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

PRINTED: 11/19/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435062	A. BUILDING ______ B. WING ______	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALCESTER CARE AND REHAB CENTER, INC	101 CHURCH STREET ALCESTER, SD 57001

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F 000	INITIAL COMMENTS Surveyor: 26632 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 11/2/21 through 11/4/21. Alcester Care and Rehab Center, Inc. was found not in compliance with the following requirement(s): F604, F610, ,F625, F657, F658, F700, F755, F760, F801, F812, F880, F85, and F886.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical	F 604	Administrator, DON, and interdisciplinary team reviewed and revised as necessary the policy and procedure for documentation to support physical devices on 11/29/2021. Administrator will educate all staff on updated policy and procedure for physical restraints on 11/30/2021 and 12/2/2021.* TM 12/10/2021 Administrator and DON ** ~~will update the physical restraint assessment before a physical device is placed on a resident~~. TM 12/10/2021 Resident 20 and 21's medical records were updated and reviewed to include proper assessment of physical devices that could be considered restraints on 11/29/2021. All other residents medical records were reviewed and revised to include assessments when physical devices are used. Administrator or designee will perform audits on *** proper documentation of physical devices in care plans and facility assessments weekly for 4 weeks and monthly for two months. TM 12/10/2021 *PT who implemented strap no longer works at facility. Administrator or designee will educate other therapy staff on facilities policy on restraints on 12/13/2021. TM 12/10/2021 ***5 random residents to ensure TM 12/10/2021	12/4/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tiffany Miller

TITLE: Administrator

(X6) DATE: 12/10/2021 ~~11/29/2021~~

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.

DEC 10 2021

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F 604	Continued From page 1 symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Based on observation, interview, record review, and policy review, the facility failed to document medical symptoms for two of two residents (20, 21) with physical devices that could restrict their free movements. Findings include: 1. Observation on 11/2/21 at 9:00 a.m. of resident 20 while he was seated in a wheelchair in the dining room for morning exercises revealed: *A cushion in a pillowcase was set on top of the right wheelchair arm rest. *The resident's right arm was resting on top of it. *A buckled black strap was wrapped across the top of his right arm and under the arm rest holding his arm on the top of the pillow. Interview with the resident at that time about the strap revealed he had no comment on it. Review of the 9/19/21 quarterly minimum data set (MDS) assessment in resident 20's electronic medical record (EMR) revealed: *Limb restraint was checked as "not used." *The resident: -Had impaired range of motion on an upper extremity on one side of his body. -Was dependent on staff for all activities of daily living (ADL). -Had moderately impaired cognitive abilities. -Clearly understood conversations and was understood when he spoke.	F 604	Administrator or designee will present findings from these audits at the monthly QAPI committee for review until the QAPI committee advises to discontinue monitoring. **created physical restraint assessment on 11/30/2021 to include a physical document to use before placing certain devices on residents and educated staff on 11/30/2021 and 12/2/2021.	TM 12/10/2021

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F 604	Continued From page 2	F 604		

Review of the care plan focus for limited range of motion of right upper extremity, initiated on 10/2/20 and revised on 9/29/21, revealed neither the cushion nor the black strap were listed as interventions.

Observation on 11/3/21 at 11:16 a.m. revealed certified nursing assistant (CNA) DD picked the arm rest cushion off the dining room floor and placed it under resident 20's right arm. The black strap was not in place.

Interview on 11/3/21 at 3:20 p.m. with interim director of nursing (DON) and MDS coordinator B revealed:
*Therapy had recommended the cushion for positioning of his arm.
*She had never seen a black strap being used.
*They do not have a documented assessment of the strap as a potential restraint.

Interview on 11/4/21 at 12:45 p.m. with interim DON/MDS coordinator B revealed she learned that activity director EE put the black strap on the resident on 11/2/21.

Interview on 11/4/21 at 12:57 p.m. with activity director EE revealed:
*The therapist instructed her how to put the black strap on.
*She took photos to show others how to put the strap on.
*The photos were posted in resident 20's room.

Observation at that time with activity director EE revealed three photos hanging on the wall in resident 20's room.

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2. Observation of resident 21 revealed:
*On 11/2/21 at 9:15 a.m., she was lying in bed on her back with a positioning alarm clipped to her gown on her left side. The resident was awake, talking nonsensically while looking at the wall, moving her legs up and down under her covers.
*On 11/2/21 at 1:00 p.m., she was at the nurses desk with eyes closed in a reclined position with feet on the floor in a wheelchair that had a padded full upright back supporting her head while she was humming along with music playing through headphones.
*On 11/3/21 at 11:20 a.m., she was sitting in the same wheelchair at the dining room table and rocking back and forth in it. A positioning alarm was clipped to her shirt on the left side.

Review of resident 21's care plan in her EMR revealed the following focuses but did not specify the use of a reclining wheelchair nor the use of a positioning alarm in bed:
*Resident wanders aimlessly, initiated on 7/8/21.
*ADL self-care performance deficit, initiated on 8/30/21.
*Actual fall with a minor injury, initiated on 7/21/21, with interventions initiated on 10/1/21:
-May require the use of a wheelchair.
-While in a wheelchair, staff were to use an "alarm at all times for safety & [and] to notify staff during self-transfers."

Review of incident progress notes in the EMR revealed resident 21 had fallen on:
*6/30/21 at 4:05 a.m., an unwitnessed fall with a cut above her left eye.
*8/30/21 at 10:15 a.m., an unwitnessed fall with resident found "scooting on her bottom" across the floor in her room.
*9/13/21 at 2:10 a.m., a witnesssed fall in the

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dining room when resident tripped over the foot rest of another resident's reclining chair.
*9/23/21 at 1:20 p.m., an unwitnessed fall with resident found "scooting on her bottom" across the floor in her room.
*9/23/21 at 2:55 p.m., an unwitnessed fall in the hallway. She appeared "weaker with ambulation and leaning more to the left." "Will obtain a rocker WC [wheelchair]...due to weakness and leaning."

Review of the 9/19/21 quarterly MDS assessment revealed:
*"Chair prevents rising" and alarms for bed and chair were each checked as "not used."
*Mobility devices, such as a walker or wheelchair, were not checked as "used."
*The resident:
-Had fallen before that MDS was completed.
-Needed guided assistance with transferring and walking.
-Had severely impaired cognitive abilities.

Review of the EMR also revealed an "in progress" significant change MDS dated 11/1/21.

Interview on 11/3/21 at 2:03 p.m. with social services designee (SSD) X revealed:
*There seemed to be a "sudden change" recently with the resident's gait from walking to small steps to shuffling.
*The "rocker wheelchair" keeps her from getting up and the rocking seems to be a "calming" movement for her.

Interview on 11/3/21 at 3:20 p.m. with interim DON/MDS coordinator B revealed:
*There were no assessments of the positioning alarm and rocker wheelchair as potential restraints.

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F 604	Continued From page 5 *They did not have a tool for assessment of potential restraints. Interview on 11/3/21 at 4:49 p.m. with interim DON/MDS coordinator B confirmed the care plan in the EMR was current through 12/29/21.	F 604		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on interview, record review, and policy review, the facility failed to investigate an incident of alleged abuse that involved two sampled residents (4 and 14). Findings include: 1. 1. Review of residents 4's and 14's medical record revealed a interdisciplinary notes revealed: *On 7/31/21 at 6:32 p.m. "Resident [4] is found	F 610	Unable to timely report Resident 4 and 14's incident due to requirement of reporting within five days of alleged violation. All other residents can be affected by this deficient practice. Policies and procedures for incident reporting reviewed and revised by Administrator, DON, and interdisciplinary team on 11/29/2021. Administrator or designee will educate all staff on updated policy and procedure for incident reporting within the facility on 11/30/2021 and 12/2/2021. *Administrator or designee will perform audits on all incidents within the facility weekly for 4 weeks and monthly for two months. TM 12/10/2021 Administrator or designee will present findings from these audits at the monthly QAPI committee for review until the QAPI committee advises to discontinue monitoring. *DON or designee is in charge of doing all initial and final reporting to the state. TM 12/10/2021 Administrator or designee will ensure all incidents are reported in a timely manner.	12/4/2021

F 610 Continued From page 6 F 610

sitting in tv area next to a female resident holding her unclothed breast. Resident did not appear to be making any further advancements and does not appear distressed about the situation but was separated from the other resident. ADON [assistant director of nursing] and Administrator notified."
*On 7/31/2021 at 6:29 p.m. "Resident [14] is found sitting in tv area with shirt unbuttoned next to another male resident while he was holding her breast. Resident did not appear to be distressed about the situation but was separated from the other resident. ADON and Administrator notified."
*Continued review of residents 4 and 14's progress notes revealed their representative and physicians had not been notified of the above incident.

Interview on 11/3/21 at 12:58 p.m. with administrator A revealed she had not reported the above incident to the SDDOH. That was because resident's 4 and 14 had not appeared upset about the incident she did not feel it was necessary.

Interview on 11/3/21 at 2:00 p.m. with interim director of nursing (DON)/ Minimum Data Set (MDS) coordinator B stated she had not remembered having been contacted regarding the above incident. She had not been involved with the investigation.

Review of the investigation documentation provided by administrator A revealed:
*On 7/31/21 at 6:00 p.m. "Nurse called due to [resident 4] touching [resident 14] breast while shirt was unbuttoned. Educated nurse to separate the residents and monitor throughout the evening to observe any further direction towards each

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F 610	Continued From page 7 other." *"Investigated [investigation] conducted by asking nurse about incident. Nurse stated they were in the lobby, both smiling and pleasant, not in distress. They both were easily separated and asked if anything was wrong. Both were pleasant about situation." *"When resident residents were checked on later, they did not seem unusual in any sense." *"Residents have been living across the hall in the same facility for 3 years, have never made accusations for/against one another." *"8/6/21Two residents have not had any further accusations since incident." Review of the provider's revised 5/19/21 Abuse, Neglect, and Exploitation policy revealed: *"All reports of abuse, neglect, and exploitation will be taken seriously with a thorough evaluation." *"The department of Health will be informed within 24 hours by Administrator, Director of Nursing, or Social Worker." *"Facility Ombudsman will be contacted by Social Worker." *"The police may be contacted at the discretion of the Administrator." *"Family will be notified by Administrator, Director of Nursing, or Social Worker	F 610		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to	F 625	Resident 33's medical records cannot be timely updated to include the bed-hold form. All other residents will be updated on bed-hold policy. Administrator and interdisciplinary team reviewed and revised as necessary notice of the bed-hold policy and procedure. Administrator or designee will provide education on the bed-hold policy to all nurses on 11/30/2021.	12/4/2021

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F 625	Continued From page 8 the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Based on interview and record review, the facility failed to provide notice of bed hold for one of one residents (33) discharged to the hospital. Findings include: 1. Review of progress notes for resident 33 in the closed electronic medical record (EMR) revealed a pattern of increasingly aggressive behaviors that put other residents at risk for injury and resulted in injury to some staff. (Refer also to F760, finding 1). A behavioral expression note on 10/21/21 stated orders were received to transfer the resident to	F 625	Administrator or designee will do audits to ensure bed-hold forms are completed weekly for four weeks and monthly for two months* ~~and~~ ** will report the results of the audits to the monthly QA committee until the QA committee advises to discontinue monitoring. *or weekly until at least one successful implementation of the policy is executed to ensure proper procedure is being followed. **Administrator or designee TM 12/10/2021	TM 12/10/2021 TM 12/10/2021 TM 12/10/2021

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F 625	Continued From page 9 the emergency room for "evaluation due to increased behaviors and aggression." There was no progress note in the EMR documenting notification of the bed hold policy to the resident's representative. Interview on 11/4/21 at 1:07 p.m. with administrator A, interim director of nursing (DON)/minimum data set (MDS) coordinator B, and business office manager GG revealed: *No bed hold form had been completed. *They held the bed for five days. *The resident's representative told the interim DON/MDS coordinator B today that the resident will not be coming back.	F 625		
F 657 SS=F	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657	Resident 20's care plan was updated to include the use of the cushion and black strap as interventions on 11/29/2021. Resident 21's care plan was updated to specify the use of a reclining wheelchair and positioning alarm in bed on 11/29/2021. Resident 18's care plan will be updated to include communication needs and the discharge plan. Unable to update timely for physical devices and behavioral management with respect to wandering as resident 33 discharged. Resident 25's care plan will be updated to include the use of bed rails. Resident 22's care plan will be updated for the use of assistive devices with transferring, antipsychotic use, antidepressant, along with goals and interventions will be updated.	12/4/2021

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F 657	Continued From page 10 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Based on observation, interview, record review, and policy review, the facility failed to revise the care plans to address: *The use of physical devices to reduce the risk of falls for three of four sampled residents (20, 21, and 33). *Communication needs and discharge plan for one of one sampled resident (18). *Behavior symptoms for one of three sampled residents (33). *The use of bed rails for one of six sampled resident (25) with bed rails. *Risk of accidents related to wandering for one of three sampled residents (33). *The use of assistive devices with transferring for one of one sampled resident (22). *Pressure ulcer healing for one of one sampled resident (25). Findings include: 1. Observation on 11/2/21 at 9:00 a.m. of resident 20 while he was seated in a wheelchair in the dining room for morning exercises revealed: *A cushion in a pillowcase was set on top of the right wheelchair arm rest. *The resident's right arm was resting on top of the pillowcase. *A buckled black strap was wrapped across the	F 657	Resident 25's care plan will be updated to contain pressure ulcer healing. All other residents care plans were update to include, but not limited to, physical devices, communication needs and discharge, behavior symptoms, risk of accidents, bed rails, and use of assistive devices with transferring. All addressed care plans will be updated on 11/30/2021 by MDS coordinator. DON and interdisciplinary team review and revised, as necessary, the policy and procedure ensuring complete and accurate care plans. DON or designee will provide education to all staff responsible for creation, review, and revision of resident care plans, including, but not limited to physical devices, communication needs and discharge, behavior symptoms, risk of accidents, bed rails, and use of assistive devices with transferring. 11/30/2021 and 12/2/2021. DON or designee will perform audits on care plans to reflect current but not limited to physical devices, communication needs and discharge, behavior symptoms, risk of accidents, bed rails, and use of assistive devices with transferring for 5 residents once per week for four weeks and monthly for two more months. DON or designee will present findings from these audits at the monthly QAPI meetings for review until the QAPI committee advises to discontinue monitoring	

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top of his right arm and under the arm rest holding his arm on the top of the pillow.

Review of resident 20's electronic medical record (EMR) care plan focus for limited range of motion of the right upper extremity, initiated on 10/2/20 and revised on 9/29/21, revealed neither the cushion nor the black strap were listed as interventions.

(Refer also to F604, finding 1.)

2. Observation of resident 21 revealed:
*On 11/2/21 at 9:15 a.m., she was lying in bed on her back with a positioning alarm clipped to her gown on her left side. The resident was awake, talking nonsensically while looking at the wall, moving her legs up and down under her covers.
*On 11/2/21 at 1:00 p.m., she was at the nurses desk with eyes closed in a reclined position sitting in a wheelchair that had a padded full upright back supporting her head while she was humming along with music playing through headphones.
*On 11/3/21 at 11:20 a.m., she was sitting in the same wheelchair at the dining room table and rocking back and forth in it. A positioning alarm was clipped to her shirt on the left side.

Review of resident 21's care plan in the electronic medical record (EMR) revealed the following focuses did not specify the use of a reclining wheelchair nor the use of a positioning alarm in bed:
*Resident wanders aimlessly, initiated on 7/8/21.
*Activities of daily living (ADL) self-care performance deficit, initiated on 8/30/21.
*Actual fall with a minor injury, initiated on 7/21/21, with interventions initiated on 10/1/21:

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F 657	Continued From page 12 -May require the use of a wheelchair. -While in a wheelchair, "TABS alarm at all times for safety & [and] to notify staff during self-transfers." Interview on 11/3/21 at 4:49 p.m. with interim director of nursing (DON)/minimum data set (MDS) coordinator B confirmed the care plan in the EMR was current through 12/29/21. (Refer also to F604, finding 2.) 3. Observation of resident 18 revealed: *On 11/1/21 at 5:20 p.m., he sat in his wheelchair outside the kitchen serving window. The cook asked him if he was ready for his supper tray. He responded with a slurred word and nodded his head. *On 11/2/21 at 4:12 p.m., the resident responded to questions with guttural sounds and body movements that indicated he understood. Review of resident 18's care plan in the EMR revealed: *A focus for communication problem, initiated on 3/2/21 and revised on 3/24/21, with a goal target date of 6/22/21 to improve communication by: -Making sounds. -Using appropriate gestures. -Responding to yes/no questions appropriately. -Using communication board. -Writing messages. *A focus initiated on 3/2/21 and revised on 3/24/21 that "family would like resident to remain" here, "discharge unknown at this time," and a statement regarding a "100 day PASRR (pre-admission screening, determined by the state) upon admission to facility," with: -A goal for surgical abdominal wound to heal	F 657		

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F 657	Continued From page 13 "before discharge is feasible." -An intervention to "establish a pre-discharge" and revise plan according to the state's "PASRR guidelines." Interview on 11/3/21 at 2:01 p.m. with social services designee (SSD) X revealed: *The staff do not need to use the communication board as they can understand resident 18's communication methods. *The 100-day PASRR limit was resolved and the state determined the resident needed long-term care. *She will get the care plan revised for both the communication board and reference to discharge related to the 100-day PASRR. Interview on 11/03/21 at 4:49 p.m. with interim DON/MDS coordinator B revealed: *She had multiple care plans that have been reviewed but she was behind getting the revisions in the EMR. *The care plan in the EMR for resident 18 is the current care plan, updated on 9/30/21 and through 12/30/21. Comparison review of the EMR care plan and a paper copy of it provided by interim DON/MDS coordinator B on 11/4/2021 revealed: *The communication board was still listed on both as part of resident 18's goal for communication. *The 100-day PASRR had been removed from the focus for remaining in the facility. 4. Closed record review of resident 33's progress notes between admission on 9/14/21 and his discharge to the emergency room on 10/21/21 revealed: *He was admitted with a cognitive decline and a	F 657		

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history of frequent falls.
*He attempted to exit the building in his wheelchair without supervision on 9/15/21.
*He needed assistance with repositioning and transferring safely due to his impaired cognition and impulsive attempts to transfer himself.
*His bed was in the lowest position with a pressure alarm and a fall mat on the floor beside his bed.
*The use of a wheelchair for mobility with pressure alarms when in his wheelchair.
*He was found in remote locations having a confrontation with other residents on 9/26/21 and 10/11/21.
*He had an unwitnessed fall on 10/11/21 at 7:35 a.m., when the staff responded to the wheelchair alarm and found the resident on his back on the floor in his room by the window.
*He had a near fall on 10/19/21 when staff responded to the alarm to find the resident standing on his wheelchair foot rests in his bathroom.
*A pattern of increasingly aggressive behaviors that put other residents at risk for injury and resulted in injury to some staff. (Refer also to F760, finding 1).

Review of the care plan initiated on 9/15/21 revealed no focuses, goals, or interventions related to:*Prevention of falls, nor revisions to address the unwitnessed fall on 10/11/21 and the near fall on 10/19/21.
*Assistance with daily living tasks.
*Behavior management related to cognitive impairment and how staff should approach him to minimize the risk of injury to the resident and staff related to his aggressive behaviors.
*Risk of wandering and exit seeking, nor revisions to address the three times, he was found in

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potentially unsafe locations.

Review of the admission MDS assessment dated 9/19/21 and signed as completed on 9/30/21 revealed:
*He had a fall in the last month before admission.
*Bed rail, bed alarm, and chair alarm were coded as used daily. The floor mat was coded as not used.
*He needed staff assistance of two or more persons for bed mobility, transferring, mobility, dressing, and using the toilet.
*No behaviors were coded.
*The resident scored as being moderately cognitively impaired.
*He reported having pain occasionally and gave an intensity rating of 5 out of a scale of 10.

The care plan was not revised after the MDS was completed to address the fall risk, preventive devices used, staff assistance, behavior management, nor pain management.

Surveyor: 43844
5. Observation on 11/2/21 at 9:45 a.m. of resident 22 revealed he had:
*Been sitting in a rocking wheelchair, in the dining room.
*A mechanical lift sling underneath of him.

Review of resident 22's medical record revealed his EMR care plan had not been updated since 9/29/21.

Interview on 11/4/21 at 10:38 a.m. with interim DON/MDS coordinator B regarding resident 22's care plan revealed she:
*Had a printed copy of his care plan from his EMR.

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-Had made changes to this printed care plan in writing.
-Agreed the written changes had not been updated in the EMR.
*Stated there was an internal communication book for staff to be aware of any changes to resident cares.
-Some of the information that had been included in the internal communication book had not been added to residents EMR.
*Had a 10/14/21 physical therapy communication on her desk.
-It stated, "Patient should have Hoyer [mechanical] lift strap underneath him at all times (in bed, wc [wheelchair], recliner, etc.) in case Hoyer is needed for safety with transfers. If Hoyer is not needed, patient can transfer with FWW [front wheeled walker] and/or EZ [mechanical] stand lift, whichever is safest for staff/patient at that time."
-This had not been included in his current written or EMR care plan.

Review of resident 22's current paper care plan revealed:
*It had been updated in writing to include:
*He had been a high risk for falls.
-He had fallen at the assisted living center before admission to this facility.
-His bed was to be left in a low position.
-He was to have had a pressure alarm on at all times.
-Keeping the mechanical lift sling under him while in a chair had not been on the care plan.
*Antipsychotic use.
-There had been no goals or interventions listed.
*Antidepressant use.
-There had been no goals or interventions listed.
*The electronic record had not been updated with

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F 657	Continued From page 17 this information. 6. Observation on 11/03/21 at 8:58 a.m. of resident 25 revealed he: *Had been in the hallway, sitting in his wheelchair. *Did not have foot pedals on the wheelchair. *Feet did not touch the floor. *Had on blue gripper socks. *Had not been wearing any leg braces. Interview on 11/03/21 at 9:03 a.m. with certified nursing assistant (CNA) DD revealed she: *Had started her employment at the facility, "A couple weeks ago." *Had thought she had access to residents care plans through the electronic medical records system, but was not certain. *Was not aware that resident 25 had leg braces. Interview on 11/3/21 at 9:07 a.m. with certified nursing assistant (CNA) DD regarding resident 25's leg braces revealed: *She had checked with a nurse and found out he did have leg braces. -The braces were not currently being worn due to his having a pressure ulcer on his right foot. --They would have been used to assist in transferring him. --She did not know how he transferred without the braces as she had not transferred him. Review of resident 25's current care plan revealed: *Staff were to assist him to put on leg braces before getting him out of bed. -There was nothing in the care plan about the braces not being used. *He had the potential for pressure ulcer development due to his obesity, immobility, and	F 657		

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diabetes.
-There was nothing in the care plan about currently having a pressure ulcer.

Interview on 11/4/21 at 10:40 a.m. interim DON/MDS coordinator B regarding resident 25's care plan revealed she:
*Thought he had been wearing, "Blue boots" as a protectant for the pressure ulcer on his right heel and to prevent one from developing on the left foot.
*Thought his heels should be, "Floated while in bed on a pillow."
-Agreed these interventions were not on his care plan.
-Agreed his using the braces had remained on the care plan and should not have been.

Surveyor: 45683
7. Observation on 11/2/21 at 10:13 a.m. of resident 25 revealed the bed had one siderail on the side of the bed nearest the wall in the up position.

Interview on 11/4/2021 at 2:45 p.m. with licensed practical nurse (LPN) M revealed:
*Resident 25 did have a siderail that he used for repositioning in bed and turning when he was being helped with personal cares.

Review of resident 25's medical record revealed:
*The quarterly MDS dated 10/10/21 was marked no for siderail use.
*There was no mention of siderail use in the care plan initiated 3/1/21. Under the focus for self-care performance deficit, the intervention for bed mobility does not include the bed rail.
*There was no documentation of a siderail assessment in the chart.

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F 657	Continued From page 19 Review of the provider's updated 11/8/18 Care Plan policy revealed: *Each discipline would update the care plan as changes occur between assessments and scheduled care conferences. Those disciplines included: -Social services. -Dietary. -MDS Coordinator. -Activities.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on interview, record review, and policy review, the provider failed to ensure professional standards of care had been followed for one of three sampled discharged residents (34). The resident had discharged against medical advice (AMA) and the provider's policy had not been followed. Findings include: 1. Closed record review of resident 34's closed record revealed: *On 9/13/21 at 1:10 p.m. a nurses progress note revealed: *Resident 34's daughter and his alternate power of attorney stated she was discharging him at that time. *Veterans administration medications were sent	F 658	Unable to update Resident 34's medical records as resident discharged on 9/13/2021. All other residents medical records were reviewed and revised to meet professional standards. Administrator, DON, and interdisciplinary team will review and revise as necessary the policy and procedure for professional standards to support a process for staff to follow when a resident discharges against medical advice.* TM 12/10/2021 DON or designee will do audits on any resident leaving AMA monthly for 3 months to ensure proper documentation and procedure is followed.** DON or designee will provide education to all staff responsible for enforcing the AMA policy on 11/30/2021 and 12/2/2021. DON or designee will present findings from these audits at the monthly QAPI committee for review until the QAPI committee advises to discontinue monitoring. *Staff responsible for against medical advice discharges will notify Administrator and/or DON to ensure policy and procedure was followed accurately. TM 12/10/2021	12/4/2021 TM 12/10/2021

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F 658	Continued From page 20 with at that time. Those medications included: -Metoprolol 45 tablets. -Potassium liquid-full bottle. -Tamsulosin 90 capsules. -Omeprazole 90 capsules. -Furosemide 45 tablets. -Amlodipine 30 - 1/2 tablets. -Quetiapine 30 - 1/2 tablets. -Vitamin D3 100 tablets. -Vitamin B12 100 tablets. -Trazadone 60 tablets. -Aspirin 81 milligram 120 tablets. -Magnesium oxide 120 tablets. *A copy of the medication administration record was sent with the daughter. *On 9/13/21 at 1:22 p.m. a social services progress note revealed: -"Residents daughter and alternate POA [power of attorney] presented at facility unannounced and went into resident's room without any facility witness and spoke with resident." -"OT [occupational therapist name] then came into writer's office and said to me 'Resident's daughter is here and said to me she is trying to take him out of the facility and said to me she is taking home.'" -"I then went to speak with the daughter and the daughter told me she is taking him out of the facility and there is no court order that deems resident incompetent." -"Resident then expressed verbally in front of myself, and DON [director of nursing], and administrator that he wishes to go home with daughter [name] after [daughters name] told him 'If you don't come home with me then you have to stay here forever so do you want to go home with me or stay here.'" *"At that point resident hesitated but then did ultimately say 'I want to go home.'"	F 658	**If no against medical advice discharges are within this three month period, it will be extended for another three month period. TM 12/10/2021	

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There was no documentation in resident 34's medical record that included:
*A "Leaving Hospital Against Medical Advice" form had been presented for the daughter or resident to sign.
*His physician had not been notified prior to him leaving. His physician had been notified by facsimile after he had already left.
*Of any attempt to have resident 34's daughter sign an AMA form.

Interview on 11/3/21 at 2:00 p.m. with interim director of nursing B revealed:
*Resident 34's daughter had not been provided with a "Leaving Hospital Against Medical Advice" form.
*There was no record of which dose of medication had been sent with resident 34.
*Agreed the AMA policy had not been followed.

Review of the provider's 12/10/09 AMA Release policy revealed:
*"When a resident or the resident's legal representative expresses the desire to leave the nursing facility before the attending facility before the completion of treatment or contrary to the advice of the attending physician."
*The procedure included:
-Notify the attending physician.
-Notify the administrator.
-Notify the director of nursing service.
*"The physician is to give the resident or his/her legal representative information concerning the risks involved in leaving the facility."
*Documentation guidelines included:
-"Complete the "Leaving the Hospital Against Medical Advice" release form."
-"Present form to resident or legal representative

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F 658	Continued From page 22 regardless of whether it is believed the resident or legal representative will sign. The release form should be offered for signature in the presence of witnesses." -"On the "Leaving Hospital Against Medical Advice" form, endeavor to obtain the resident's signature and/or the signature of the legal representative." -"If the resident refuses to sign: --In the space provided for the resident's signature, write the words "Resident refuses to sign." Beneath this line, sign your name and the exact time, date, and give a brief notation concerning the circumstances of the refusal." --"Any person, preferably an employee of the facility, who was present when the release was offered and refused, may sign as a witness to the refusal." -"In addition to completing the "Leaving Hospital Against Medical Advice" form, complete all other documentation per facility procedure."	F 658		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior	F 700	Resident 2, 22, and 25 will have side rail assessments including risk versus benefit of use. Resident 4's care plan will include the use of a rock in place wheelchair. All other residents medical records were reviewed and revised to include side rail assessments and the use of rock in place wheelchairs on 11/29/2021. Administrator, DON, and interdisciplinary team reviewed and revised as necessary the policy and procedure for bed rails on 11/29/2021. Administrator and DON created physical restrains assessment form to evaluate risk versus benefit of use and if the least restrictive alternative attempts have been made on 11/22/2021	12/4/2021

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F 700	Continued From page 23 to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, interview, record review, and policy review, the provider failed to ensure safety assessments had been completed and documented for: *Four of four sampled residents (2, 22, 25, and 27) who had side rails on their beds. *One of one sampled resident (4) who used a rock in place wheelchair. Findings include: 1. Observation on 11/3/21 at 10:42 a.m. of resident 2's room revealed she had bilateral half side rails on her bed. Review of resident 2's medical record revealed: *She had been admitted on 6/24/19. *Her brief interview of mental status (BIMS) completed on 10/25/21 revealed she had severe cognitive impairment. *Her care plan for activities of daily living had initiated the use of bilateral half side rails for bed mobility on 8/6/20. *There had been no documentation of a side rail safety assessment being completed. *There had been no documentation of risk of use education versus benefit of use education being completed.	F 700	DON or designee will provide education to all staff on bed rails, rock in place, and physical restraints on 11/30/2021 and 12/2/2021. DON or designee will perform audits on bed rails weekly for four weeks and monthly for two more months. DON or designee will present findings from these audits at the monthly QAPI meetings for review until the QAPI committee advises to discontinue monitoring.	

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F 700	Continued From page 24	F 700		

2. Observation and interview on 11/2/21 at 4:07 p.m. revealed resident 27 had bilateral half side rails. She was not able to tell me how she used them. Was very confused of what they were even for.

Review of resident 27's medical record revealed:
*She had been admitted on 10/8/20.
*Her BIMS completed on 10/12/21 revealed he had moderate cognitive impairment.
*Her last revised care plan 02/24/21 revealed she used bilateral one-half siderails to encourage independence with turning and red-positioning in bed.
*There had been no documentation of risk of use education versus benefit of use education being completed.

Interview 11/3/21 with interim director of nursing B revealed she did have an assessment tool to use for siderails. She had not been using the assessment tool.

Surveyor: 43844
3. Observation on 11/2/21 at 9:42 a.m. of resident 22's room revealed his bed frame had side rails attached to the upper half of his bed.
*He had not been in his room.

Review of resident 22's medical record revealed:
*He had been admitted on 9/13/21.
*His brief interview of mental status completed on 9/13/21 revealed he had severe cognitive impairment.
*His handwritten care plan included the use of one-half side rails for bed mobility.
*There had been no documentation of a side rail safety assessment being completed.
*There had been no documentation of education

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F 700	Continued From page 25 of the risk of use versus benefit of use being completed. Interview on 11//3/21 at 11:37 a.m. with interim DON/MDS coordinator B regarding side rail assessments revealed: *They had not documented completion of a safety assessment. *They had obtained physician orders. *She had a sample of a side rail safety assessment. -The medical director needed to review and approve the form. *They did not provide informed consent for side rail usage. *She stated they did provide a verbal risk of use education versus benefit of use education. -They did not document that this education had been provided. Surveyor: 45683 4. Observation on 11/2/21 at 10:13 a.m. of resident 25 revealed his bed had one siderail on the side of the bed nearest the wall in the up position. Interview on 11/4/2021 at 2:45 p.m. with licensed practical nurse (LPN) M revealed resident 25 did have a siderail that he used for repositioning in bed and turning when he was being helped with personal cares. Review of resident 25's medical record revealed: *The quarterly MDS dated 10/10/21 was marked no for siderail use. *There was no mention of siderail use in the care plan initiated 3/1/21. Under the focus for self-care performance deficit, the intervention for bed mobility does not include the bed rail.	F 700		

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F 700	Continued From page 26 *There was no documentation of a siderail assessment in the chart. Surveyor: 26632 5. Observation on 11/3/21 at 10:30 a.m. of resident 4 revealed he used a rock in place wheelchair. He was able to transfer himself out of the chair onto the couch. Staff were required to assist him with transfers to other surfaces. Review of resident 4's medical record revealed: *He had been admitted on 5/30/19. *His BIMS completed on 8/2/21 revealed he had severe cognitive impairment. *His last revised care plan on 8/2/21 had no documentation on the use of the rock in place wheelchair. *There had been no documentation of risk of use education versus benefit of use education being completed. Review of the provider's revised June 2019 Physical Restraint policy revealed: *"Prior to physical restraint application (other than emergency), the Assistive Device Assessment will be completed in PointClickCare." *"The assessment will be reviewed by the Interdisciplinary Team, Resident/Representative, and the physician." *There was no mention of the use of assistive devices, such as side rails or rock in place wheelchairs.	F 700		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 755	Unable to acquire secondary signature for Residents 32's medication disposition form. RN JJ will be re-educated on medication destruction policy on 11/30/2021.	12/4/2021

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F 755	Continued From page 27 them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Surveyor: 43844 Based on observation, interview, record review, and policy review the provider failed to ensure: *Medication destruction one of three sampled resident's closed record (32) had been completed by a registered nurse (RN) and a witness. *Controlled medication of lorazepam had not been double-locked in the medication refrigerator. *The controlled medication of lorazepam in the	F 755	Administrator, DON, and interdisciplinary team will review and revise as necessary the policy and procedure for destroying all medications. All other residents can be effected by this deficient practice. Controlled medications stored in the fridge are double locked effective 11/26/2021. DON or designee will provide education to all licensed personnel responsible for medication destruction on 11/30/2021 and 12/2/2021. DON or designee will perform audits on medication destruction and proper storage of controlled medication in the fridge for four weeks and monthly for two more months. Administrator or designee will present findings from these audits at the monthly QAPI meetings for review until the QAPI committee advises to discontinue monitoring.	

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F 755	Continued From page 28 medication refrigerator was not included in the daily count. Findings include: 1. Closed record review of resident 32's record revealed: *He had died on 10/14/21. *His remaining medications had been destroyed on 10/23/21. -The medications had been destroyed by a registered nurse and no witness. Interview on 11/3/21 at 4:44 p.m. with administrator A and interim director of nursing (DON)/Minimum Data Set (MDS) coordinator B revealed: *The process for medication destruction would have been: -Non-narcotic medications were to have been destroyed by one RN and a witness. -Narcotic medications were to have been destroyed by two RN's or an RN and a pharmacist. Review of the provider's undated Medication Destruction Policy revealed: *"E) Medication destruction occurs only in the presence of at least two licensed healthcare professionals." -"5)Signature of 2 licensed witnesses (2 Registered witnesses in the case of Narcotics)." Interview on 11/3/21 at 4:58 p.m. with administrator A and interim DON/MDS coordinator B regarding medication destruction revealed they were not aware the provider's policy required two nurses to witness and document the destruction of medications.	F 755		

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F 755	Continued From page 29 Surveyor: 26632 2. Observation and interview on 11/4/21 at 9:25 a.m. with RN JJ revealed: *A small clear plastic box in the medication room refrigerator. *That box had a numbered tag on it. *The box contained two lorazepam 2 milligram per milliliter (mg/ml) injectable vials. *There was also a full bottle of lorazepam 2 mg/ml oral solution. *RN JJ stated those medications were not counted with the rest of the controlled medications on the medication carts. *She agreed those medications were not double locked. Interview on 11/4/21 at 9:45 a.m. with interim DON/MDS coordinator B confirmed the above findings. Review of the provider's revised August 2014 Medication Storage in the Facility policy revealed: *"Controlled-substances that require refrigeration are stored within a locked box within the refrigerator." *"This box must be attached to the inside of the refrigerator."	F 755		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Based on interview, record review, and policy review, the facility failed to ensure one of one	F 760	TM 12/10/2021 *Administrator, DON, and interdisciplinary team will review and revise as necessary the policy and procedure for ordering medications from pharmacy. All nurses are to check the status on pending orders at beginning of every shift to monitor completion of order as of 11/29/2021. DON or designee will provide education on outstanding orders to all licensed personnel on 11/30/2021 and 12/2/2021.	12/4/2021

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F 760	Continued From page 30 resident (33) received a new order for antipsychotic medication to treat aggressive behaviors resulting in harm to others. Findings include: 1. Review of progress notes for resident 33 in the closed electronic medical record (EMR) revealed a pattern of increasingly aggressive behaviors: *On 9/16/21, resident is "resistive with repositioning/transfers and yells out at that time." *On 9/24/21, "continues to resist and yells out with transfers and repositioning." *On 9/26/21, the resident was seen "kicking and swinging" at another resident. *On 9/27/21, "hitting at staff" with "clinched fists" when turning resident in bed. "Question if resident is in pain...or behavioral as resident is noted at times to get self up without concerns." *Between 9/29/21 and 10/2/21, resistance and yelling out during transferring and repositioning. *On 10/4/21, struck a certified nursing assistant (CNA) in the face while assisting the resident. *On 10/6/21, "Physically abusive to staff with transferring as resident did hit staff multiple times today." *On 10/7/21, "Pleasant except for transfers and repositioning as resident will resist and yell at staff." *On 10/10/21, resident hit two CNAs in the face or side of the head with closed fists and grabbed their hair, yelling profanity at them, while assisting him to bed. *On 10/11/21: -At 5:56 p.m., four staff assisted with toileting and perineal care due to yelling, screaming, and resistance. -At 7:46 p.m., the resident was heard yelling and found "swinging a closed fist" at another resident. -At 11:55 p.m., "very combative with staff hitting	F 760	DON or designee will perform audits on medication orders two times weekly for four weeks and monthly for two more months. DON or designee will present findings from these audits at the monthly QAPI meetings for review until the QAPI committee advises to discontinue monitoring. *Resident 33 did not admit to facility with orders for antipsychotic medication. Resident 33 received antipsychotic medication in the hospital, however, was not an order upon admission that the facility was to continue. Nurse on duty is responsible for reviewing and confirming orders entered by the pharmacy. TM 12/10/2021	

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F 760	Continued From page 31 and punching staff when they offer or attempt to assist resident." The resident told staff to "leave him alone." *On 10/12/21: -At 3:25 a.m., combative and yelling as two staff assisted with incontinence care and getting him into bed. -At 5:26 a.m., two staff held the resident's arms while a third cleaned him, and he attempted to "hit staff and bite the arms." *On 10/14/21, "CNA's report resident continues to yell out with transfers and toileting. MA (medication aide) reports she did not even touch him and he started yelling out." *On 10/17/21, the resident swung at another resident but was not close enough to hit the resident. *On 10/19/21: -At 9:53 a.m., the bath aide reported the resident "swung out at her and punch [sic] her in her face." The resident also "told another resident to move/get out of the way in a mean way." -At 10:16 a.m., CNA reported the resident "punched her in the stomach during a transfer...he would not stay sitting up in bed and resistive with transfer." -At 7:28 p.m., the resident's chair alarm was sounding and was found in his bathroom by CNA and nurse "standing on the foot pedals of his wheelchair" by the toilet. He "became physically aggressive swinging closed fists..." The nurse "was hit in the side of head to knock glasses off to floor." *On 10/21/21: -At 8:36 a.m., resident was yelling out and screaming when assisted by staff. -At 11:29 a.m., CNA reported to nurse "about" 9:15 a.m. that the resident "kicked (another resident) in the right shin and attempted to punch"	F 760		

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F 760	Continued From page 32	F 760		

the resident.

Further review of the EMR revealed an antipsychotic medication was ordered but not started for seven days:
*On 10/13/21, an order note documented a new order for an antipsychotic medication related to "agitation."
*On 10/13/21, the order summary report included "monitor & document mood/behaviors/agitation...every day and night shift for monitoring for 14 days."
*On 10/21/21, a physician communication note documented:
-The physician responded to the "fax sent yesterday re: Residents [sic] behaviors" with an order to increase the dose of the antipsychotic medication.
-The increase dose order was "faxed to (facility) pharmacy."
-The pharmacy called and said "they never filled any (antipsychotic medication) for him yet."
-The nurse "looked back" and discovered the medication "was never rec'd (received) and never started."
-The physician was notified and he re-ordered the original dose of the antipsychotic medication.

A behavioral expression note on 10/21/21 summarized actions taken in response to his behaviors:
-"Administration (admininstrator, assistant DON, and social services designee) informed of the (behavior pattern)."
-The antipsychotic medication was started in the morning.
-The resident's respresentative and physician were informed of the resident's behavior patterns.
-"Orders received to transfer to (emergency

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F 760	Continued From page 33 room) for evaluation due to increased behaviors and aggression." Review of the medication administration record confirmed the antipsychotic medication was documented as given at 8:00 a.m. on 10/21/21. Interview on 11/04/21 at 12:00 p.m. with interim DON/MDS coordinator B revealed: *The pharmacy receives and processes orders every day. *It is "very rare that a pending order would pass onto the next shift." *After this medication delay, she and "the nurses got together and decided" the nurses would monitor the pending order report and follow-up if the order was not processed the same day. *She said it was unknown if the resident's behaviors "would have been better" if he had been started on it sooner. *The resident had the same medication in the hospital before he transferred to the facility, but the order did not carry over to his admission orders at this facility. Review of the policy for "processing medication orders" at the pharmacy revealed: *"New orders will be received and processed daily until the close of business and processed for normal delivery." *"Any orders after normal business hours will be processed as STAT order for immediate delivery."	F 760		
F 801 SS=D	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry	F 801	Unable to meet requirement of having certified dietary manager by designated date due to length of course. TM 12/10/2021 Will register employee* into the program on 12/1/2021 to become CDM within facility.** TM 12/10/2021	12/4/2021

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F 801	Continued From page 34 out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.	F 801	All residents have the potential to be effected by this deficient practice. Administrator will audit the process of the completion of the course once weekly until the facility has a CDM within the facility. Administrator or designee will present findings from these audits at the monthly QAPI meetings for review until the QAPI committee advises to discontinue monitoring. *AA TM 12/10/2021 **Employee HH will remain in the dietary department but will not be the employee who attains the CDM. TM 12/10/2021	

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§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-
(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.
This REQUIREMENT is not met as evidenced by:
Surveyor: 06365
Based on interview and employee list review, the facility failed to designate a dietary manager to meet the requirements for certification no later than 5 years after November 28, 2016.
Findings include:

1. Interview on 11/1/21 at 4:50 p.m. with dietary manager HH revealed she had:

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F 801	Continued From page 36 *Been the manager for "years." *Not started dietary manager (DM) certification course. *Not decided yet if she wants to. Interview on 11/3/21 at 2:20 p.m. with DM HH confirmed she had been employed as the DM since before September 2016, and she had not started the certification course. Review of an employee list provided by the facility revealed the DM HH's hire date was 2/1/15. Interview with administrator A on 11/4/21 at 12:04 p.m. confirmed DM HH had not been enrolled in the DM certification course.	F 801		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812	Unable to timely address the unsanitary deficient practice for residents 6 and 9. All residents have the potential of being affected by unsanitary deficient practices. Administrator, Dietary Manager, and interdisciplinary team will review and revise as necessary the policy and procedure for safe serving and distribution of food, hand hygiene and glove use. *TM 12/10/2021 Dietary Aide E, F, and Cook 2 will be re-educated by Dietary Manger or designee on safe serving, distribution of food, hand hygiene, and glove use on 11/30/2021 and 12/2/2021. Dietary Manager or designee will provide education to all dietary employees on safe serving and distribution of food, hand hygiene and glove use on 11/30/2021 and 12/2/2021. Dietary Manager or designee will perform audits on safe serving and distribution of food, hand hygiene, and glove use, weekly for four weeks and monthly for two more months.	12/4/2021

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F 812	Continued From page 37 This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Based on observation and interview, the facility failed to ensure food safety during two of two meal services observed. Findings include: 1. Observation on 11/1/21 at 5:00 p.m. revealed unsafe serving and distribution of food: *Cook II moved between touching food items and non-food items using her gloved hands without hand hygiene and changing gloves throughout the meal service, including: -Shuffling through the residents' diet cards with both hands as she prepared to dish up the next group of residents' dishes. -Touching plates and serving utensils with her left hand and the handles of the delivery carts with her right hand to reposition them closer to her. -Picking up buttered bread slices with her right hand to place them on plates. -Using her right thumb to position the green beans that she scooped onto the plates with her left hand. -Getting the tip of her right forefinger into the applesauce in a small bowl as she picked it up to put it on the delivery cart. *After a resident requested a hamburger instead of the main entree, cook II: -Used the same gloved right hand to reach into the plastic bag with hamburger buns and removed one bun out of the bag. -Took off the top half of the bun with her left hand and laid it on the stainless steel counter opposite the stove top where the hamburgers were being kept warm. -While holding the bottom half of the bun in her	F 812	Dietary Manager or designee will present findings from these audits at the monthly QAPI meetings for review until the QAPI committee advises to discontinue monitoring. *All dietary employees are to receive education yearly on proper food safety regimens by the dietician. TM 12/10/2021	

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F 812	Continued From page 38	F 812		

right gloved hand, she used her left hand to scoop a hamburger from the pan onto the bun.
-While holding the bottom bun and hamburger in her right hand, she used her left hand to pick up the top of the bun and move it towards the corner of the same stainless steel counter onto the top of papers in an open red binder.
-Set the bottom bun and hamburger on a plate then used both gloved hands to squeeze ketchup onto the hamburger.
-Used her right hand to place the top bun onto the completed hamburger.

*A plate of food dished up for a resident was incorrectly placed in front of another resident:
-Dietary aide (DA) E served a plate of food from the delivery cart to resident 6.
-Resident 6 repositioned herself up to the table and faced the plate while DA E walked away from the table toward the kitchen.
-Before DA E got to the kitchen, cook II told her that plate was for resident 9.
-DA E immediately turned around, walked back to the table, and removed the plate from in front of resident 6.
-She then delivered the same plate of food to the resident 9.

Observation on 11/2/21 at 11:07 a.m. revealed dietary aide F distributed beverages in an unsanitarty manner:
-She touched various unclean surfaces, such as beverage containers and delivery cart handles.
-She touched the rims (drinking surface) of glasses and cups when she placed them on the delivery cart in the kitchen and then placed them onto the table in front of the residents.
-She did not practice hand hygiene between touching the unclean surfaces and the rims of the

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F 812	Continued From page 39 glasses and cups. Inteview on 11/3/21 at 2:20 p.m. with dietary manager HH revealed the above were unsafe food practices, and she had provided education to staff about hand hygiene and glove use.	F 812		
F 880 SS=E	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 infections before they can spread to other	F 880	The Administrator, DON, infection control nurse and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for whirlpool tub cleaning. DON or designee will provide education to all staff about their roles and responsibilities for proper whirlpool tub cleaning on 11/30/2021 and 12/2/2021. CNA Z, Nurse M, Maintenance Director AA will be re-educated about proper procedure whirlpool tub cleaning. All other staff responsible for that role will also be re-educated. DON or designee will audit proper whirlpool tub cleaning two times weekly per week weekly for four weeks and once per month for two more months. DON or designee will present the audit findings at the monthly QAPI meetings for review until the QAPI committee advises to discontinue monitoring.	12/4/2021

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F 880	Continued From page 40	F 880		

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:
Surveyor: 43844
Based on observation, interview, and policy review, the provider failed to ensure proper

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infection control practices were completed for one of one observation of whirlpool tub cleaning by certified nursing assistant (CNA) (Z) had been completed correctly.

1. Observation, interview, and product directions review, 11/2/21 at 8:38 a.m. with CNA Z revealed she:
*Rinsed the whirlpool tub with clean water and then began cleaning the tub.
-Filled the whirlpool approximately half full of fresh water.
-Had a gallon of "Classic" disinfectant.
-Poured a capful of disinfectant into the tub.
-Stated, "A capful is about 2 ounces."
--Thought this is the amount needed.
-Turned the jets on in the tub.
*Upon review of directions from the gallon of disinfectant, she agreed the directions stated to add two ounces of disinfectant per gallon of fresh water.

Interview on 11/4/21 at 8:44 a.m. with maintenance director AA revealed the whirlpool tub contained approximately 60 gallons of water when full.

Interview on 11/4/21 at 8:46 a.m. with CNA Z revealed she thought she had filled approximately 1/2 full when she added the disinfectant to it.

Interview on 11/2/21 at 10:36 a.m. with licensed practical nurse M regarding the training of bath aide revealed she:
*Had thought they were cleaning it correctly.
*Had been doing random disinfecting audits.
-Had not provided education to CNA Z on the appropriate way to disinfenct the whirlpool.
*Thought the regular bath aide would have known

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F 880	Continued From page 42 how to correctly do the disinfecting. -The regular bath aide was not working for one month. Review of manufacturer's directions for use of "Classic" disinfectant revealed 2 ounces of the disinfectant should have been added to each gallon of water. Review of provider's Revised October 2010 Whirlpool and Shower Cleaning/Disinfecting policy revealed: *"Policy Statement: Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC [Centers for Disease Control] recommendations for disinfection and the OSHA [Occupational Safety and Health Administration] Bloodborne Pathogens Standard. Properly cleaning a whirlpool tub is necessary to prevent growth of microorganisms and prevent cross-contamination from one resident to another." -"For internal piping and pump disinfecting: Fill whirlpool to top of water inlet, add 10 oz [ounces] whirlpool disinfectant, circulate pump for one minute and let set for 10 minutes."	F 880		
F 885 SS=E	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents	F 885	All residents have the potential to be effected by lack of transparency of communication regarding the positive staff member and the contracted speech therapist that exposed other residents. The Administrator, DON, infection control nurse and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for appropriate notice to residents and their representatives when a positive case is identified and we are in outbreak status. **	12/4/2021 TM 12/10/2021

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F 885	Continued From page 43 or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Surveyor: 43844 Based on interview and policy review the provider failed to notify residents, their representatives, or families when the facility was in a COVID-19 outbreak. Findings include: 1. Interview on 11/2/21 at 3:25 p.m. with administrator A revealed: *A contracted speech therapist had tested positive for COVID-19 on 10/27/21. -Three residents had been exposed to this therapist and notified of same. --No other residents, their representatives or families had been notified of the outbreak status of the facility. *A dietary employee had tested positive for COVID-19 on 11/1/21. --No residents, their representatives, or families had been notified of this update in outbreak status of the facility.	F 885	Administrator or designee will provide education to all staff about their roles and responsibilities for COVID-19 testing on 11/30/2021 and 12/2/2021. Discussion for other system changes included collaboration with the South Dakota Quality Improvement Organization with the Administrator with the date to be determined to identify other potential risk cause analysis.* Administrator or designee will audit proper communication between families weekly per week for four weeks and once per month for two more months. *** TM 12/10/2021 Administrator or designee will present the audit findings at the monthly QAPI meetings for review until the QAPI committee advises to discontinue monitoring. *Risk cause analysis was completed on 11/30/2021 and was discussed during call with South Dakota Quality Improvement Organization that was held on 12/01/2021. **All positives are reported to the DON and Administrator to ensure proper procedures are done to notify all involved with positive cases. ***If no outbreak occurs, audit process will be extended by three months to ensure procedure is being followed. TM 12/10/2021	* TM 12/10/2021 TM 12/10/2021 TM 12/10/2021

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*She stated no notification was sent because the current positive cases did not provide direct patient care.

*Administrator A provided, to the survey team, an undated letter notifying families that an employee had tested positive for COVID-19 on 10/31/21.

Interview on 11/02/21 at 4:38 p.m. with administrator A revealed:
*No staff had exposure to the speech therapist who had tested positive on 10/27/21.
*Two staff members had been exposed to the dietary employee who had tested positive for COVID-19 on 10/31/21
-These two staff members were tested for COVID-19 on 11/1/21.
*She would be sending the undated letter to families notifying them of an employee testing positive for COVID-19 on 10/31/21.
-She sent this letter after speaking with this surveyor on 11/2/21 at 3:25 p.m.

Review of Centers for Medicare & Medicaid Services Center for Clinical Standards and Quality/Quality, Safety & Oversight Group QSO-20-29-NH memo of May 6, 2020 <https://www.cms.gov/files/document/qso-20-29-nh.pdf> regarding notification of confirmed or suspected COVID-19 cases among resident and staff in nursing homes revealed:
*The facility must inform residents, their representatives, and families of those residing in facilities by 5:00 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19.

Review of Centers for Disease Control and Prevention's (CDC) Interim Infection Prevention

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F 885	Continued From page 45 and Control Recommendations to Prevent SARS-CoV-2 [COVID-19] Spread in Nursing homes <www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html> 9/10/21 guidance revealed: *Healthcare personal (HCP), residents and families were to be notified of an outbreak in the facility. *An outbreak consisted of: -One resident or HCP.	F 885		
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and	F 886	The Administrator, DON, infection control nurse and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the policy and procedure for COVID-19 testing for all staff.*TM 12/10/2021 Administrator or designee will provide education to social services designee on testing all unvaccinated staff according to county positivity rate. On 11/22/2021 documentation is now being recorded for all unvaccinated staff to ensure testing is being conducted according to the COVID-19 testing guidelines. Administrator or designee will provide education to all staff about their roles and responsibilities for COVID-19 testing on 11/30/2021 and 12/2/2021. Administrator or designee will audit all testing completion two times per week for four weeks and once per month for two more months. Administrator or designee will present the audit findings at the monthly QAPI meetings for review until the QAPI committee advises to discontinue monitoring.	12/4/2021

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F 886	Continued From page 46 (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Surveyor: 43844 Based on interview, record review, and policy review the provider failedto test all unvaccinated	F 886	*SSD is responsible to complete all testing. SSD will give documentation of tested staff to administrator for review. Administrator will be responsible for testing if SSD is not available. TM 12/10/2021	

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F 886		F 886		

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staff per their county positivity rate to detect COVID-19 in staff members.

1. Interview on 11/2/21 at 10:38 a.m. with administrator A regarding COVID-19 testing for non-vaccinated employees revealed she:
*Stated testing was based upon county positivity rate.
-The county positivity rate was above 10% from 8/8/21 through 10/31/21.
*Had scheduled testing two times per week since 8/8/21, typically on Wednesday and Fridays.
-Stated when staff was not able to test at the scheduled time, "We try to catch them, probably miss occasionally."
*Stated the social services designee, director of nursing, and all nurses knew how to test staff for COVID-19.
*Stated staff who refuse testing would be required to wear an N95 mask while at work.
*Thought there had been additional testing done that had not been placed in their documented testing binder.

Interview on 11/3/21 at 1:03 p.m. with administrator A revealed she:
*Had not been able to find additional test results.
-Thought they had been done at the nurses station.

Review of provider's employee vaccinated listing revealed there had been 19 of 51 employee's (C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, and U) who had not been vaccinated.

Review of the provider's COVID-19 documented testing for staff from 10/1/21 through 10/31/21 revealed:
*Testing had been completed on the following

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	435062	A. BUILDING ____ B. WING ____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALCESTER CARE AND REHAB CENTER, INC	101 CHURCH STREET ALCESTER, SD 57001

(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 886	Continued From page 48 dates. -10/1/21 for one unvaccinated staff person (U). -10/7/21 for two unvaccinated staff persons (C and F). -10/9/21 for one unvaccinated staff person (F). -10/12/21 for one unvaccinated staff person (F). -10/15/21 for two unvaccinated staff persons (N and U). -10/20/21 for three unvaccinated staff persons (C, R, and U) and one vaccinated employee (V). -10/27/21 for two unvaccinated staff persons (F and R) and 3 staff persons of unknown vaccination status, (V, W, and X). -10/29/21 for one unvaccinated staff person (J) and one staff person of unknown vaccination status (X). -10/31/21 for one unvaccinated staff person of unknown vaccination status (X). -11/1/21 for one unvaccinated staff person (F) and one staff person of unknown vaccination status (Y). *Review of provider's Staff/Resident Testing During COVID-19 Pandemic policy revealed: -"Policy: ACRC [Alcester Care and Rehab Center] policy on staff testing for COVID-19 to prevent spread of infection into facility. -Purpose: Appropriately implement safe infection control procedures. a. Administrator will document county positivity rate every week. i. If positivity rate is 5-10% the facility will test unvaccinated staff once a week. ii. If the positivity rate is above 10%, the facility will test unvaccinated staff 2x [times] a week. iii. If the positive rate returns to a lower rate, the facility must remain resting [testing] at the same frequency for 2 weeks."	F 886		

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F 886	Continued From page 49 Review of Centers for Disease Control and Prevention's (CDC) Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 [COVID-19] Spread in Nursing homes <www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html> 9/10/21 guidance revealed: *Unvaccinated staff were to be tested based off county level positivity rates. *Healthcare personal (HCP), residents and families were to be notified of an outbreak in the facility. *An outbreak consisted of: -One resident or HCP *A person should be designated as the infection control person to oversee the COVID-19 effort and management of infection control program.	F 886		

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E 000	Initial Comments Surveyor: 06365 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 11/1/21 through 11/4/21. Alcester Care and Rehab Center, Inc. was found not in compliance with the following requirements: E0013 and E0041.	E 000		
E 013 SS=E	Development of EP Policies and Procedures CFR(s): 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD	E 013	Administrator and interdisciplinary team will review and revise the evacuation plan and update specificity in evacuating residents, sheltering in place, meeting spots, number of persons serving food and water, location of additional supplies, and ensure all emergency preparedness is precise in details. Administrator or designee will present updates on emergency preparedness at QAPI and all staff education on 11/30/2021 and 12/2/2021. Administrator or designee will do audits to ensure plan is up to date monthly for 3 months and will report the results of the audits to the monthly QA committee until the QA committee advises to discontinue monitoring.	12/4/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tiffany Miller	Administrator	11/29/2021

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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E 013	Continued From page 1 Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Based on interview and emergency preparedness plan review, the facility failed to provide sufficient detail to achieve a common understanding	E 013		

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E 013	Continued From page 2	E 013		

regarding:
*Procedures for evacuation.
*Subsistence needs for sheltering in place.
This has the potential to affect all residents residing in the facility at the time of an emergency situation.
Findings include:

1. Review of the facility's emergency preparedness plan revealed the following procedures were not sufficiently detailed:
*Residents were to be evacuated:
-In an "orderly fashion" without specifying the order of priority, such as resident needs.
-To "possible meeting spots" without specifying the locations nor how many persons each location could accommodate.
*Subsistence needs for sheltering in place included:
-Three days of food and water without specifying how many persons would be served for three days, where those supplies were stored, nor how and where additional supplies would be obtained if sheltering in place lasted longer than three days.
-The city of Alcester would continue with the disposal of sewage and waste without a backup plan if the city services were also affected.

Interview with administrator A on 11/4/2021 at 12:04 p.m. revealed she agreed the procedures needed more definition:
*She defined "orderly fashion" as starting with "dependent" residents but agreed others may not define it the same way.
*There was no calculation for the provision of food and water.
*There needed to be a back-up plan for obtaining more food and water and for disposing of sewage

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E 013	Continued From page 3 and waste if the city was unable to provide that service.	E 013		
E 041 SS=E	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life	E 041	Administrator and interdisciplinary team reviewed and revised as necessary the policy and procedure for maintenance and upkeep on facility generator. Administrator or designee will provide education on generator maintenance to maintenance director or designee on 11/30/2021. Maintenance Director changed generator battery on 11/10/2021 and implemented emergency generator monthly test log on 11/30/2021 to record exercise time, time hour meter reading, transfer switch, battery, oil, water, amps per le Administrator or designee will do audits to ensure monthly test log is completed monthly for 3 months and will report the results of the audits to the monthly QA committee until the QA committee advises to discontinue monitoring.	12/4/2021

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E 041	Continued From page 4 Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.	E 041		

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E 041	Continued From page 5 (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Surveyor: 40506 A. Based on record review and interview, the provider failed to document generator battery conductivity monthly (no testing was being done in the past year). Findings include: 1. Record review on 11/2/21 at 2:10 p.m. revealed there was not any documentation of the battery conductivity in the monthly maintenance logs for the generator. Interview with the maintenance supervisor at the time of the record review confirmed that testing had not been done. He stated he was unaware of the monthly battery conductivity testing requirement. The deficiency affected one of numerous requirements for generator maintenance. B. Based on record review and interview, the provider failed to document generator annual	E 041		

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E 041	Continued From page 6 maintenance. Findings included: 1. Record review on 11/2/21 at 2:10 p.m. revealed there was not any documentation of annual maintenance (including oil change) for the generator. Interview with the maintenance supervisor at the time of the record review confirmed there was no documentation. He stated he performed the maintenance himself but was unaware of any documentation requirement. The deficiency affected one of numerous requirements for generator maintenance and contributed to all requirements for generator maintenance. C. Based on observation and interview, the provider failed to replace the generator battery as required (battery installed in September 2014). Findings include: 1. Observation on 11/2/21 at 2:45 p.m. revealed the generator battery was marked with September 2014 for the installation date, making the battery approximately eighty-five months old. Generator batteries are recommended to be replaced every twenty-four to thirty months. Interview with the maintenance supervisor at the time of the observation confirmed that finding. The deficiency affected one of numerous requirements for generator maintenance.	E 041		

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	435062	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**11/02/2021**

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K 000	INITIAL COMMENTS Surveyor: 40506 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 11/2/21. Alcester Care and Rehab Center, Inc. was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K223, K351, and K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to maintain three randomly observed fire	K 223	Maintenance personnel or designee will address the laundry room, cross corridor doors at previous memory care addition, and entry to administration addition. Fire pins are ordered on 11/29/2021 and will be installed when the parts arrive. All other fire doors will be reviewed to ensure that the secondary latching mechanism is installed and operating effectively. Maintenance director or designee will audit all fire doors to ensure they are operating correctly weekly for 4 weeks and monthly for two months. Maintenance director or designee will present findings from these audits at the monthly QAPI committee for review until the QAPI committee advises to discontinue monitoring.	12/4/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tiffany Miller	Administrator	11/29/2021

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

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K 223	Continued From page 1 doors (laundry room, cross corridor doors at previous memory care addition, and entry to administration addition) as required. Findings include: 1. Observation on 11/2/21 at 10:15 a.m. revealed the cross-corridor 90-minute fire doors separating the new addition built for a memory unit did not have a second latching mechanism. 2. Observation on 11/2/21 at 10:30 a.m. revealed the 90-minute fire door into the laundry room did not have a properly functioning closer and the door did not latch. 3. Observation on 11/2/21 at 11:15 a.m. revealed the 90-minute fire doors separating the administration addition did not have a second latching mechanism. Interview with the maintenance supervisor at the time of the observation confirmed that finding. The deficiency affected one of numerous requirements for doors with self closing devices and had the potential to affect 100% of the occupants of each smoke compartment.	K 223		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection	K 351	Administrator, DON, and interdisciplinary team will review and revise as necessary the policy and procedure for keeping sprinkler systems free of unobstructed space in linen closets and storage shelves and all other sprinkler system areas. Administrator will re-educate maintenance director on the separation distance from the sprinkler requirement on 11/30/2021.	12/4/2021

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ALCESTER CARE AND REHAB CENTER, INC	**101 CHURCH STREET** **ALCESTER, SD 57001**

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K 351	Continued From page 2 measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to maintain unobstructed space adjacent to the sprinkler deflector so the water discharge was not interrupted in three randomly observed linen closets and one recreational therapy shelf. Findings Include: 1. Observation on 11/2/21 at 10:00 a.m. revealed three randomly selected linen closets on the resident wings all had linen storage within six inches of the sprinkler head. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated he was unaware of the required separation distance from the sprinkler. 2. Observation on 11/2/21 at 11:40 a.m. revealed storage shelves for recreational therapy in the auxiliary dining access walkway had storage within two inches of the sprinkler head. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated he was unaware of the required separation distance from the sprinkler.	K 351	Administrator will educate all staff on 11/30/2021 and 12/2/2021 to keep all sprinkler systems clear in all areas. Maintenance Director or designee will conduct weekly audits for four weeks and monthly for two months to ensure all sprinkler systems are able to work properly. Maintenance Director or designee will report updates to monthly QA Committee.	

PRINTED: 11/19/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435062	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**11/02/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 351	Continued From page 3 The deficiency affected four locations required to be equipped with unobstructed fire sprinkler protection. Ref: 2012 NFPA 101 Section 19.3.5.1, 9.7.1	K 351		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power	K 918	Administrator and interdisciplinary team reviewed and revised as necessary the policy and procedure for maintenance and upkeep on facility generator. Administrator or designee will provide education on generator maintenance to maintenance director or designee in charge of the maintenance of the generator on 11/30/2021. Maintenance Director changed battery on 11/10/2021 and implemented emergency generator monthly test log on 11/30/2021 to record exercise time, time hour meter reading, transfer switch, battery, oil, water, amps per leg, volts, power factor, and cool down run time. Administrator or designee will do audits to ensure monthly test log is completed monthly for 3 months and will report the results of the audits to the monthly QA committee until the QA committee advises to discontinue monitoring.	12/4/2021

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K 918	Continued From page 4 source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Surveyor: 40506 A. Based on record review and interview, the provider failed to document generator battery conductivity monthly (no testing was being done in the past year). Findings include: 1. Record review on 11/2/21 at 2:10 p.m. revealed there was not any documentation of the battery conductivity in the monthly maintenance logs for the generator. Interview with the maintenance supervisor at the time of the record review confirmed that testing had not been done. He stated he was unaware of the monthly battery conductivity testing requirement. The deficiency affected one of numerous requirements for generator maintenance. B. Based on record review and interview, the provider failed to document generator annual maintenance. Findings included: 1. Record review on 11/2/21 at 2:10 p.m. revealed there was not any documentation of annual maintenance (including oil change) for the generator. Interview with the maintenance supervisor at the time of the record review confirmed there was no documentation. He stated he performed the maintenance himself but was unaware of any documentation requirement. The deficiency affected one of numerous requirements for generator maintenance and	K 918		

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	435062	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**11/02/2021**

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K 918	Continued From page 5 contributed to all requirements for generator maintenance. C. Based on observation and interview, the provider failed to replace the generator battery as required (battery installed in September 2014). Findings include: 1. Observation on 11/2/21 at 2:45 p.m. revealed the generator battery was marked with September 2014 for the installation date, making the battery approximately eighty-five months old. Generator batteries are recommended to be replaced every twenty-four to thirty months. Interview with the maintenance supervisor at the time of the observation confirmed that finding. The deficiency affected one of numerous requirements for generator maintenance.	K 918		

South Dakota Department of Health

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	10591	A. BUILDING: ____ B. WING ____	11/04/2021

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ALCESTER CARE AND REHAB CENTER, INC	101 CHURCH ST ALCESTER, SD 57001

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S 000	Compliance/Noncompliance Statement Surveyor: 26632 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 11/1/21 through 11/4/21. Alcester Care and Rehab Center, Inc. was found not in compliance with the following: S236.	S 000		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;	S 236	Employees BB and CC medical files were reviewed and revised to reflect the correct tuberculin screening requirements. Unable to correct the noncompliance target date of 14 days of date of hire. The tuberculosis policy will be reviewed and revised as needed and all staff responsible for admissions will be re-educated on the correct process for compliance. Business office manager or designee will audit resident medical records to ensure the documentation occurs for all new hires weekly for 4 weeks and monthly for two months. Business office manager will present findings from these audits at the monthly QAPI committee for review until the QAPI committee advises to discontinue monitoring.	12/4/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tiffany Miller	Administrator	11/29/2021

South Dakota Department of Health

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S 236	Continued From page 1 This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 43844 Based on record review and interview, the provider failed to ensure two of five sampled employees (BB and CC) had completed the two-step method for the Manitou tuberculin (TB) skin test or TB screenings within fourteen days of being hired. Findings include: 1. Review of employee BBs personnel file revealed: *She had been hired on 4/15/21 and started on 6/2/21. *Her first TB skin test had been completed on 8/3/21. *Her second TB skin test had been completed on 8/10/21. 2. Review of employee CCs personnel file revealed: *She had been hired on 6/14/21. *Her first TB skin test had been completed on 7/27/21. *Her second TB skin test had been completed on 8/5/21. Interview on 11/3/21 at 2:50 p.m. with registered urse (RN)/interim director of nursing (DON)/minimum data set (MDS) coordinator B and administrator A revealed regarding TB screenings for employees BB and CC revealed: *They had not known why those above employees had not been given their TB skin tests in a timely manner. *Those TB skin tests had not followed the state guidelines for TB screenings for new employees. Interview on 11/4/21 at 9:11 a.m. with RN/DON/MDS B revealed:	S 236		

South Dakota Department of Health

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S 236	Continued From page 2	S 236		

*Administrator A was in charge of employee files.
*Any nurse would have been able to complete a TB vaccination.

Interview on 11/4/21 at 1:01 p.m. with administrator A revealed:
*Department heads are each responsible for their departmental employees files.
*Department heads would have notified a nurse that a TB vaccination would have needed to be done.
*Nurses would have provided the TB vaccinations.
*She agreed the TB vaccinations should have been given within fourteen days of employment.

Review of the provider's undated TB [Tuberculosis] Screening Protocol policy revealed:
*"Purpose: All new staff and residents entering facility as an admit or re-admit need to be tested for exposure to TB. If resident or staff has had a TB test within the past year from another healthcare facility, only a 1-step Test [Tuberculin skin test] is required. This illness can be picked up from healthcare facilities OR the community. There are cases of TB in SD [South Dakota] and IA [Iowa]."
-"Protocol: Regulations require that screening is completed within 2 weeks."
*The policy did not include who was responsible to ensure TB vaccinations were completed.