South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	63502	A. BUILDING: _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD COURT	2101 N SANBORN MITCHELL, SD 57301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 8/23/23 through 8/24/23. Rosewood Court was found not in compliance with the following requirements: S337 and S633.	S 000		
S 337	44:70:04:11 Care policies Each facility shall establish and maintain policies, procedures, and practices that follow accepted standards of professional practice to govern care, and related medical or other services necessary to meet the residents' needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, manufacturer's label review, and policy review, the provider failed to ensure one of one observed unlicensed assistive personnel (UAP) D had performed safe handling and disposal of a used needle following insulin administration by one of one observed resident (5) creating a risk of needle stick injury. Findings include: 1. Observation and interview on 8/23/23 at 4:30 p.m. with UAP D during resident 5's insulin administration revealed: *UAP D brought the insulin supplies into the resident's room. Those items included: -A Novolin N Insulin Flexpen device. -A plastic UltiGuard Safe Pack container that held new insulin pen needles in the bottom compartment and had an opening at the top for the disposal of the used pen needles. --The product label indicated it was for convenient dispensing and safe sharps disposal.	S 337	-Unable to correct prior non-compliance of this deficiency. -All medication trained staff will be in-serviced by nursing staff by 9/7/23 and the policy and procedure for handling sharps will be reviewed. -All medication trained staff will demonstrate to nursing staff the proper disposal of Insulin Flexpen needles using the Ultiguard Safe Pack System per the manufacture recommendations. -All medication trained staff will be observed for proper disposal of sharps by nursing staff monthly x 1 year. -The administrator will audit the monthly compliance of the sharps policy and procedure and will review the audit form quarterly with the QA committee.	9/7/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David Harris

TITLE: Administrator

(X6) DATE: 9/5/23

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S 337	Continued From page 1	S 337		

*UAP D assisted the resident to perform her insulin self-administration by attaching a new needle to the pen and ensuring an accurate dose of insulin was set.
*She then removed the cap from the needle and handed the pen device to the resident.
*The resident self-injected the insulin into the skin of her abdomen.
*When the resident finished she handed the insulin pen device with the used needle back to the UAP.
*UAP D recapped that used needle with the plastic cap that was previously on the needle.
*The UAP then put the needle end of the pen device down into the top of the UltiGuard Safe Pack and turned it several times.
*After that she lifted the insulin pen device out of the UltiGuard Safe Pack's opening and attempted to put the pen device's regular plastic cap back onto it.
*At that time the surveyor noticed the used needle was still attached to the end of the pen and it was bent at a ninety-degree angle.
*She was instructed to stop her efforts to ensure she did not get a needle stick injury.
-UAP D had not known the used needle was still intact and bent on the end of the pen device until she was alerted to that.
*She indicated she normally did not use the UltiGuard Safe Pack to dispose of those used needles.
-Her usual process was to recap the used needle, spin the recapped needle off with her hands, and then put that recapped needle into the sharps disposal container on the side of the medication cart.
*She was not sure how the UltiGuard Safe Pack container worked and was unsure if she had been trained on its use.
*She was careful when recapping used needles.

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S 337	Continued From page 2 *She agreed recapping used needles was not a safe practice and it created a risk of a needle stick injury. Interview and review of the UltiGuard Safe Pack instructions for use on side of the container with UAP D immediately following the above observation revealed: *The instructions included a step-by-step process to ensure safe removal of the used needle including: -"1. Remove pen needle from storage. Use pen needle as directed. Do NOT attempt to recap needle!" -"2. After giving the injection, leave pen needle on pen injector. Carefully insert pen needle tip into center of red opening on top of the UltiGuard Safe Pack and push in with slight pressure. Do not push into opening with excessive force." -"3. Rotate pen injector counter-clockwise to remove pen needle from pen. Store pen as directed." -"4. Turn the UltiGuard Safe Pack's handle a full 360 degrees to eject pen needle into container. If pen needle did not eject, rotate handle again until pen needle is ejected." *The reference also had illustrations which included the following: -To put the used uncapped needle directly into the top of the pack. -To spin the pen device counterclockwise to safely remove the needle. -After the needle was removed from the pen, to use the dial on the side of the container to put the needle into the sharps device. *After review she confirmed she had not followed the instructions in the above observation which was likely why the needle remained attached to the pen.	S 337		

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S 337	Continued From page 3 Interview on 8/23/23 at 4:45 p.m. with administrator A and registered nurse B regarding the above observation and process revealed: *They confirmed safe handling and disposal of a used needle had not occurred by UAP D. -They were not aware her usual process included recapping used needles. *Staff should never recap a used needle as that was not a safe practice. *Used needles should have been handled in a way to ensure needle stick injuries would not occur. *They expected staff to follow the manufacturer's instructions of the UltiGuard Safe Pack container and the policy for handling sharps. *They completed initial and annual training with all UAPs regarding medication administration processes. *They were unsure if any UAPs had been trained on the use of the UltiGuard Safe Pack container. -Training on specific devices such as the UltiGuard Safe Pack should have been done. Review of the provider's April 2020 Medical Waste and Sharps Handling policy revealed: *"All employees must safely handle medical waste and sharps in the correct manner. Sharps are defined as any objects that can penetrate the skin including, but not limited to, needles, lancets, scalpels, broken glass, and broken capillary tubes..." *"4. All sharps will be disposed of in rigid biohazard sharps containers..." *"6. Needles will not be recapped, bent, broken, or otherwise manipulated. If a sharps container is not conveniently available, the used sharp will be carried in a sharps shuttle or in a tray with sides on it to the nearest sharps container and disposed of there."	S 337		

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S 633	Continued From page 4	S 633		
S 633	44:70:07:04 Storage and labeling of medications Containers with contents that will not be used within 30 days of issue or with contents that expire in less than 30 days of issue shall bear an expiration date. If a single dose system is used, the drug name and strength, expiration date, and a control number shall be on the unit dose packet. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, manufacturer's label review, and policy review, the provider failed to ensure one of one sampled resident's (1) insulin pen device had not been used past the manufacturer's recommendations of twenty-eight days after it was opened. Findings include: 1. Observation, interview, and manufacturer's label review on 8/23/23 at 12:10 p.m. with unlicensed assistive personnel (UAP) C related to insulin in the medication refrigerator revealed: *An opened Novolog Insulin Flexpen for resident 1 had a handwritten date of 7/18/23 on it. -That handwritten date had not specified if it was the opened date or the use by date. *Resident 1's box of unopened Novolog Insulin Flexpens indicated the pen should have been discarded twenty-days after it had been opened. *UAP C indicated staff wrote opened dates on medications but had not typically written the use by dates on them. -She confirmed the insulin pen should not have been used after the twenty eight days recommended by the manufacturer's instructions for use. *Resident 1 had been receiving her scheduled	S 633	-Unable to correct prior non-compliance of this deficiency. -All scheduled or PRN multi-dose medications will now be labeled with a sticker stating: Date Opened and Date Expired per pharmacy and manufacture recommendations. -All medication trained staff will be in-serviced of the new labeling system. Policy and procedure of Storage and Labeling of Medications will be reviewed by nursing staff by 9/7/23. -Nursing staff will audit all scheduled and PRN multi-dose medications weekly to ensure medications are not used after the expiration date. This practice will be done indefinitely. -The administrator will audit the monthly compliance of the labeling of scheduled and PRN multi-dose medications and will review the audit form quarterly with the QA committee.	9/7/23

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dose of Novolog insulin every evening.
*Review of the resident 1's other opened Basaglar insulin pen and resident 5's opened Novolin N insulin pen revealed similar handwritten opened dates.
-Those pens had not been past the manufacturer's recommended use by dates based on their opened date.
--They had no use by dates written on them to ensure they were discarded according to the manufactuer's instructions.

Interview on 8/23/23 at 12:15 p.m. with administrator A and registered nurse B revealed:
*They confirmed the manufacturers' instructions should have been followed for use by dates of those medications.
-Resident 1's insulin pen should have been discarded and not used after 8/15/23.
*There was no use by date written on the pens for staff to reference and ensure the pens were discarded according to the manufacturer's recommended dates.
*They agreed there was a potential risk to the resident when a medication was used past the recommended use by date.

Review of the provider's revised April 2020 Medication Administration Procedures policy revealed:
*"24) Expiration dates are checked on containers and removed from supplies if outdated..."
*There was no mention of a process for establishing opened by or use by dates for medications.

Review of the provider's revised April 2020 Drug Disposal policy revealed:
*"...when medications have expired, the medications must be removed immediately from

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S 633	Continued From page 6 the medication cart and placed in the locked cabinet at the nurse's station for destruction..." *There was no mention of a process for establishing opened by or use by dates for medications.	S 633		

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{S 000}	Compliance Statement A revisit survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted on 9/18/23, for all previous deficiencies cited on 8/24/23. All deficiencies have been corrected, and no new noncompliance was found. Rosewood Court was found in compliance with all regulations surveyed.	{S 000}		

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