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

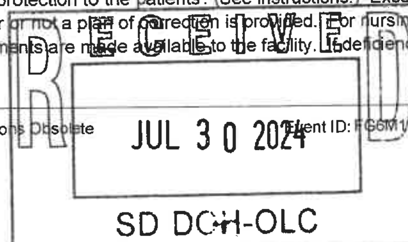
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A098	A. BUILDING ______ B. WING ______	C 07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD CARE CENTER VERMILLION	**125 S WALKER STREET VERMILLION, SD 57069**

(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 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 6/25/24 through 6/27/24, and on 7/1/24. Sanford Care Center Vermillion was found not in compliance with the following requirements: F578, F658, F684, F689, F812, F838, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/25/24 through 6/27/24, and on 7/1/24. The area surveyed was resident neglect related to a fall from a mechanical device. Sanford Care Center Vermillion was found not in compliance with the following requirement: F658. On 6/27/24 at 2:12 p.m., immediate jeopardy was identified related to observation, assessment, and monitoring of a resident's (20) repeated actions of self-harm resulting in multiple wounds to both of his lower legs at F689. Administrator A and director of nursing B were notified of the immediate jeopardy and a removal plan was requested. On 6/28/24: *At 4:23 p.m. administrator A provided their plan for the removal of the immediate jeopardy to the survey team. *At 5:06 p.m. the provider's removal plan was reviewed and accepted by the survey team. On 7/1/24 at 10:43 a.m. the survey team reviewed the provider's documentation for the removal plan and the immediacy was removed. The resident census was 58.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE
, CEO 07/23/2024

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 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide	F 578	1. RN C received verbal doctor's order on 7/2/24 for Resident 2's DNR order and placed in his chart. 2. RN C checked all residents charts for their code orders and compared to their banners to ensure all matched on 7/2/24. No other discrepancies found. 3. Social Worker added a check for Advanced Directives to her admission checklist for all new admits to the facility to ensure we obtain the documents in a timely manner. She will place copy in the paper chart and document in her progress note what the directive is. DON emailed nursing staff 7/23/24 to send a copy of all code status change orders received to RN C and wrote reminder on Communication board for staff as well of this. DON will update new nursing orientation education for this as well. 4. RN C will conduct weekly audit of at least 4 residents based off MDS schedule to compare code status order and banner to ensure they match. She will continue to audit with MDS schedule and include new admits in this audit. RN C or designee will report results of audits at monthly QAPI meeting beginning on 8/7/24 until the facility demonstrates sustained compliance as determined by the committee.	7/31/24

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F 578	Continued From page 2	F 578		

the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on record review interview, and policy review the provider failed to have a physician's order in place consistent with one of one (2) sampled resident's advance directive.
Findings include:

1. Review of resident 2's electronic medical record (EMR) revealed:
*The banner at the top of his EMR when opened on 6/26/24 displayed DNR [do not resuscitate].
*He had a full code (permission for life-sustaining measures, including resuscitation) order dated 4/29/19.

*Interview on 7/1/24 at 5:10 p.m. with director of nursing (DON) B and Minimum Data Set (MDS) nurse C revealed:
DON B stated she did not have a current order for resident 2's DNR and to talk to MDS nurse C.
*MDS nurse C stated she had faxed the physician on 7/1/24 to request an order but did not have one in resident 2's chart.

Review of provider's 8/1/23 advance directive policy including cardiopulmonary resuscitation (CPR) and automated external defibrillator (AED) procedure revealed:
*"1. Advance directive orders are to be reviewed with resident/healthcare decision-maker at each care plan meeting to ensure no changes are needed. Document this discussion in the PN-Care Conference Note."
*2. If a resident who has an advance directive informs a staff member he or she has changed his or her decision, the resident's wishes for

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F 578	Continued From page 3 different measures will be followed and the physician will be contacted for updated orders." *"5. Physician's orders in response to resident's requests and/or advance directives regarding life-sustaining measures must be specific, e.g., do resuscitate or do not resuscitate, whether to hospitalize, whether antibiotics are to be used, etc. "Code" or "No Code" orders do not have a universally accepted definition and therefore will not be accepted.	F 578		
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 and record review the provider failed to properly store eye drops, lotions, gels, creams, lotions, and ointments for 2 of 20 residents (1 and 16). Findings include: 1. Observation and interview on 6/25/24 at 10:16 a.m. with resident 16 in his room revealed: *He had 2 boxes of eye drop medication on his bedside table. One was latanoprost (for pressure inside the eye) and one was Carboxmethylcell. *He stated they were left in his last night by the nurse who didn't come back to pick them up. 2. Observation on 6/25/24 at 10:34 a.m. of resident 2's room revealed: *A container that had anti itch lotion, Vicks vaporub, vaseline, Aquaphor, aloe gel, simple	F 658	A1. Resident 16 had eyedrops removed from his room on 6/25/24 by LPN L. Resident 2's over the counter medications were removed from his room on 6/27/24 by the RN C except for the cough drops which he had an order to keep at bedside. On 7/5/24, order received from physician to keep these items identified in 2567 at resident 2's bedside. These were placed back in his room in the nightstand. 2. DON and RN C checked all resident rooms on 7/5/24 for bedside medications that did not have an order. No other residents were affected. 3. Education was provided to all staff via OnShift by Clinical Care Leader on 6/27/24 and again by Director of Nursing (DON) on 7/9/24 to report any bedside medications found in resident rooms to the charge nurse and the charge nurse will verify if there is an order for medications to be left at bedside. Nurses educated by DON that self-administration assessment needs to be completed by nurse if order is received from physician for medications to be at bedside. If bedside medications are ordered, the medications will be kept in resident's nightstand table. Education on this was provided to staff in the Directed Inservice Training beginning on 7/18/24. Any staff not available to complete inservice training by 7/31/24, will need to complete it before their next scheduled shift.	

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F 658	Continued From page 4 saline wound wash and Metholatum in it, on a stand next to his recliner. 3. Interview on 6/25/24 at 10:23 a.m. with licensed practical (LPN) L revealed: *She stated maybe resident 16's eye drops were left in his room due to his positive coronavirus disease (COVID-19) test but was unsure. *He was cognitively intact, which was demonstrated by his score of 14 for brief interview for mental status (BIMS). 4. Interview on 6/25/24 at 3:45 p.m. with director of nursing (DON) B and minimum data set nurse C revealed: *There are no orders for medications left at bedside due to COVID unless for cough drops. *There should not be any medications left at a residents bedside without an order. *MDS nurse C confirmed resident 2 had a bedside order for cough drops, -She confirmed resident 16 did not have an order for anti itch lotion, vicks vaporub, vasoline, aquaphor, aloe gel, simple saline wound wash and metholatum left in his room. Record review of residents 2 and 16's electronic medical record revealed. *Resident 2 had an order for cough drops at bedside and self administration. *Resident 16 did not have an order for bedside medications nor for self administration. B. Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, observation, interview and policy review, the provider failed to ensure one of one resident (37) was transferred as directed in his care plan	F 658	A4. The DON or designee will complete audits on resident rooms to ensure bedside medications have physician order 3 per week for 4 weeks; twice per week for 4 weeks and two times per month for 3 months. The DON or designee will report results of the audits at the monthly QAPI meeting beginning on 8/7/24 until the facility demonstrates sustained compliance as determined by the committee. B.1 Resident 37's care plan prior to his fall on 6/3/24 stated to use the EZ sit to stand lift with resident for transfers. Staff did use the correct lift, the EZ sit to stand lift, on 6/3/24 with Resident 37 when he fell onto the garbage can. They then used the Hoyer total lift to get him off the garbage can. The RN C changed the care plan and Kardex on the morning of 6/4/24 to Hoyer total lift for transfers after listening to morning report and hearing of Resident 37's fall. A lift assessment was done on Resident 37 on 7/18/24 by DON and determined the Hoyer lift was the appropriate lift so no care plan/ Kardex changes were needed as that's what it states to use for transfers. 2. DON and RN C will audit all residents' Kardex's with care plans to ensure the transfer/lift information matches. DON and RN C will review all residents and complete lift assessment on all to ensure appropriate lift/ transfer is documented on their care plan and kardex. 3. An algorithm/lift assessment was created by the DON and RN C on 7/18/24 to determine if resident needs a mechanical lift and if so, which one would be appropriate for use. This will be used on admit, annually and PRN with resident changes. A lift/safe resident handling competency will be completed by all staff with the Clinical Learning and Development Specialist (CLDS) beginning on 7/9/24 along with staff education	

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F 658	Continued From page 5 and then fell from a mechanical lift. Findings include: 1. Review of SD DOH FRI report received 6/10/24 at 11:26 a.m. revealed: *On the evening of 6/3/24 at 7:50 p.m. resident 37 slipped out of the sit-to-stand lift, after lifting his arms while in the EZ stand lift. *Two staff were assisting the resident at the time certified nursing assistant (CNA) H and CNA I. *The waist belt was on resident 37 and secured properly. *The leg belt was not used. *An EZ total mechanical lift was then used to place him in his bed. 2. Review of resident 37's electronic medical record (EMR) and paper medical record revealed: *He admitted to the facility on 1/4/23. *His current Brief Interview for Mental Status (BIMS) score was 03, which indicated he had severe cognitive impairment. *His active diagnosis was: -Chronic kidney disease, stage 4 (severe). -Unspecified dementia, unspecified severity, with other behavioral disturbance. -Depression. -History of falling. -Essential hypertension. -Weakness. *Review of the resident's fall history for last six months revealed: -On 2/13/24 at 6:00 a.m. he fell with no injuries while he was ambulating. -On 2/22/24 at 11:44 p.m. he fell with a skin tear after being observed on the floor by staff. -On 5/23/24 at 1:31 a.m. he fell and was observed on floor in another resident's room, no injuries were noted.	F 658	to use all belts with the lifts when transferring residents for their safety. The CLDS will educate nursing staff on the new lift assessment process and using the algorithm. Any staff not available to complete the competency and education with CLDS by 7/31/24, will need to complete it before their next scheduled shift. 4. The DON or designee will complete a C.N.A transfer audit to ensure all belts are being used with lifts/transfers and appropriate lift is being used. Audits will be completed for 3 x week for 4 weeks, 2 x for 4 weeks, and 2 x monthly for 3 months. The DON or designee will report results of the audits at the monthly QAPI meeting beginning on 8/7/24 until the facility demonstrates sustained compliance as determined by the committee.	7/31/24

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F 658	Continued From page 6 -On 6/3/24 at 7:50 p.m. he slipped out of an EZ sit-to-stand lift, landing on a garbage can, EZ total mechanical lift was used to get him off floor and transferred into his bed, no injuries noted. *His care plan with a start date of 1/10/23, regarding activities of daily living (ADL) functional status/rehabilitation potential problem revealed: -"Partial/moderate to substantial/max assist of one with transfers, fluctuates (hoyer lift if a lift is needed)." -"Independent/supervision with ambulation." -"Independent/supervision with locomotion." -"Supervision to partial/moderate assist of one with toileting." -Last revised 6/4/24 at 10:34 a.m. *His current care plan revealed: -"Partial/moderate to substantial/max assist of one with transfers, fluctuates (hoyer lift if a lift is needed)." -"Independent/supervision with ambulation." -"Independent/supervision with locomotion." -"Supervision to partial/moderate assist of one with toileting." -Last revised 6/4/24 at 10:34 a.m. *Identified problem falls: -Total mechanical lift for all transfers with two assist, approach start date 6/4/24. -Keep bed in lowest position with brakes locked. -Last revised 6/4/24 at 12:52 p.m. *A kardex (staff pocket care plan) type dated 2/13/24 on the special care unit (SCU) revealed: -"Transfers partial/moderate to substantial/max fluctuates EZ lift-prn." -"Ambulation independent to supervision with walker-fluctuates at times not walking utilizing w/c." -"Supportive devices: walker, glasses, bariatric bed, gripper socks (as allows), motion sensor, tubigrips and Hoyer [total mechanical lift] (Do not	F 658		

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utilize EZ lift), w/c with pressure relieving cushion-PRN (as needed)."
*A kardex type dated 2/13/24, pen dated 6/4/24 on the SCU revealed:
-"Transfers partial/moderate to substantial/max fluctuates EZ lift-prn."
-"Ambulation independent to supervision with walker-fluctuates at times not walking utilizing w/c."
-"Supportive devices: walker, glasses, bariatric bed, gripper socks (as allows), motion sensor, tubigrips and Hoyer (Do not utilize EZ lift), w/c with pressure relieving cushion-PRN (as needed)."

3. Observation on 6/25/24 at 2:10 p.m. of resident 37 revealed a posted note not to use the sit-to-stand lift, and to use the total mechanical lift.

4. Interview on 6/26/24 at 10:12 a.m. by phone with CNA I revealed:
*Resident 37 was transferred with the EZ stand lift.
*No total lift sling was under the resident in his wheelchair prior to the transfer.
*Resident was having a bowel movement, and the staff were cleaning him in the sit-to-stand lift.
*Resident 37 let go of the hand bars on the lift and slid out of the sit-to-stand lift.
*The waist belt of the sling was secured.
*The leg strap was not secured.
*Staff placed feet on the footplate of the lift.
*She had not read his care plan to see how he was to be transferred, she followed what the prior shift had used to transfer the resident.

5. Interview on 7/1/24 at 10:45 a.m. with director of nursing (DON) B revealed:

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F 658	Continued From page 8 *There are no lift assessments. *There is no lift assessment policy. *The nurse would determine based on observation what type of lift device would be used. 6. Interview on 7/1/24 at 10:55 a.m. with CNA G revealed: *She was unsure when the no sit-to-stand lift note was placed in resident room. *She followed the Kardex in the resident binder. *The Minimum Data Set nurse (MDS) C or DON B determined what lift to use on residents. *Resident 37 had been having fainting-like spells when he used the sit-to-stand lift. *One person can use the sit-to-stand lift with residents and two staff were to use the total mechanical lift with residents. *She found out resident 37 was no longer to use the sit-to-stand lift during verbal report but could not recall the date that had occurred. *She provided the staff kardex dated 6/4/24 that indicated staff were to no longer use the stand lift for resident 37. 7. Interview on 7/1/24 at 11:25 a.m. by phone with registered nurse (RN) E revealed: *EZ sit-to-stand lift had been used PRN for resident 37 for a couple weeks prior to the fall on 6/3/24. *He had not had any fainting-like episodes before the one on 6/3/24 that she was aware of. *Report from shift to shift is recorded, she stated she did not always have time to listen to that report and would get a verbal report from the previous nurse instead. *CNA's were to read the care plans, she was unaware if they do read them. *Nurses would determine the amount of	F 658		

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assistance needed and any devices that need to be used with residents.
*Care plans were updated by DON B or MDS nurse C.
*She had given CNA H and CNA I education on the proper use of the lifts on the night of 6/3/24.
*She had emailed MDS nurse C and senior social worker J and informed them of everything that was done and that she felt the CNA's needed more education.
-She never heard back about the email she sent.

8. Interview on 7/1/24 at 11:52 a.m. by phone with CNA H revealed:
*She is a PRN (as needed) staff member.
*The sit-to-stand lift harness was in resident 37's room on 6/3/24, and they had used that.
*She stated the waist buckle and leg buckle were used during the transfer.
*Resident 37 slid through the harness, and landed on the garbage can.
*They had asked for assistance over the call system.
*They had used the total mechanical lift to get him off the garbage can and placed him into his bed.
*She had not worked on the North wing for nine months.
*Resident 37 had been ambulating with a walker the last time she had worked prior to that incident.

9. Interview on 7/1/24 at 12:05 p.m. with MDS nurse C revealed:
*Resident 37 had moved to the SCU in April 2023.
*CNAs were to fill out the GG charting (focuses on patient's functional abilities and goals).
*That tells her how they are being transferred.
*She stated resident 37 was "chicken winging"

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F 658	Continued From page 10	F 658		

(lifting arms up) in the stand lift.
*That was when he was changed to a total lift for transfers.
*Staff had used the sit-to-stand lift as needed on resident 37 for a couple of weeks before the incident on 6/3/24 PRN.
*She might have forgotten to have changed the date on his care plan when she updated it.
*She was unsure of the date resident 37 was changed to a total mechanical lift transfer on his care plan.
*She was not aware of any fainting-like episodes before 6/3/24.
*She had updated the kardex.

10. Review of education for CNA I revealed:
*Safe resident handling training was completed on 1/21/24 and again on 5/8/24

Review of education for CNA H revealed:
*Safe resident handling training was completed on 4/26/23.

11. Review of the manufacturer's user manual for the EZ Way Smart Stand dated 9/29/23 revealed:
*"The EZ Way Smart Stand was designed specifically for toileting and changing briefs of patients."
*"The EZ Way Smart Stand can also be used for transferring the patient from chair, wheelchair, toilet or bed, and can be used for ambulation."
*"As patients do vary in size, shape, weight and temperament, these conditions must be taken into consideration when deciding if the EZ Way Smart Stand is suitable for their needs."
*"Patients should be able to bear some weight, have upper body strength and be able to follow simple commands."
*"If a patient does not meet each of these three

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F 658	Continued From page 11 criteria, an EZ Way total body lift must be used." Review of the manufacturer's user manual for the EZ Way Smart Lift dated 6/14/23 revealed: *"The EZ Way Smart Lift was designed primarily to lift patients from the bed, chair, toilet and floor." *"The maximum lifting capacity is located by the model and serial number of the lift." *"The EZ Way Smart Lift was designed to be operated safely by one person. However, with some patients, it is best to use two people." 12. Review of the provider's Mobility support and positioning policy dated 5/6/24 revealed: Criteria: *"The resident must weigh less than the maximum weight capacity of the total lift, sit-to-stand or stand aid and sling or harness." *"A total lift should be used for those residents who are unable to provide weight-bearing assistance, have impaired sitting balance, are uncooperative, rigid, difficult to turn or unable to follow verbal cues." Safety: *Always check the kardex, or care plan/service plan prior to the transfer or repositioning task for type and amount of assistance needed Follow any specific lift/transfer instructions for the resident."	F 658		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		

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F 684	Continued From page 12 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the provider failed to deliver appropriate wound care, assessment and monitoring for one of one (20) sampled residents observed with wounds. Findings include: 1. Observation and interview on 6/25/24 at 9:29 a.m. with resident 20 revealed: *He was sitting on the edge of his bed scratching at his leg. *He had multiple open areas with some active bleeding on his bilateral lower legs and bandages on some of them. *There was a white towel under his bare feet with dried blood on it and another lying to his left with dried blood on it. *Bandage wrappers were on the floor by his feet. *He stated his legs are better because he has been taking care of them. *He stated he kept his tools in alcohol. *He stated he had good medicine here but the nurse took it from him and said it was dangerous and he could not have it. *He stated he was doing okay for the shape he was in. *His shower has two discolored towels on the floor that appeared to have been wet then dried multiple times and had what appeared to be dried blood on them. Interview on 6/26/24 at 4:15 p.m. with RN F in regards to resident 20 revealed he: *Had a picking disorder and could have sharps in	F 684	1. Resident 20's wounds were cleaned and treatment completed according to physician's order on 6/27/24 by LPN L. Resident # 20's wounds were assessed using skin assessment tool. RN C updated Resident 20's care plan on 6/28/24 for treatment and assessment of the wounds twice weekly by nursing and prn until healed. 2. Other residents with wounds and their wound documentation will be reviewed for appropriate wound care and assessment by the DON or RN C. 3. On 6/27/24, the DON and RN C educated resident 20 on hand hygiene and infection prevention to include making sure his wounds were covered when leaving his room. Resident 20's care plan was updated by the RN C on 6/27/24 to offer tubi-grips for covering of wounds when leaving room and for the hand-washing education provided to him. OnShift education was sent to staff on 6/27/24 to make sure all skin/wound assessments are completed in full. DON re-educated nursing staff on 7/9/24 to make sure charting was complete and measurements on all wounds were done. Directed In-service training by the DON was started on 7/18/24 for all staff to review the wound policy, the standing orders for wounds including charting, complete assessments and resident refusal of cares. Any staff not available to complete inservice training by 7/31/24, will need to complete it before their next scheduled shift. 4. DON or designee will audit wound care treatments and skin assessments 2 x week for 4 weeks, 1 x for 4 weeks, and 1 x monthly for 3 months. The DON or designee will report results of this audit to the monthly QAPI committee meeting beginning on 8/7/24 until the facility demonstrates sustained compliance as determined by the committee.	7/31/24

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his room.
*Tried to cut bugs out of his skin.
*Would not let any nurses take care of the open areas on his legs.
*Is independent and is allowed to leave the premises.
*Would go to a store on public transit and buy what he wanted and would bring it back to his room.
*He was aware that his sharps and cutting of himself were care planned.

Interview on 6/27/24 at 1:30 p.m. with RN K in regards to resident 20 revealed:
*He had concerns regarding resident 20 and stated, "I can't believe he isn't septic with his cutting."
*Resident 20 "had all kinds of sharps" from a "Hobby knife kit" he had bought from at a local store.
-Nurses do not provide his wound care, he did his own.
-RN K did not work resident 20's hall but was aware of his cutting behavior.
-He said all of resident 20's wounds on his legs were from his cutting himself and he had no injuries from falls or scraping on his bed frame that he knew of.

Interview on 6/27/24 at 1:45 p.m. and again at 2:05 p.m. with LPN L revealed:
*She did not do wound care for resident 20 and she had concerns about him cutting himself.
*She was not sure how many open areas he had.
*There had been no pictures for documentation of his wounds.
*There was no sharps inventory or count of how many sharps resident 20 had in his possession.
*She had concerns about his history of falls and

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the potential he could fall and be injured by a sharp object.
*She would organize his room due to her concerns, he would allow that, but he would tell her to not take anything.
*She stated the previous social worker was aware of him cutting himself with the sharps he had.
*She stated that she does not participate in care conferences but has reported her concerns and all the staff management were aware of his cutting himself with the sharps he had in his room.
*He was not on any antibiotics but had an order for Neosporin to self-administer in his room.
*He has not been tested for infectious diseases.
*Certified nurse aides (CNA's) should report any new wounds or concerns.

Interview and observation on 6/27/24 at 1:40 p.m. with resident 20 revealed:
*He has eleven open areas on his inner lower left leg with four small bandages and his right lower inner leg had eight open areas with three large bandages.
*He stated the bandages are because "those I made bleed, so I put band-aids on them."
*He said he cleaned them himself but had not been educated by the facility staff on how to clean tools or his open areas.
-" I have a bottle of alcohol I clean my legs first, then use hot water, and then put Neosporin on them.
-A bottle of 91% alcohol was under his bed and was approximately a third full.
-He stated he used the alcohol to clean his "scalpels" a couple of times a day.
-There was no redness observed to the surrounding tissue of his visible open areas.

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Record review of resident 20's care plan dated 4/25/24 revealed.
*"Behavioral symptoms included cutting and or picking off warts and scabs on his skin. He utilizes scalpels he gets at the hardware store."
-He declines to follow physician recommended advice of no cutting warts off his skin, and will decline skin-care and other treatments at times needed to properly address his self-inflicted wounds (see delirium). He will regularly create or manipulate his own or facility items to "fix" them or create things (ie. Using a belt for a strap on his wheelchair). He was encouraged not to create restraints for himself and to seek staff input before "fixing" facility property."
-He will not utilize scalpels in a way that puts his well-being or life into question.
-He will not harm himself outside of cutting off his warts/scabs.
*"Approach date 6/23/21 noted, allow [resident 20] to have sharps in his room.
-Remove sharps with conversations regarding self-harm with these sharps.
-Offer education in regard to safety/infection control as needed.
-Assess for pain and offer pain medications, as able, with thoughts of death-statements. As needed PRN1, PRN 2, PRN 3.
-Discipline noted, all staff and social services."
*"Long-term goal target dated 4/22/24 noted, that [resident 20] will have fewer episodes of refusing care.
-Resident will consider physician-recommended interventions to treat what is causing ailments.
-Resident will be more open to allowing RN's to treat open areas on his skin related to infection prevention."
*"Approach start dated 4/27/20 noted, "redirect resident as needed.

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F 684	Continued From page 16 -Document refusal of care when it occurs. -Assist in applying antibacterial creams and appropriate dressings for open area to the skin, PRN. -Ask RN's to assist in evaluating and treating wounds. As needed PRN 1, PRN 2, PRN 2. -Discipline noted, all staff, nursing and social services." *"Problem start date 6/23/21, environment noted, -[Resident 20] keeps sharps in is room related to behavioral concerns/delusions of bugs in his skin. -As long as there is no self-harm ideation/intent, he is able to have these in his room due to resident rights and continued non-compliance with having them removed. (Similar care plan noted under behavioral symptoms) -[Resident 20] is sensitive to others touching items in his room, even for infection control reasons. He sternly requests that he is consulted before environmental services (ES) deep-cleans his room, as he is not compliant with this task and has had verbal interactions with ES and others before over items in his room being tidied/moved. -He likes to be in charge of where his dirty clothes go and often keeps paints on tables that are still clean and has his wallet and things in it. It has been care planned that he will have a laundry basket in his room to put his dirty clothes in and staff will take the clothes from the basket only to wash. -He will independently buy items at Walmart related to his delusions of bugs. He has no cognitive impairment and is self-sufficient enough to go out and about to purchase his own things. Education has been provided to him on the safety of certain pesticides and those items have been removed but it causes more agitation for him." *"Long term goal target date 2/8/24 noted, [resident 20] will be able to keep sharps in his	F 684		

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room, per his refusal to comply with Sanford policies and concerns for safety without sharps to pick at his skin (as he relies on dull/other unsanitary means to pick at his skin when sharps are not available).
-He will not utilize scalpels in a way that puts his well-being or life into question.
-He will not harm himself outside of cutting off his warts/scabs.
*[Resident 20] will work with ES and certified nursing assistants (CNA's) to keep his room somewhat tidied and disinfected.
-He will refrain from verbal interactions with others over his room cleanliness.
-He will be understanding of the basic infection control measures that have to be taken with is room, in reference to bloodied or dirty cloth items and other unsanitary items on the floor of his room.
-He will put his dirty clothes in the laundry basket provide for ES to know what is dirty and what is clean.
-He will be aware of certain pesticides that he brings into his private room and sue them with caution."
*"Approach start date 6/23/21 noted, allow [resident 20] to have sharps in his room.
-Offer education in regard to safety/infection control as needed.
-Assess for pain and offer pain medications, as able, with thoughts of death-statements.
-Consult with resident prior to deep-cleaning his room.
-Help mediate infection control needs and resident rights between resident ES staff.
-Help to remove unsanitary cloth items as they are seen, and replace them with unsullied linens/washcloths/towels.
-Staff will be respectful to only grabbing the dirty

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F 684	Continued From page 18 clothes out of his laundry basket to clean. -Staff will be respectful and continue to educate [resident 20] on the dangers of some of the pesticides that he purchases and has in his room. -As needed, PRN 1, PRN 2, PRN 3. -Disciplines, all staff and social services." *"Problem start date 1/6/20 noted, delirium, [resident 20] believes there are microscopic bugs under his skin. -He believes this is why his skin itches and, possibly why he gets warts -He cuts off his warts and scabs to stop the itching from the bugs under his skin. (see behavioral symptoms)." *"Long-term goal target date of 4/22/24 noted, [resident 20} will utilize other methods of itch-control outside of cutting off his warts. He will speak with his physician about the bugs under his skin and/or the itching of his skin."	F 684		
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 observation, interview, and record review the provider failed to provide adequate supervision for 1 of 1 resident (20) to prevent actions of self-harm. Findings include:	F 689		

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1. IMMEDIATE JEOPARDY NOTICE

Notice of immediate jeopardy was given verbally and in writing on 6/27/24 at 2:12 p.m. to administrator A for F689 and director of nursing B for F689 Accidents related to the prevention of his self-harm.

*Observation on 6/25/24 of resident 20 in his room revealed he had multiple open areas, some of which were actively bleeding on his bilateral lower legs while holding a sharp instrument.
*Multiple staff interviews revealed they were aware that he had various sharp tools in his possession and used these sharps to cut himself to remove bugs he believed were under his skin.
*Record review of resident 20's care plan revealed he was allowed to have sharps he purchased in his possession to remove perceived bugs from his skin.

On 6/28/24 at 4:23 p.m., administrator A provided the survey team with a written plan for removal of the immediate jeopardy. The removal plan, after revisions, with guidance from the long -term care advisor for the South Dakota Department of Health, was approved by the survey team on 6/28/24 at 5:06 p.m.:

*"All sharps have been removed from [Resident 20's] room.
*Psychiatry, primary care provider and counselor have been notified of these changes for guidance in managing any adverse behavioral changes.
*[Resident 20] has been re-educated on hand hygiene, sharps in his room, infection prevention to include covering wounds.
*Updates to the care plan include removing sharps, offering tubi-grips for arms and lower legs

F 689

1. The DON and RN C removed Resident 20's sharps from his room on 6/27/24 and alcohol on 6/28/24. The DON and RN C educated Resident 20 on 6/27/24 that he could no longer keep any sharps in his room and that we would need to monitor this and remove any sharps that he may obtain. He signed an acknowledgement indicating he understood this on 6/27/24. CNAs were educated to check Resident 20's room each shift for sharps and document this on their flowsheet 6/28/24 and Nurses are doing random weekly checks in Resident 20's room looking for sharps and documenting on treatment sheet along with checking resident shopping bags upon return from shopping trips for any sharps. The care plan was updated on 6/27/24 by RN C to include one-hour checks while in facility for behaviors given resident's psychiatric history for 48 hours. Psychiatry Nurse Practitioner, Primary Care provider & Counselor were notified by RN C of these changes for guidance in managing any adverse behavioral changes; no further recommendations were received. The Center of Excellence for Behavioral Health in Nursing Facilities was contacted on 6/27/24 for advice by the CEO. They recommended he see Psychiatrist physician; referral made and appointment scheduled for 8/15/24. We also added a treatment order for nursing documentation for behavior/mood of Resident 20 daily. Resident 20's behavior documentation will be reviewed at weekly IDT meeting and PRN with adjustments to care/ treatment plan as warranted.
2. The DON, RN C and C.N.A's on duty checked all resident rooms for sharps on 6/27/24 and no sharps were found.

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F 689	Continued From page 20 for covering of wounds when leaving his room, handwashing education, wound assessment completed 6/27/24, one-hour check while in the facility for behaviors given resident psychiatric history for 48 hours then re-evaluate. *Center of Excellence for Behavioral Health in Nursing Facilities contacted with expected response within two business days. *6/28/24 Addendum, in addition to the skin/wound assessment completed on 6/27/24; on 6/28/24, director of nursing B spoke to [resident 20] about dressing changes. *Resident agreed to let nursing staff change dressing twice a day (BID). *Nursing staff will monitor for any signs of infection during BID dressing changes and notify the physician if any noticed. These will be documented on [resident 20's] treatment. *Nursing will remove soiled towels and washcloths when in his room providing dressing changes. This has been included in the treatment plan and added to the certified nursing assistant (CNA) flowsheet. *Resident was informed that he would not need to buy wound/dressing supplies. *Sharps removed from resident 20's room. *All other current resident rooms were checked for sharps and any of concern were removed. *6/28/24 addendum, they had discussed with [resident 20] that his bags would be checked upon return from shopping. *Resident signed previous acknowledgment form that he agreed to staff removing sharps that he may bring back. *Staff will conduct random weekly room checks and will chart in [resident 20's] chart as a treatment. *This has been added to [resident 20's] treatment plan and CNA flowsheet.	F 689	3. On 6/27/24 all staff were educated via OnShift to bring and report to charge nurse any sharps found in any resident's room for nurse to lock up in med room and nursing staff will complete a progress note on this finding. On 6/27/24 all staff were educated via OnShift to report any resident self-harm behavior including cutting to charge nurse for follow up and assessment. The Improvement Advisor revised the Admission agreement on 6/27/24 to add sharp items such as knives to the list of items not permitted in resident rooms. Resident family primary contacts were emailed by the CEO on 6/27/24 to state that for the safety of all residents and staff, prior to bringing any sharp items into the facility for a resident, please consult with facility staff. Staff were re-educated on these items in the Directed Inservice education beginning on 7/18/24. Any staff not available to complete inservice training by 7/31/24, will need to complete it before their next scheduled shift. 4. DON or designee will audit Resident 20's chart to ensure that the above items are being completed and documented by C.N.A. and nursing staff and following up immediately with any staff variances and will report results of audits to the monthly QAPI committee meeting beginning on 8/7/24 to determine further frequency of audits until sustained compliance. A check for sharps in resident rooms will also be added to quarterly environmental rounds and any variances will be reported to the DON immediately. The DON or designee will report at the monthly QAPI meeting beginning 8/7/24 if any sharps have been found on environmental rounds for a period of at least one year or until the committee determines sustained compliance.	7/31/24

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F 689	Continued From page 21 *They added a treatment order for nursing documentation for behavior/mood of resident 20 daily. *[Resident 20's] behavior documentation will be reviewed at weekly interdisciplinary team (IDT) meetings and as needed (PRN) with adjustments to care/treatment plan as warranted. *Admission packet updated regarding review of sharps for safety. *[Resident 20's] primary contacts have been re-educated on notifying staff prior to bringing/getting sharps items to resident via email. *[Resident 20] has been re-educated on proper hand hygiene for infection prevention and sharps. *Staff have been re-educated on sharps in rooms and planned review of infection prevention practices related to transmission through OnShift. *They receive this education annually at minimum. *A skills fair reviewing infection prevention is scheduled for July 9th and annually for staff. *Sharps restriction added to admissions packet. *Staff re-educated on infection prevention practices and safety of all residents related to sharps in resident rooms. *6/28/24 addendum, staff were educated on 6/27/24 through onshift message about the removal of sharps for any resident. *Additional education provided to nursing staff on 6/28/24 related to resident 20 returning from shopping, the need to look in resident 20's bags for any sharp objects that staff would need to remove and secure in the medication room, staff will reiterate to resident that he is not able to have those items in his room *PRN treatment order added to check bags upon returning from shopping outings. *Staff will also be educated on the weekly random	F 689		

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room checks that will be conducted on [resident 20's] room for sharps found, those items will be removed and secured in the medication room.
*Treatment order added to document these random weekly room checks for [resident 20], also added to CNA flowsheet to check room BID."

On 7/1/24 at 10:43 a.m., the survey team determined the immediacy was removed. After removal of the immediacy, the severity and scope was a level G.

2. Observation and interview on 6/25/24 at 9:29 a.m. with resident 20 revealed:
*He was sitting on the edge of his bed scratching at his leg.
*He had multiple open areas with some active bleeding on his bilateral lower legs and bandages on some of them.
*He was dressed in only boxers holding and was holding a wooden handled tool with a flat top type screwdriver in his hand with his leg crossed, with his right ankle on his left knee.
*There was a card table across from him that had two table lamps clamped to each side of it.
*Pouches were hanging below each lamp contained various tools, scissors and glasses and a magnifying glass.
*There was a white towel under his bare feet with dried blood on it and another lying to his left with dried blood on it.
*Bandage wrappers were on the floor by his feet.
*He stated his legs are better because he has been taking care of them.
*He stated he kept his tools in alcohol.
*He stated he had good medicine here but the nurse took it from him and said it was dangerous and he could not have it.
*He stated he was doing okay for the shape he

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F 689	Continued From page 23 was in. *He stated he was sad when he first had to come here and when first came to live there but no it was "not so bad." *His shower has two discolored towels on the floor that appeared to have been wet then dried multiple times and had what appeared to be dried blood on them. Interview on 6/25/24 at 4:00 PM CNA P in regards to resident 20 revealed: *He picked at his legs, and thought there was something under his skin. *Staff would take the tools he used to pick at his skin, but he would get them back. Interview on 6/26/24 at 4:15 p.m. with RN F in regards to resident 20 revealed he: *Had a picking disorder and could have sharps in his room. *Tried to cut bugs out of his skin. *Would not let any nurses take care of the open areas on his legs. *Had a brother or friend who was aware he cuts himself. *Was aware that staff had removed the sharp objects he used to cut himself. *Is independent and is allowed to leave the premises. *Would go to a store on public transit and buy what he wanted and would bring it back to his room. *He was aware that his sharps and cutting of himself were care planned. Telephone interview on 6/27/24 at 9:30 a.m. and 1:20 p.m. and with the regional long-term care ombudsman revealed. -She was not contacted by the provider and was	F 689		

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not aware of resident 20's situation.
-The Center of Excellence for behavioral health in nursing homes should have been contacted by the provider.

Interview on 6/27/24 at 12:25 p.m. with the behavioral counselor for the provider revealed she:
*Started seeing resident 20 in March of 2022.
-Initially because he was having suicidal ideations.
-He had lost his longtime girlfriend and had expressed if he had a gun he would end things.
-His primary hallucination was bugs under his skin but then it changed to psoriatic arthritis in June 2022.
The psychiatrist adjusted his medications and his cutting had decreased. Then he had some issues when applying for Medicaid and was questioned about his finances, which she felt caused him anxiety and increased his behavior of cutting.
-When his partner or his own health would decline he would have increased anxiety and cutting of himself. the issue of cutting gets worse.
-His vision is getting worse. She wasn't sure if that would increase his safety risk.
-He does not cause self-harm other than his belief of bugs in his body.
-He had denied having a plan of self-harm.
-She was aware of an instance of him having believed he had seen his long-term friend in his room after she had passed.
-He had acted angry or snippy with staff but was not aggressive with them.
-His cutting was not as regular when his friend was still alive.
-She stated some of his wounds such as the ones under the large bandages were from his leg having been caught on the edge of his bed. There

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F 689	Continued From page 25 was no incident report to support this. -She would see him every 4-5 weeks. -He had expressed in January 2024 that he felt more like living. Interview on 6/27/24 at 1:30 p.m. with RN K in regards to resident 20 revealed: *He had concerns regarding resident 20 and stated, "I can't believe he isn't septic with his cutting." *Resident 20 "had all kinds of sharps" from a "Hobby knife kit" he had bought from at a local store. -Nurses do not provide his wound care, he did his own. -RN K did not work resident 20's hall but was aware of his cutting behavior. -He said all of resident 20's wounds on his legs were from his cutting himself and he had no injuries from falls or scraping on his bed frame that he knew of. -He does not believe resident 20 would hurt anyone or himself intentionally, "he is just trying to get the bugs out of his skin, which there aren't any." -He was not aware of a list of what tools he had or a way to track what he brought back from outings. -He has had fewer visitors but RN K why. Interview on 6/27/24 at 1:45 p.m. and again at 2:05 p.m. with LPN L revealed: *She did not do wound care for resident 20 and she had concerns about him cutting himself. *She was not sure how many open areas he had. *There had been no pictures for documentation of his wounds. *There was no sharps inventory or count of how many sharps resident 20 had in his possession.	F 689		

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*She had concerns about his history of falls and the potential he could fall and be injured by a sharp object.
*She would organize his room due to her concerns, he would allow that, but he would tell her to not take anything.
*She stated the previous social worker was aware him cutting himself with the sharps he had.
*She stated that she does not participate in care conferences but has reported her concerns and all the management were aware of his cutting himself with the sharps he had in his room.
*He was not on any antibiotics but had an order for Neosporin to self-administer in his room.
*He has not been tested for infectious diseases.
*Certified nurse aides (CNA's) should report any new wounds or concerns.

Interview and observation on 6/27/24 at 1:40 p.m. with resident 20 revealed:
*He has eleven open areas on his inner lower left leg with four small bandages and his right lower inner leg had eight open areas with three large bandages.
*He stated the bandages are because "those I made bleed, so I put band-aids on them."
*He said he cleaned them himself but had not been educated by the facility staff on how to clean tools or his open areas.
-" I have a bottle of alcohol I clean my legs first, then use hot water, and then put Neosporin on them.
-A bottle of 91% alcohol was under his bed and was approximately a third full.
-He stated he used the alcohol to clean his "scalpels" a couple of times a day.
-There was no redness observed to the surrounding tissue of his visible open areas.

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Interview and observation on 7/1/24 at 9:05 a.m. with resident 20 revealed:
*He had tubi-grip (elastic tubular bandage) on his bilateral lower legs and stated, his wounds were better and he hoped they stayed that way. His mood was pleasant.
*There was a hand washing reminder sign in his room and bathroom.

Record review of resident 20's care plan dated 4/25/24 revealed.
*"Behavioral symptoms included cutting and or picking off warts and scabs on his skin. He utilizes scalpels he gets at the hardware store."
-He declines to follow physician recommended advice of no cutting warts off his skin, and will decline skin-care and other treatments at times needed to properly address his self-inflicted wounds (see delirium). He will regularly create or manipulate his own or facility items to "fix" them or create things (i.e. Using a belt for a strap on his wheelchair). He was encouraged not to create restraints for himself and to seek staff input before "fixing" facility property."
- "Long-term goal date of 7/29/24 noted, "he would decrease his use of sharps. He was able to keep sharps in his room, per his refusal to comply with Sanford policies and concerns for safety without sharps to pick at his skin (as he relies on dull/other unsanitary means to pick at his skin).
-He will not utilize scalpels in a way that puts his well-being or life into question.
-He will not harm himself outside of cutting off his warts/scabs.
-He will not harm or threaten others with his scalpels."
*"Approach date 6/23/21 noted, allow [resident 20] to have sharps in his room.
-Remove sharps with conversations regarding

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F 689	Continued From page 28 self-harm with these sharps. -Offer education in regard to safety/infection control as needed. -Notify the physician/registered nurse (RN) if statements of self-harm manifest. -Assess for pain and offer pain medications, as able, with thoughts of death-statements. As needed PRN1, PRN 2, PRN 3. -Discipline noted, all staff and social services." *"Long-term goal target dated 4/22/24 noted, that [resident 20] will have fewer episodes of refusing care. -Resident will consider physician-recommended interventions to treat what is causing ailments. -Resident will be more open to allowing RN's to treat open areas on his skin related to infection prevention." *"Approach start dated 4/27/20 noted, "redirect resident as needed. -Ask for help or re-approach if resident becomes abusive or resistive. -Keep environment calm and relaxed. -Remove from public area when behavior is unacceptable. -Document refusal of care when it occurs. -Assist in applying antibacterial creams and appropriate dressings for open area to the skin, PRN. -Ask RN's to assist in evaluating and treating wounds. As needed PRN 1, PRN 2, PRN 2. -Discipline noted, all staff, nursing and social services." *"Problem start date 6/23/21, environment noted, -[Resident 20] keeps sharps in is room related to behavioral concerns/delusions of bugs in his skin. -As long as there is no self-harm ideation/intent, he is able to have these in his room due to resident rights and continued non-compliance with having them removed. (similar care plan	F 689		

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F 689	Continued From page 29 noted under behavioral symptoms) -[Resident 20] is sensitive to others touching items in his room, even for infection control reasons. He sternly requests that he is consulted before environmental services (ES) deep-cleans his room, as he is not compliant with this task and has had verbal interactions with ES and others before over items in his room being tidied/moved. -He likes to be in charge of where his dirty clothes go and often keeps paints on tables that are still clean and has his wallet and things in it. It has been care planned that he will have a laundry basket in his room to put his dirty clothes in and staff will take the clothes from the basket only to wash. -He will independently buy items at Walmart related to his delusions of bugs. He has no cognitive impairment and is self-sufficient enough to go out and about to purchase his own things. Education has been provided to to him on the safety of certain pesticides and those items have been removed but it causes more agitation for him." *"Long term goal target date 2/8/24 noted, [resident 20] will be able to keep sharps in his room, per his refusal to comply with Sanford policies and concerns for safety without sharps to pick at his skin (as he relies on dull/other unsanitary means to pick at his skin when sharps are not available). -He will not utilize scalpels in a way that puts his well-being or life into question. -He will not harm himself outside of cutting off his warts/scabs. -He will not harm or threaten others with his scalpels. -He will be accepting of the removal of sharps from his room if there is question of self-harm or harm to other with these utensils.	F 689		

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F 689	Continued From page 30 *[Resident 20] will work with ES and certified nursing assistants (CNA's) to keep his room somewhat tidied and disinfected. -He will refrain from verbal interactions with other over his room cleanliness. _he will be understanding of the basic infection control measures that have to be taken with is room, in reference to bloodied or dirty cloth items and other unsanitary items on the floor of his room. -He will put his dirty clothes in the laundry basket provide for ES to know what is dirty and what is clean. -He will be aware of certain pesticides that he brings into his private room and sue them with caution." *"Approach start date 6/23/21 noted, allow [resident 20] to have sharps in his room. -Remove sharps with conversations regarding self-harm with these sharps. -Offer education in regard to safety/infection control as needed. -Notify physician/RN if statements of self-harm manifest. -Assess for pain and offer pain medications, as able, with thoughts of death-statements. -Consult with resident prior to deep-cleaning his room. -Help mediate infection control needs and resident rights between resident ES staff. -Help to remove unsanitary cloth items as they are seen, and replace them with unsullied linens/washcloths/towels. -Staff will be respectful to only grabbing the dirty clothes out of his laundry basket to clean. -Staff will be respectful and continue to educate [resident 20] on the dangers of some of the pesticides that he purchases and has in his room. -As needed, PRN 1, PRN 2, PRN 3.	F 689		

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F 689	Continued From page 31 -Disciplines, all staff and social services." *"Problem start date 1/6/20 noted, delirium, [resident 20] believes there are microscopic bugs under his skin. -He believes this is why his skin itches and, possibly why he gets warts -He cuts off his warts and scabs to stop the itching from the bugs under his skin. (see behavioral symptoms)." *"Long term goal target date of 4/22/24 noted, [resident 20} will utilize other methods of itch-control outside of cutting off his warts. He will speak with his physician about the bugs under his skin and/or the itching of his skin." *"Approach start date 1/7/20 noted, Help communicate [resident 20's] concerns about itchiness and bugs to his physician as needed. -Help to apply anti-itch lotion as prescribed. -Encourage scratching/patting his skin as a way of itch-control as needed. -Utilize frequent checks if he is utilizing his scalpel to cut off warts or scabs. *Discipline noted, all staff and social services." *"Problem start date 12/02/19 noted visual function. -[Resident 20] has impaired vision and utilizes corrective lenses for reading activities. -Per [resident 20], an optometrist visit in 2020 relays that he is slowly losing his eyesight, and may be absent of useful vision in the future." *"Long term goal target date of 7/29/24 noted, resident will have optimal ability. -He will utilize glasses/corrective lenses as preferred. -He will be accepting of staff assistance in managing glasses, as able and as needed." *"Approach start date 12/2/19 noted, visual aides. -Keep glasses clean and encourage use. -Keep glasses readily available.	F 689		

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F 689	Continued From page 32 -Adequate lighting in room. -Encourage activities appropriate for visual acuity. -Optometrist visits as needed. -Monitor for appropriate navigation of small objects related to possibly losing vision in his eyes. -As needed, PRN 1, PRN 1, PRN 3. *Discipline noted, all staff and social services."	F 689		
F 812 SS=D	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, record review, and policy review, the provider failed to maintain the temperature of the memory care unit (MCU)'s pantry refrigerator below 41 degrees Fahrenheit (F). Findings include:	F 812	1. No specific resident affected. The Director of Nutrition Services placed a new thermometer in the refrigerator in the North unit (memory care unit) pantry on 6/26/24. The DON placed a temperature log on the refrigerator on 6/26/24. 2. Only residents on our North unit for dementia/locked wing affected. Other refrigerators in the facility were checked by the DON and RN C on 7/17/24 and no issues found. 3. The DON updated the night nurse task sheets with directions to check the North unit refrigerator temperatures and document on the June form she placed on the refrigerator on 6/26/24. The DON educated the night nurse 6/27/24 and all nurses on 7/9/24 via read and sign that the night nurse duties include checking the north unit's refrigerator temperature recordings each night. The DON also posted on 7/9/24 a reminder poster on the refrigerator/freezer in the North unit pantry that states to keep the thermometer in the back of the refrigerator and freezer and make sure the door is shut. The day shift med aide is to document the daily temperatures on the temperature log on the clipboard with the night nurse double checking that it is done and to turn the log into the DON at the end of each month. On 7/17/24 the DON placed a reminder note on the North unit medication cart for the med aides to check and document the North unit pantry's refrigerator and freezer temperatures daily.	

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F 812	Continued From page 33 1. Observation on 6/25/24 at 3:33 p.m. of the MCU's pantry refrigerator revealed: *The thermometer inside the refrigerator read 46 degrees Fahrenheit (F). *The Refrigeration Temperature Log located on a clipboard hanging on the wall next to the refrigerator had no documented refrigerator temperatures for December 2023 and no other monthly logs were found. *Contents of the MCU's pantry refrigerator included: -Numerous eight fluid-ounce soda cans. -Six opened 48-ounce containers of juice labeled "Refrigerate after opening." -Three four-ounce Mighty Shakes labeled "Thaw at or below 40 degrees F. Use thawed product within 14 days. Keep Refrigerated." 2. Interview on 6/25/24 at 3:40 p.m. with certified nursing assistant (CNA) I revealed she: *Had not normally worked on the MCU. *Was not sure whose responsibility it was to record the fridge's temperature. *Was not sure how long the mighty shakes had been in the fridge. 3. Observation on 6/26/24 at 9:18 a.m. revealed: *The thermometer inside the MCU's pantry refrigerator read 50 degrees F. *The Refrigeration Temperature Log located on a clipboard hanging on the wall next to the refrigerator had no documented refrigerator temperatures for June 2024. 4. Interview on 6/26/24 at 10:30 a.m. with director of nursing (DON) B revealed: *The night nurses' responsibilities included to check the refrigerator temperatures on the	F 812	OnShift education sent to nursing/med aide staff on 7/23/24 by Clinical Care Leader to educate nursing and med aides on this process; will also orient new nursing and med aide staff on this process. 4. The DON or designee will check the temperature log in the North unit pantry weekly to ensure there are no gaps in documentation and that temperatures will be less than 41 degrees Fahrenheit for the refrigerator and the freezer temperature are at or below 5 degrees Fahrenheit or will follow up with the staff who was on that day for additional one on one education. The audit will be completed 2x weekly for 4 weeks, weekly for 4 weeks, and monthly for 3 months. The DON or designee will report results of this audit at the monthly QAPI meeting beginning on 8/7/24 to determine further frequency of audits until sustained compliance.	7/31/24

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	43A098	A. BUILDING ______ B. WING ______	C 07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD CARE CENTER VERMILLION	125 S WALKER STREET VERMILLION, SD 57069

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F 812	Continued From page 34	F 812		

nursing units which included the MCU's pantry refrigerator.
*She would have expected the refrigerator temperatures to be between 32 and 41 degrees F.
*She agreed the 6/25/24 refrigerator temperature of 46 degrees F and the 6/26/24 refrigerator temperature of 50 degrees F was too warm to adequately refrigerate food items.

5. Interview on 6/26/24 at 12:28 p.m. with DON B revealed:
*A new thermometer was placed in the MCU's pantry refrigerator.
*She provided and explained she had updated the Night Nurse Tasks sheet that day with directions to "Check North Fridge Temp (record on form)."
*She clarified the North nursing unit was the MCU.
*She agreed refrigerator temperature checks had not been completed for the months of December 2023 through May 2024 as she had no completed Refrigeration Temperature Logs in her office and was not sure where else the completed logs could have been.

6. Observation and interview on 6/26/24 at 2:16 p.m. with certified nursing assistant (CNA) I revealed the MCU's pantry refrigerator had a new thermometer that read 44 degrees F. CNA G adjusted the dial inside the refrigerator to make it colder and stated she would recheck the temperature later that day.

7. Observation on 6/26/24 at 3:28 p.m. revealed the thermometer inside the MCU's pantry refrigerator read 40 degrees F.

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F 812	Continued From page 35	F 812		

8. Observation on 6/27/24 at 7:35 a.m. of the MCU's pantry refrigerator revealed:
*The thermometer inside the refrigerator read 32 degrees F.
*The documented temperature on the Refrigeration Temperature Log form for 6/26/24 was 38 degrees F.

9. Observation on 7/1/24 at 11:05 a.m. of the MCU revealed:
*The thermometer inside the pantry refrigerator read 40 degrees F.
*The posted June 2024 Refrigeration Temperature Log form had documented temperatures for that pantry refrigerator:
-For 6/26/24: 38 degrees F.
-For 6/27/24: 34 degrees F.
-For 6/28/24: 33 degrees F.
-For 6/29/24: 32 degrees F.
-For 6/30/24: 33 degrees F.
*A new Refrigeration Temperature Log form had been started for July 2024.

10. Interview on 7/1/24 at 3:58 p.m. with DON B revealed she had discussed the task of monitoring the MCU's pantry refrigerator temperatures in person with the night nurse the morning of 6/27/24 and had emailed the nurses on staff educating them that the nurses' night shift duties included monitoring the MCU's pantry refrigerator temperatures.

11. Review of the provider's 12/25/23 Refrigerator for Patient Food, Use Care and Monitoring-Vermillion policy revealed:
*Purpose: "To ensure clean, proper and safe storage of refrigerated and frozen food in clinical areas ...To establish temperature ranges for the safe storage of refrigerated food items."

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F 812	Continued From page 36 *Policy: "Refrigerator and freezer temperatures will be monitored and logged." *Procedure: -"Monitor and log food refrigerator temperatures at least daily, maintaining temperatures at or below 41 degrees Fahrenheit or 4 degrees Celsius. -"If refrigerator/freezer temperature exceeds the upper or lower range limits take the following action:" --"Staff should adjust refrigerator/freezer thermostat. Document adjustment under comments section on log." --"Check and document temperature again in approximately 1 hour. If temperature is still out of range, contact Maintenance. Maintenance determines if the refrigerator can be repaired or replaced.	F 812		
F 838 SS=F	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 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	F 838		

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F 838	Continued From page 37 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, 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.	F 838	1. No specific residents affected. 2. All residents have the potential to be affected. 3. The CEO, DON, RN C and Improvement Advisor created a Vermillion-specific Facility Assessment tool to evaluate our resident population including diagnoses of residents to identify the resources such as staffing and equipment needed to provide the necessary person-centered care and services the residents require was on 7/9/24. This tool will be evaluated and updated as necessary but at least annually. Vermillion-specific staffing resources were added to the document which included calling staff not scheduled, using staff from other departments, using administrative staff/nursing leaders, using Sanford/GSS float pool and staffing agencies. 4. The DON or designee will conduct a random audit for 5 months to check on days when there are staffing challenges to identify the staffing resources used to fulfill the staffing needs. The DON or designee will report results of this audit at the monthly QAPI meeting beginning on 8/7/24 to determine further frequency of audits until sustained compliance.	7/31/24

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F 838	Continued From page 38 §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to ensure the facility assessment had addressed the staffing resources needed to ensure appropriate care and services were available to the residents. Findings include: 1. Review of the provider's undated facility assessment revealed: *The assessment did not address their resources for staffing needs. *The assessment was an eleven-page excel spreadsheet that included: -An overall monthly trending analysis of census that indicated it was a 64-bed nursing facility that had. --One dementia care unit of 12 beds. --General units of 52 beds combined. --A January through May overall census average of 58. -A Physical Function and Care Needs analysis of residents including: --Assistance needed with bathing, dressing, transferring, toilet use, eating, and mobility. --Bowel and bladder status. --Cognitive disabilities. --Skin integrity. --Cultural sensitivity, religious and ethnicity care recognition. --Communication. --Conditions. --Medication use. --It had not specified how many staff were needed to care for the residents or how they would have been scheduled/assigned.	F 838		

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F 838	Continued From page 39	F 838		

-A Medical Diseases and Conditions analysis of residents including those with diagnoses of:
--Cancer.
--Heart/Circulation.
--Gastrointestinal.
--Genitourinary.
--Infections.
--Metabolic.
--Musculoskeletal.
--Neurological.
--Nutritional.
--Psychiatric/Mood Disorder.
--Pulmonary.
--Vision.
--It had not specified how those diagnoses would have impacted their care needs such as how much assistance the residents would have potentially required from the staff.
*There had been no mention of:
-The usual amount of assistance required by the residents based on their medical and mental health diagnoses.
-How the facility would have been staffed to ensure the residents' care needs were met.

Interview and facility assessment review on 7/1/24 at 4:27 p.m. with director of nursing (DON) B and Minimum Data Set (MDS) nurse C revealed:
*The eleven-page excel spreadsheet was their facility assessment.
*They agreed the assessment had not included or addressed their staffing needs.

Interview and facility assessment review on 7/1/24 at 4:46 p.m. with administrator A revealed:
*She confirmed the eleven-page excel spreadsheet was their facility assessment.
*She stated they did not have a connecting piece

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F 838	Continued From page 40 between the spreadsheet and the staffing needed to ensure appropriate care and services were available to the residents, including the competencies (knowledge and skills) needed of staff to meet the needs of the residents. *There was no specific policy on the process for the facility assessment.	F 838		
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, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880	1. Resident 48 had potential to be affected; no negative outcome. RN F (is actually an LPN) was educated by CLDS on proper glucometer cleaning process and completed competency on it with her on 7/9/24. 2. All residents who have blood sugars checked by staff could potentially be affected. No identified concerns. 3. Glucometer cleaning process changed to be completed with the super Sani-wipes (purple top) that have the two-minute contact time for disinfection on 7/9/24. All nursing staff were re-educated on proper glucometer cleaning process via DON's read and sign education put out on 7/9/24. CLDS began completing glucometer cleaning competencies with all remaining staff on 7/18/24. Any staff not available to complete glucometer cleaning competency and education by 7/31/24 will need to complete it before their next scheduled shift. 4. An audit of staff performing glucometer cleaning will be done by the DON or designee 2 x week for 4 weeks, then 1 x week for 4 weeks and then monthly for 3 months with report of results to the monthly QAPI committee meeting beginning on 8/7/24 to determine further frequency of audits until sustained compliance.	7/31/24

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F 880	Continued From page 41 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, policy review, and manufacturer's instructions	F 880		

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review, the provider failed to clean and disinfect one of one community shared blood glucose meter for two of two sampled residents (44 and 48) that resulted in a potential increased risk for bloodborne pathogen infections. Findings include:

1. Observation and interview on 06/25/24 at 4:02 p.m. and 4:18 p.m. with registered nurse (RN) F revealed:
*RN F completed a blood glucose check for resident 44.
*She then wiped the blood glucose meter with a gray top Sani-cloth (germicidal) wipe and placed the blood glucose meter on the medication cart.
*RN F stated that glucose meter was to be first wiped off with a wipe to clean visible blood or fluids off the glucose meter and then with another one to wet it and let it dry for two minutes.
*She did not know if there was a policy on how to clean a glucose meter.
*She used that same blood glucose meter to check resident 48's blood glucose and again wiped it with a gray top Sani-cloth wipe and placed it on the medication cart.

2. Interview on 6/27/23 at 8:40 a.m. with RN/ clinical learning and development specialist D regarding the blood glucose meter cleaning and disinfecting procedure revealed:
* She stated the glucose meter cleaning process involved wiping off any visible blood/fluid with a wipe and then another wipe to wet it and let it dry.
*She stated that the dry time was different. If staff used a purple top Sani-cloth the dry time was two minuets or the gray top Sani-cloth dry time was three minutes.
*She admitted that the glucose meter should have been cleaned per the directions on the gray top Sani-cloth wipe container.

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F 880	Continued From page 43 *She admitted that the glucose meter could not stay wet for either the two or three minute contact time by just wiping it and placing it on the medication cart as observed above. 3. Interview on 07/01/24 at 11:38 a.m. with director of nursing (DON) B revealed, she would have expected staff to follow the proper process to clean the glucose meter and use the correct contact time for the wipe used. 4. Review of the provider's 1/31/24 Blood Glucose Monitoring Disinfecting and Cleaning-R/S (Rehabilitation/Skilled Care), LTC (Long-term Care) policy revealed: *The policy referred to CMS requirements and best practices, that indicated blood glucose meters should have been cleaned and disinfected after each resident use whether the meter was assigned to a resident or shared among residents. *The policy referred to the user manual for specific instructions for each meter. *"Cleaning procedure: -2. Cleaning and disinfecting can be completed by using a commercially available EPA-registered disinfectant or germicide wipe. -4. Remove the wipe from container and follow the label instructions to disinfect the meter". 5. Record review of the provider's StatStrip Glucose Hospital Meter user's manual revealed: *"Dilute Bleach. A 10% solution of household bleach (Sodium Hydrochloride) may be used. *70% Isopropyl (rubbing) alcohol may be used. *Commercial surface decontamination preparations that are approved for use by your facility can be used. Apply to a small test area first to ensure surface finish integrity.	F 880		

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F 880	Continued From page 44 *Avoid harsh solvents such as benzene and strong acids". 6. Review of the Sani-Cloth container lable regarding directions for use revealed: *"To clean, disinfect and deodorized hard, nonporous surfaces: -Surface to remain wet for three (3) minutes. *Contact time: -Allow surface to remain wet for three (3) minutes".	F 880		

PRINTED: 07/16/2024
FORM APPROVED

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
	10697	A. BUILDING: ______ B. WING ______	06/27/2024

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 6/25/24 through 6/27/24, and on 7/1/24. Sanford Care Center Vermillion was found in compliance.	S 000		

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

CEO 07/17/2024

STATE FORM 6899 6DD511 If continuation sheet 1 of 1

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

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	43A098	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	06/25/2024

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SANFORD CARE CENTER VERMILLION	125 S WALKER STREET VERMILLION, SD 57069

(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
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 6/25/24. Sanford Care Center Vermillion was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO	07/17/2024

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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.

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

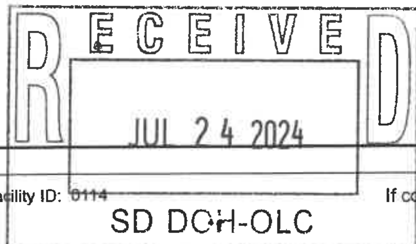
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A098	A. BUILDING ______ B. WING ______	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD CARE CENTER VERMILLION	**125 S WALKER STREET** **VERMILLION, SD 57069**

(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
E 000	Initial Comments 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 on 6/25/24. Sanford Care Center Vermillion was found in compliance.	E 000		

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

[signature], CEO 07/17/2024



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