policy revealed: *"Purpose: To define the personnel's responsibility in initiating and maintaining the resident's care plan." *"Policy: Using an interdisciplinary approach, each resident will have an individualized plan of care which addresses the resident's needs and severity of condition, impairment, disability, or disease and based on the universal care standards identified by the ...staff as the minimum standards for all residents." -"The IDT [interdisciplinary team] ... will identify individualized care and treatment goals during the care planning conference. The care plan will be revised as needed." *"Responsibility: It is the responsibility of the IDT members to assess the resident, individualize the plan of care, evaluate the effectiveness and the plan of care, revise the plan of care as the resident's needs change and attend care conferences."	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: A. Based on observation, interview, record review, and policy review, the provider failed to continually monitor, treat, and document weekly a wound for one of one sampled resident (15's) ears per the physician's orders and the provider's policy. Findings include:	F 658	Unable to correct prior noncompliance of continually monitoring, treating, and documenting weekly on resident 15's ear. DON or designee will ensure resident 15's ear will be monitored, treated, and documented weekly going forward. Unable to correct prior noncompliance of letting physician know when resident 9's blood sugar is out of range. DON or designee educated all nurses on resident 9's order and to let physician know when blood sugar is out of range. Resident 9's care plan and TAR has been updated to match order.	3/8/24

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F 658	Continued From page 8 1. Observation and interview on 2/6/24 at 4:01 p.m. with resident 15 in her room revealed: *There was a scab on the top portion (antihelix) on the resident's left ear. *The scab was brown and crusty. *The edges of the scab were raised and bright red. The surrounding skin faded from red to purple. *She could not remember what happened to her ear. *She stated the area would hurt if she started to "mess" with it. 2. Review of resident 15's electronic medical record (EMR) revealed: *She had a Brief Interview for Mental Status score of 6, indicating she had severe cognitive impairment. *Her most recent "skin observation tool" completed on 2/2/24 revealed "no new redness or bruising noted." -The skin assessment did not mention what areas on the resident's body were assessed. *There was no documentation in her care plan indicating she had a wound on her ear. *Her care plan included the following interventions: -"SKIN INSPECTION: I require SKIN inspection and observation for redness, open areas, scratches, cuts, bruises and report changes to the nurse daily and with weekly bath/shower or PRN [as needed]." Initiated on 12/27/23. -"Licensed nurse to complete skin assessment weekly and PRN [as needed]." Initiated on 11/3/21. -"Monitor skin for any redness, abnormalities and report to licensed nurse." Initiated on 11/3/21. *She had the following physician's orders: -"Observe and monitor left ear for	F 658	DON, nurse manager, or designee will educate all nurses on following resident physician orders along with any updated policies by 3/8/24. Administrator, DON, and interdisciplinary team will review and revise policies and procedures as necessary. DON or designee will audit nurses following physician orders weekly for 4 weeks and monthly for 2 months. DON or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	

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signs/symptoms of infections. Apply antibiotic ointment as needed to open area. [One] time a day for [patient] picking at wound on ear." Ordered on 12/12/23, started on 12/13/23.
-"Skin Assessment one time a day every [Thursday]." Ordered on 2/28/22, started on 3/3/22.

3. Interview and observation on 2/7/24 at 9:55 a.m. with resident 15 revealed:
*She was aware of the scab on her ear and again confirmed that it hurt when touched.
*She did not remember how she injured her ear, or how long it had been there.
*The edges around the scab were still raised and bright red. The skin surrounding the scab was dark red. There was no more evidence of purple discoloration.
*She said she did not sleep on her left side.
*She denied use of any pad or pillow overlay to reduce the pressure on her ear.

4. Interview on 2/7/24 at 2:11 p.m. with certified nurse aide (CNA) P revealed:
*She restarted her traveling staff contract at the facility in September 2023. She noted that the scab on resident 15's ear was present at that time.
*She confirmed that resident 15 did sleep on her left side at times.
*Resident 15 did not like people touching her left ear.
*She was aware there was a PRN ointment available for her ear.
*The wound on her ear had not gotten any worse or any better. It had remained unchanged for some time.

5. Interview on 2/7/24 at 2:18 p.m. with licensed

F 658 Continued From page 10 F 658

practical nurse (LPN) F revealed:
*The wound on resident 15's left ear started as a dry patch of skin that she constantly picked at.
-It turned into an open wound.
-The wound was much worse when it first started.
*They had been putting triple antibiotic ointment on the wound.
*Resident 15 oftentimes refused the ointment.
*The more they attempted to treat it, the more she picked at it.
*If they left it alone, the resident would leave it alone.
*She looked at the wound on her ear each morning.
-They had a "treatment order" to "observe and monitor left ear" which they checked off each day.
*She guessed they were successful with putting ointment on the wound about twice per week.
*If resident 15 refused, the strategy was to try again at a later time or have someone else try to assist her with the ointment.
*She would chart the new skin issues or if the wound had a significant change on the weekly skin assessments.
-In that instance, she indicated that "the area is already part of her chart to check daily," which was why she had not assessed the wound in the weekly skin assessment.
*Resident 15's physician was aware of the wound and had evaluated it multiple times.

Interview on 2/7/24 at 2:39 p.m. with director of nursing (DON) B revealed:
*The wound on resident 15's left ear started out as a dry patch of skin.
*She would constantly pick at the skin, which developed into an open wound and then it had become infected.
*Her physician prescribed an oral antibiotic in

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addition to the antibiotic ointment.
*The area had improved.

Interview on 2/7/24 at 5:05 p.m. with nurse manager C revealed that it was her expectation for the nurse performing the weekly skin assessment to chart any new skin issues.

Continued interview on 2/7/24 at 5:13 p.m. with DON B revealed:
*During the weekly skin assessment, the nurses assessed any new bruising, redness, skin tears, and any skin breakdown issues.
*When asked about her expectations of tracking the progress of a known wound, she indicated she would not "necessarily" expect to see old wound documentation on the assessment.
-However, she then provided the following example: If a resident was noted to have a new bruise, she would have expected a nurse to assess the size of the bruise, the color, and investigate the source of the bruise. She would have expected the nurse to chart on that bruise the following week again to track the healing progression.

Continued interview on 2/8/24 at 9:22 a.m. with DON B revealed:
*It was noted that both resident 15 and another resident had scabbing skin issues.
*The other resident's scabs had been assessed with weekly skin assessments to track changes because they were worsening.
*Resident 15's scab was a known skin issue and was not worsening

6. Review of resident 15's EMR revealed:
*The first documentation of the wound on her left ear was on 9/24/23 in a health status note:

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-"Redness, edema and scab noted to left ear. [DON B] notified and states this is not a new issue. [DON B] will follow up with clinic [appointment] tomorrow."
*On 9/25/23, resident 15 was seen by a nurse practitioner at a local clinic and was diagnosed with "Left ear cellulitis." The following physician orders were prescribed:
-"Apply warm compress to left ear three times per day."
-"Cleanse ear gently with anti-microbial soap and water, pat dry."
-"Then apply triple antibiotic ointment 3 times per day for 10-14 days."
-"If no improvement after 72 hours then we can do an oral antibiotic such as Keflex if needed."
-"Reach out if patient becoming febrile (>100.3)."
-Between 9/26/23 and 10/4/23 when the above orders were active, resident 15 accepted the treatment a total of 3 times.
*On 10/4/23, resident 15's physician assessed her ear and indicated the following:
-"Assessment & Plan: (1) Cellulitis of helix of left ear: This really seems like it is minimal at this time. We will add mupirocin 2% ointment 3 times a day for 10 days. They can stop it sooner if it is healed ... She was at the clinic a little over a week ago with concerns about an infection on her left ear. Staff says that she is not letting them do warm compresses to it. It does seem like it is gradually improving ... Eschar left ear with mild surrounding erythema."
-A physician's order for "Mupirocin ointment 2% apply topically to left ear three times daily x 10 days or until healed" was active from 10/4/23 to 10/14/23. During that time, resident 15 refused the treatment 5 times.
-There was no indication that her physician further assessed the wound or was notified of the

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refusals.
*The only documentation of the wound on her left ear in the weekly "skin observation tool" assessment between August 2023 and February 2024 was on 10/19/23, "Left ear slightly red. [No] other areas of redness or bruising noted."
-There were no measurements or any further tracking of the wound healing.
*From September 2023 to February 2024, resident 15 refused to allow a nurse to assess her skin on the following dates:
-9/7/23, 9/21/23, 11/9/23, 11/16/23, 11/23/23, 11/30/23, 12/7/23, 12/19/23, 1/4/24, and 1/25/24.
*The status of resident 15's left ear wound was charted in her progress notes on 10/7/23 and 10/8/23.
*A physician's order for "Observe and monitor left ear for signs/symptoms of infections. Apply antibiotic ointment as needed to open area" was started on 12/13/23 and prompted the charge nurse to checkmark on the resident's Treatment Administration Record (TAR) each day to indicate that the area was "observed."
-There were no other assessments of the wound with that order.
-There was no indication as to how many times they were able to successfully apply the ointment to the wound.

Review of the provider's 10/4/22 "Minor Skin Injuries" policy revealed:
*Under the "Procedure" section:
-"1. Identified minor skin injuries will be evaluated by nursing."
-"2. The minor skin injuries will be treated according to physician orders. If there is no order, the minor skin injury will be placed on the EMAR [electronic medication administration record] under skin assessments to be monitored daily

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until healed. Document in the nurse's notes when the injury is healed."
-"3. The size of the minor skin injury needs to be documented under Skin Assessments with the treatment/daily monitoring."
-"4. Document in the nurse's notes the following information: Mechanism of injury if known or applicable. Size of injury. Treatment if applicable. Notification of family and physician."

B. Based on record review and interview the provider failed to report one of one sampled resident (9) abnormal blood glucose levels to the physician as ordered. Findings include:

1. Review of resident 9's EMR revealed:
*There was a physician's order to call resident 9's physician if his blood glucose levels were greater than 400 milligrams (mg) per deciliter (dL) or less than 70 mg/dL.
*Resident 9's blood glucose levels were to have been checked four times a day according to his physician's order on the TAR.
*Blood glucose levels on the following dates were:
-11/12/23 at 7:38 a.m. was 62 mg/dL
-11/12/23 at 9:15 p.m. was 415 mg/dL
-11/15/23 at 7:02 a.m. was 65 mg/dL
-11/15/23 at 7:56 p.m. was 527 mg/dL
-12/12/23 at 7:23 a.m. was 58 mg/dL
-12/28/23 at 7:38 a.m. was 57 mg/dL
*There was no documentation located in the EMR that resident's abnormal blood glucose levels were reported to his physician.

2. Interview on 2/8/24 at 12:13 p.m. with registered nurse (RN) G revealed:
*The nurse would have called or faxed the physician the resident's blood glucose levels

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according to the physician's order.
*Communication with the physician regarding the resident's blood glucose levels would have been documented in the resident's EMR under the progress notes tab in the nurse's notes.
*RN G did not know why there was no documentation that the resident's physician was notified of the blood glucose results, stating "That is where they should be."

Interview on 2/8/24 at 12:20 p.m. with DON B revealed:
*If the resident's blood glucose level was low the nurse would have fed the resident and checked the blood glucose level after they had eaten and before administering the scheduled insulin. She stated they always call the physician if a resident's blood glucose level was high.
*When asked why there was no documentation that the nurse called the physician when resident 9's blood glucose levels were greater than 400 mg/dL or less than 70 mg/dL, she stated that the nurse would have called the physician and she was going to confirm that with the clinic and provide the documentation of that communication.

Interview with DON B on 02/12/24 at 9:00 a.m. to follow up regarding the documentation from the clinic revealed:
*There was no documentation the clinic could provide that the nurse had called the physician on those dates listed above when the residents blood glucose levels were abnormal.
*She agreed that the nurses had not been calling the physician with the resident's blood glucose levels per the physician's order.

Interview with administrator A on 12/12/24 at 1:00

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F 658	Continued From page 16 p.m. revealed: *The provider was unable to provide a policy and procedure for processing physician orders. *All physician orders were noted and sent to the pharmacy. *The pharmacy would enter all physician orders into the resident's Medication Administration Record (MAR) and TAR through the EMR. *The nurse would then verify the physician's order for accuracy in the resident's EMR.	F 658		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, interview, observation, and policy review, the provider failed to implement adequate monitoring and supervision for one of one sampled resident (39) who had a history of unsafe wandering and elopement, which resulted in two separate incidents of successful elopement that the facility staff were not aware of until the resident had already left the building. Findings include: 1. IMMEDIATE JEOPARDY According to resident 39's electronic medical record, there were two instances since the previous recertification survey (exit date 8/31/23) where she left the building without the staff's	F 689	On 2/9/24 resident 39 began wearing an alerting device on her wrist to set boundaries for alarms to go off on facility phone if resident leaves facility boundary. Resident also wears a tile necklace around her neck. Charge nurse will carry facility phone with them at all times throughout shift. All interventions have been added to resident 39's care plan. DON or designee will provide elopement education to all staff by 3/8/2024. No other elopement risk residents at this time. Administrator, DON, and interdisciplinary team will review and revise policies and procedures as necessary. DON or designee will audit resident 39's devices operation and being worn daily for 2 weeks, then four times weekly for 2 weeks, and monthly for 2 months. DON or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	3/8/24

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knowledge.

On 10/19/23 at around 5:30 p.m., the facility experienced a blackout in electricity for approximately two to three minutes according to their report submitted to the South Dakota Department of Health. During that time, the generator failed to initiate emergency electricity within the required 10 seconds. Due to that lapse in electricity, the door alarms were not active. Resident 39 was able to exit the facility without anyone's knowledge. Staff noticed her wandering around in the employee parking lot through the dining room windows.

On 1/3/24 at around 1:00 p.m., a housekeeper had finished her shift and walked out of the building into the employee parking lot. She happened to notice resident 39 wandering around in the employee parking lot, approximately 45 yards from any of the building's exit doors. She assisted the resident partway back to the building when the charge nurse responded to the door alarm.

In both instances, the resident was immediately placed on 15-minute checks for 24 hours, then 30-minute checks for the next 24 hours, then returned to the normal 60-minute checks as noted in her care plan. She was wearing her "Tile" brand tracking device on both instances, a device that tracked GPS location. That device was implemented in June of 2023 after the resident eloped and was found about a mile away from the facility near the grocery store by a citizen in the community. The device was used solely for tracking purposes and did not alarm if the resident left the building. The provider failed to reassess their interventions after both elopement

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incidences to further prevent her from eloping.

IMMEDIATE JEOPARDY NOTICE
Notice of immediate jeopardy was given verbally and in writing to administrator A, director of nursing B, and nurse manager C on 2/8/24 at 3:17 p.m.

IMMEDIATE JEOPARDY REMOVAL PLAN
On 2/12/24 at 7:31 a.m., administrator A provided a final written immediate jeopardy removal plan. The removal plan was approved by the survey team on 2/12/24 at 8:35 a.m. with guidance from the long-term care advisor for the South Dakota Department of Health.

The provider gave the following acceptable immediate jeopardy removal plan:
"Interventions were put into place following [resident's] last elopement on 1/3/24. The interventions put in place on 1/3/24 included 15-minute checks, which graduated to [30-minute] checks followed by [60-minute] checks until resident was determined safe. Hourly checks have continued for resident to ensure resident is safe from falls and elopement. Removable stop sign Velcro barrier put on door resident exited. Once interventions put in place, resident has not since eloped. Resident does wander facility hallways and look out windows, but does not attempt to exit."
On 2/1, UTI [urinary tract infection] PIP [performance improvement plan] was put in place as resident begins displaying wandering behaviors when UTI is present.
In addition to those the following interventions have been put in place:
Resident has been put on 15-minute checks immediately to ensure resident is in the facility

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and safe. Nurses and oncoming staff to be educated for resident on 15-minute checks. Nurse is responsible for 15 minute checks, and can delegate to staff on duty as needed. Checks will be documented on daily shift sheets with resident's name, date, time, initial, and what resident was doing at time of check. Once determined wandering has reduced, IDT [interdisciplinary team] will determine whether to change frequency of resident checks.
All oncoming nursing staff educated on correct charting for 15-minute checks. Staff educated prior to next scheduled shift on high-risk elopement residents.
Elopement policy updated on 2/8/2024.
Elopement policy to be reviewed and discussed with any further updates at all staff meeting on 2/16/24.
An alerting device has been put into place in addition to the tile tracker to set boundaries for alarms to go off on facility phone if resident leaves facility boundary. Charge nurse will carry facility phone with them at all times throughout shift.
Resident care plan updated to include interventions.
All staff meeting on 2/16 to provide all staff about high-risk elopement patients.
Elopement drill scheduled monthly going forward.
The generator company visited the facility on 2/8/24 to ensure proper operation of generator. The company is putting a report together regarding proper operation of generator."

The immediate jeopardy was removed on 2/12/24 at 11:30 a.m. after verification that the provider had implemented the removal plan. After the removal of the immediate jeopardy, the scope and severity of the citation level was D.

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2. Review of resident 39's electronic medical record (EMR) revealed:
*On 10/18/23, staff witnessed the resident leave the building.
*She continued to display anxious behaviors of wandering and attempting to transfer her husband from surface to surface throughout the night on 10/18/23 and into the morning of 10/19/23.
*On 10/19/23, staff were not aware the resident had left the building and saw her in the parking lot through the dining room windows.
-The following incident note was entered at 6:20 p.m.: "This nurse witnessed CNA's [certified nurse assistants] running out the front door of building after the facility experienced a black out. The black out [blackout] of electricity was approximately 2 minutes. This nurse went to the front door to investigate. CNA's were bringing resident back in through the front door by the time this nurse got to the door. CNA's stated that they saw the resident walking around the side of the building through the dining room windows and went outside to get resident. Resident stated that she was looking for a donut. Resident brought back in to the facility and sat by the nurses station. CNA was able to get a donut from the kitchen and resident stated that was good. Vital signs 116/75, 88 bpm, 18 respirations, 94% O2 on room air, no complaints of pain. DON contacted, Faxed MD [medical doctor] office with notes and spoke [with] family member regarding elopement."
*It was noted on 10/20/23 that resident 39 was removing the "Tile" brand tracking device "multiple times during the day."
*She was started on an antibiotic on 10/23/24 due to a positive UTI result.

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*On 12/6/23, her physician added gabapentin 100mg twice per day as needed for anxiety.
*On 12/12/23, she attempted to exit the building through the emergency exit door in the dining room TV area. The following behavior note was entered into her record:
-"Pt [Patient/resident] stood up from dining table and walked to TV area. Pt opened the south side door in the TV area by the dining room. Alarm went off and pt did not exit the building. Pt redirected, and then requested staff to open up restroom in dining hall. When asked where pt was going when she pushed open the door, the pt giggled and said, I don't like to go out that door because of the alarm."
*On 1/2/24, she attempted to exit the building again at the "East Door." Staff witnessed her exit the building and guided her back inside.
*On 1/3/24, staff were not aware the resident left the building. A housekeeping staff had just clocked out and went to the parking lot. She saw the resident wandering around in the parking lot. The following incident note was entered into her record at 1:52 p.m.:
-"Data: Resident was found in the back parking lot by housekeeping staff [housekeeper L] and walked back to the building. Nursing staff [registered nurse G] was able to meet housekeeping staff in back lot and resident brought back in. Alarm to the living room emergency exit was alerting. Resident walked out the living room emergency exit and was walking very quickly in the back parking lot. Housekeeping staff stated that she had to run to catch up to her in the lot. Resident brought immediately back into facility. Resident approximately out of the facility for 1-2minutes max. Action: Resident assessed when returned to facility. No signs/symptoms of distress noticed.

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Resident alert and oriented x1. Resident was then found to have a coat on and looking for a hat. Staff redirect to remove coat and sit in the recliner. Staff sitting with resident for about 10 minutes to redirect from trying to leave again. Gabapentin 100mg administered. Resident currently sitting with two other staff members. [15-minute] safety checks were started immediately. Response: Continuing to monitor for resident safety."
*The resident was found to have been positive for a UTI on 1/5/24 and was started on an antibiotic.
*On 1/20/24 and 2/4/24, she was witnessed attempting to exit the same emergency exit door in the dining room TV area.
-On both occasions, she said she was looking for her room.
-On 2/4/24 at 6:57 p.m., a behavior note entered into her record read, "After dinner pt walked to door to the right of the TV and pushed it open. Staff followed pt and asked "[Resident 39], where are you going?" Pt states she is going to her room. Pt followed staff back into the dining room and laughed, asking if the alarm went off. [Administrator A] notified, Son notified via phone."

3. Interview on 2/7/24 at 12:25 p.m. with licensed practical nurse (LPN) F and nurse manager C revealed:
*Resident 39 wore a "Tile" brand tracking device that tracked her GPS location.
*They had an application (app) on the facility's iPad to see the location of the "Tile" brand tracking device.
*They confirmed the device did not alarm or alert staff if the resident left the building.
*They indicated that resident 39 had a tendency to remove the "Tile" brand tracking device and would hide it in her dresser drawers.

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-They speculated that the resident knew what the device was used for.
*If they noticed that resident 39 was anxious or was displaying wandering behaviors, their interventions were to:
-Ask her if she needed help with anything.
-Offer an alternative activity, such as coloring.
-Offer a snack or a beverage.

Continued interview on 2/7/24 at 2:05 p.m. and 4:25 p.m. with LPN F revealed:
*There was a physician's order that prompted the nurse twice per day to check the placement of the "Tile" brand tracking device.
*They kept the device on a string and the resident wore it as a necklace.
*Resident 39 was on hourly checks.
-There were several residents on hourly checks for fall and elopement risks.
-She walked the halls each hour to lay eyes on each resident during the hourly checks.
*With the elopement on 10/19/23, the power went out for approximately two to three minutes.
*Resident 39's room was situated in between two fire doors. The employee door was across the hall from her room, giving her a direct route outside to the employee parking lot.
-The fire doors automatically shut when the electricity went out.
-Resident 39 happened to have been in the hallway when the electricity went out and the fire doors closed.
-Resident 39 was able to exit the building without the door alarms sounding.
*Some of the CNAs in the dining room had seen resident 39 in the parking lot through the dining room windows.
-They informed LPN F immediately.
*If they found resident 39 displaying unsafe

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wandering behaviors, the protocol was to put her on 15-minute checks for 24 hours, then 30-minute checks for the next 24 hours, then back to the regular 60-minute checks.
*She tried to complete the hourly checks at the top of each hour.

4. Interview on 2/7/24 at 5:23 p.m. with director of nursing B revealed:
*She completed a wandering assessment upon admission, 72 hours after admission, one month after admission, and then quarterly thereafter.
*She confirmed the door alarms did not sound when resident 39 eloped on 10/19/23.
*She confirmed the door alarms did sound when resident 39 eloped on 1/3/24.
-The emergency exit door in the dining room TV area only alarmed at the nurse's station, not in the dining room itself.
*They noticed a trend that resident 39 would usually have a positive UTI if her wandering and eloping behaviors increased.
*The resident currently had a UTI.

Interview on 2/7/24 at 5:45 p.m. and again on 2/8/24 at 9:18 a.m. with administrator A revealed:
*The power outage on 10/19/23 "didn't last very long."
*During a power outage, she expected staff to have completed a head count to ensure all residents and staff were accounted for.
*A record of the "head count" was requested from when the power went out on 10/19/23.
-She said, "As far as a head count, there's no formal check sheet for a head count. It would be in the charting."
*When asked where in the charting it would have been located at, administrator A said she did not know.

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*When asked in the event of an elopement, did they perform a head count to see if everyone was accounted for, she said, "I'm not sure, I would have to look at the policy."

5. Random observations throughout the survey revealed that resident 39 would wander towards the exit doors several times per day. Each time, a staff member successfully intervened and redirected her towards her room.

6. Interview on 2/8/24 at 11:16 a.m. with director of nursing B revealed:
*The "Tile" brand tracking device was implemented after she eloped in June 2023.
-Someone in the community found her near the grocery store in town and brought her back to the facility.
-The grocery store was about a mile away from the facility.
*She had been on hourly checks since that incident.
*All staff were aware they needed to monitor resident 39 closely due to her wandering behaviors.

7. Interview on 2/8/24 at 11:25 a.m. with activities director Q revealed:
*They had a variety of activities for resident 39 if she displayed unsafe wandering behaviors.
*They first invited her to the group activities if there was one going on.
*Staff invited her to have a cup of coffee.
*Other activities that resident 39 enjoyed included coloring, folding laundry, reading the paper, and watching certain TV shows.
*There was usually an activity aide in the building until 7:30 p.m. which helped the resident to keep busy.

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8. Interview on 2/8/24 at 11:59 a.m. with certified medication aide K revealed:
*During meals if they could not find resident 39, they first checked her room.
*She usually tried the exit doors because she was looking for her room.
*Resident 39 and her husband sat at a dining room table by themselves.
-Her husband learned to sit and wait for his wife to finish her meal rather than going back to their room after he finished eating because much of resident 39's anxiety came from not being able to find her husband.
*She confirmed that resident 39 had a PRN medication to help with anxiety.

9. Interview on 2/8/24 at 12:15 p.m. and again on 2/12/24 at 9:30 a.m. with housekeeper L revealed:
*On 1/3/24, she had just clocked out for the day and exited the employee door into the parking lot.
*She saw resident 39 with her walker wandering around in the parking lot.
-The resident was walking very quickly away from the building.
-She had to run to catch up to resident 39.
*The resident was about 45 yards from the exit door.
*When she ran to catch up with resident 39, she said to the resident, "Oh [resident 39], you're not supposed to be out here!" The resident responded with, "No I'm not."
*She started walking with the resident back to the building.
-At that time, RN G came out to the parking lot and assisted the resident back inside.
*She did not know how long the resident was outside.

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10. Interview on 2/8/24 at 12:24 p.m. with RN G revealed:
*On 1/3/24, the resident walked out of the emergency exit door in the dining room TV area.
*The alarm sounded at the nurse's station.
*She ran out the employee exit door into the parking lot.
*She saw resident 39 walking with housekeeper L.
*She assisted the resident back inside and assessed her for injuries.
*Resident 39's physician and family were notified, along with the facility's leadership team.
*She was placed on 15-minute checks for 24 hours, then 30-minute checks for the next 24 hours, then back to the regularly scheduled hourly checks.

11. Review of resident 39's Treatment Administration Record at approximately 3:25 p.m. on 2/8/24 revealed that the hourly check for 4:00 p.m. had already been checked as having been completed.

12. Review of the resident 39's care plan on 2/8/24 revealed:
*She was admitted on 5/19/23.
*Under the activities section, there was an intervention that read, "I will go to the activity room to read the paper. I will Walk the halls, sometimes I get confused where my room is and staff help remind me where it is." Initiated on 11/28/23.
*There was a focus area that read, "I am an elopement risk/wanderer r/t [related to] disoriented to place and wanders aimlessly." Initiated on 6/7/23, revised on 9/13/23.
*The associated interventions included the

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F 689	Continued From page 28 following: -"Distract me from wandering by offering pleasant diversions, structured activities, food, conversation, television, book." Initiated on 6/7/23, revised on 9/13/23. -"Elopement 6/11. One to one care until 0600 6/12, then 10minute checks of resident [until] 0600 6/13, then as long as no exit seeking has been demonstrated, then advance to 30minute checks of the resident until 0600 6/14, then resume hourly checks starting 0600 on 6/14 as long as no exit seeking is still demonstrated." -"6/14 [resident 39] seen pacing by front door carrying purse waiting for daughter so she can leave. Redirected [resident 39] successfully. Call made out to family to verify if they are coming to get her or not. Will continue to do 30 min checks on [resident 39] until no exit seeking has been observed." Initiated on 6/12/23, revised on 6/14/23. -"I am on hourly checks for fall prevention and elopement risk." Initiated on 6/7/23, revised on 9/13/23. -"I wear a tile device that tracks location for safety. Staff are to check placement 4 times a day." Initiated on 6/23/23, revised on 9/13/23. -"I will have 15min check for the first 24hrs and then 30min for 24hrs then hourly unless determined a need for change, d/t [due to] elopement attempt on 10/19/23." Initiated on 10/20/23, revised on 10/25/23. -"Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate." Initiated on 6/7/23. -"My triggers for wandering/eloping are phone calls from family members or visitations from family members. My behaviors are de-escalated	F 689		

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by redirection." Initiated on 6/7/23, revised on 9/13/23.
*Her care plan had not included the elopement from 1/3/24.

13. Review of the provider's December 2021 "Missing Resident" policy revealed:
*The policy came from their Emergency Preparedness binder.
*There was a handwritten "Elopement" at the top of the policy.
*"Missing Resident (Elopement) is defined as: Elopement is when a resident leaves the nursing facility unattended without the facility's knowledge."
*"1. The person discovering the absence of a resident will immediately notify the Charge Nurse/Personal Care Aide/LPN in charge and Nursing Supervisor/LPN of the areas where the person resides. Staff should provide the time and location of when the resident was last seen as well as the clothing the resident was wearing when last seen."
*"2. Unit staff will immediately check the resident's chart and the unit sign-out book to determine if the resident in in fact on an authorized absence. Ask other staff for any information about the resident's location or possible activities, including possible destinations."
*"8. After receiving information about the missing resident, all staff should quickly proceed to their designated search zone and begin a thorough search process, including closets, under beds, utility rooms, bathrooms, showers, tub rooms (in the bathtub), behind hedges, in corners, in and under automobiles, etc. The designated search zones for each department are listed at the end of this section. After a room is searched the magnet

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F 689	Continued From page 30 on the inside of the door frame will be moved to the corridor side of the frame indicating the room has been searched." -The policy did not list the designated search zones for each department. -There were no magnets on the inside of door frames in the building.	F 689		
F 812 SS=F	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: Based on observation, interview, and record review, the provider failed to: *Properly label and store several food items in two of two coolers. *Maintain one of one ice machine in a clean and sanitary manner that prevented the growth of an unidentified black substance.	F 812	Unable to correct prior noncompliance of correct labeling and storing food items and ice machine cleanliness. Maintenance director took down/removed ventilation duct from kitchen immediately on 2/7/24. Dietary manager removed kitchen cleaning chemicals were removed from storeroom immediately on 2/7/24. Updated cleaning checklist will be created by 3/8/24 for kitchen staff. Dietary manager or designee will monitor completion of checklist and ensure chemicals are appropriately stored. Administrator, Dietary manager, or designee will provide education to all necessary dietary staff regarding above identified areas along with updated policies by 3/8/2024. Administrator, dietary manager, and others as necessary will review, revise, or create policies and procedures as necessary. Dietary manager or designee will audit above identified areas weekly for 4 weeks and monthly for 2 months. Dietary manager or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	3/8/24

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*Maintain one of two overhead ventilation ducts to prevent the buildup of dust.
*Properly store kitchen cleaning chemicals separately from the emergency drinking water supply.
Findings include:

1. Observation on 2/6/24 from 7:55 a.m. to 8:13 a.m. in the kitchen revealed:
*In the reach-in cooler labeled "Refrigerator: Kitchen Reach-In:"
-Seven beverage cups of unidentified liquids were not covered or labeled.
-36 dessert plates of angel food cake with strawberries and whipped topping were not covered.
-There was a plastic container of an unidentifiable red substance that was not labeled or dated.
-One of the chocolate milk jugs did not have a cap on it.
-There was a full pitcher of red liquid that was not labeled or dated.
*The reach-in ice machine had a buildup of an unidentifiable black substance on the inside walls, and on the wires that were inside the machine to the left of the ice tray.
-The black substance appeared to have been either mold, mildew, or algae growth.
*The overhead ventilation duct above the convection oven was caked with a thick layer of dust.
*There was a tray of ten additional dessert plates that were not covered or labeled in the walk-in cooler.
*There were 9 cases of drinking water stored directly beneath kitchen cleaning chemicals in the dry storage closet.

2. Interview on 2/6/24 at 10:56 a.m. with

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F 812	Continued From page 32 administrator A after requesting kitchen-related policies revealed: *They did not have a specific policy on food storage or labeling. *It was her expectation that all food items should have been properly labeled and dated. -The practice was to have kept food items no longer than five days. *For any policies they did not have, they followed the food code. 3. Observation and interviews on 2/8/24 from 10:03 a.m. to 10:19 a.m. with dietary cook I, dietary prep cook H, and dietary manager D revealed: *The beverages and desserts for lunch that day were covered and labeled. *They agreed the beverages and desserts from 2/6/24 should have been covered and labeled. *They indicated that the maintenance department cleaned the ice machine per manufacturer's guidelines twice per year. -They denied that they ever wiped down the inside of the ice machine. -Dietary manager D indicated she was not aware of the unidentified black growth inside the machine. *Cooks H and I indicated they used to have a cleaning checklist, but they did not know where it was. *Dietary manager D confirmed there was no cleaning checklist in place at that time. *None of them were aware of the dust buildup in the overhead ventilation duct above the convection oven. *They did not know when the last time that duct was cleaned. *Dietary manager D was aware that the cases of drinking water were stored directly beneath the	F 812		

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kitchen cleaning chemicals.
-She understood the potential danger of contaminating the drinking water bottles with cleaning chemicals.
-She agreed the chemicals should not have been stored in the dry storage closet.
-She indicated they stored the other chemicals in the housekeeping closet and in the basement.

3. Review of the provider's March 2023 "Maintenance Ice Machine Interior Cleaning and Sanitation" policy revealed:
*Under the "Purpose" section:
-"To prevent the growth of microorganisms during the storage of ice and sanitation procedures are established to minimize the risk of contamination."
-"Cleaning and sanitizing procedure performed every six months for efficient operation."
*The procedures described a step-by-step process to clean the interior components of the ice machine.
*The policy did not indicate how often the inside walls should have been cleaned to prevent the growth of unknown substances.

Review of the provider's March 2023 "Dietary Services Ice Machine Cleaning Sanitation" policy revealed:
*Under the "Purpose" section:
-"To prevent the growth of microorganisms during the handling and storage of ice and sanitation procedures are established to minimize the risk of contamination."
*Under the "Procedure" section:
-"1. Cleaning procedure performed between the bi-annual cleaning and sanitizing cycles-this procedure does not require removing the ice from the bin. Bi-annual cleaning and sanitizing cycles

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F 812	Continued From page 34 completed by the maintenance department." *The policy did not indicate how often the inside walls of the ice machine should have been cleaned to prevent the growth of unknown substances. Review of the provider's "Semi-Annual Assignment Worksheet" revealed: *"C. Water filter on ice machine" was completed on 6/21/23 and 12/21/23.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880	All resident care items have been removed from under the sink. ALL residents and staff have the potential to be affected if staff to not adhere to identified areas. Administrator, DON, medical director, and any others as necessary will ensure ALL staff responsible for resident care item storage have received education/training with demonstrated competency and documentation by 3/8/24. Administrator, DON, and interdisciplinary team will review and revise policies and procedures as necessary. DON or designee will audit proper storage of resident care items 2 times weekly for 4 weeks and monthly for 2 months. DON or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	3/8/24

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F 880	Continued From page 35 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and policy review the provider failed to ensure infection control measures were followed for the storage of resident ear cleaning supplies in one of one medication storage rooms. Findings included:

Observation and interview on 2/7/24 at 9:17 a.m. with licensed practical nurse (LPN) F regarding the medication room review revealed:
*There were items stored in the cabinet under the sink.
*Those items stored in the cabinet under the sink included the following:
-Four containers of medication destroyer.
-Two one-gallon containers of hand sanitizer.
-A spray bottle of Clorox cleaning spray.
-A one-gallon container of vinegar.
-A large can of wasp and hornet spray.
-Biohazard bags.
-A large plastic basin with two bags of ear curettes, a box of ear curette spoons, a bag of ear cleaning tips, a smaller gray emesis basin and, an ear flush spray bottle with a small plastic hose attached.
*LPN F stated the items in the basin were the facilities ear cleaning supplies for flushing and cleaning resident's ears.
*She was not aware resident care items were not to have been stored under the sink.
*She agreed that if the sink pipes leaked into the plastic basin with the ear cleaning supplies it would have been a breach of infection control.
*She agreed that the ear cleaning supplies should not have been stored in the cabinet under the sink.

Observation and interview on 2/8/24 at 8:15 a.m.

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F 880	Continued From page 37 with nurse manager C regarding the medication storage room revealed: *She agreed that the cabinet under the sink was not an appropriate storage location for resident care items and had the potential to be a breach of infection control. Review of the providers March 2023 Infection Control and Prevention policy revealed: *"Purpose: The primary aim of infection prevention and control at Dells Nursing and Rehab is to prevent residents and staff from acquiring an infection while in our healthcare facilities." -"E. Facility Management --a. The facility shall maintain the interior and exterior of the facility in a safe, clean and orderly manner."	F 880		