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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435114 | A. BUILDING _____ B. WING _____ | C 06/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| DIAMOND CARE CENTER | 901 N MAIN AVE BRIDGEWATER, SD 57319 |

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| F 000 | INITIAL COMMENTS<br><br>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/18/24 through 6/21/24. Diamond Care Center was found not in compliance with the following requirements: F554, F641, F657, F686, F698, F700, F727, F761, F848, F851, and F880.<br><br>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/18/24 through 6/21/24. Areas surveyed included care of a pressure ulcer and potential inappropriate sexual touch between a resident with cognitive capacity and a resident lacking cognitive capacity. Diamond Care Center was found not in compliance with the following requirements: F600 and F686. | F 000 | | |
| F 554 SS=D | Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)<br><br>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, observation, record review, and policy review the provider failed to ensure two of two sampled residents (8 and 9) had been routinely assessed for safe self-administration of medication. Findings include:<br><br>1. Interview and observation on 6/19/24 at 9:03 a.m. with resident 8 revealed:<br>*She was in her bed, eating breakfast.<br>*A bottle of nasal spray was in a small plastic | F 554 | This deficiency has the potential to impact all residents.<br><br>DON/Administrator reviewed and updated policy for residents self-admin medications. All medications found in resident's rooms without self-administration and bedside orders have been removed.<br><br>Resident's orders and rooms (with resident permission) have been audited for medications of compliance by DON. | 07/23/2024 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brianna Morris
TITLE: Administrator
(X6) DATE: 07/23/2024

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

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| F 554 | Continued From page 1<br>container on her rolling bedside table that had her breakfast tray on it.<br>*Registered nurse (RN) N came into the room, and told resident 8 it was time for her medications.<br>-Resident 8 asked her to leave the medications on her breakfast tray.<br>-RN N stated she was not sure if there was a self-administration physician order, so she was not able to leave them.<br>--She then made sure that resident 8 took the medications.<br>-RN N did not acknowledge the medication in the container or have resident 8 self-administer that medication.<br><br>Interview on 6/21/24 at 7:57 a.m. with RN N regarding residents who self-administered medications revealed:<br>*She thought "there might be two" residents who self-administered their medications, residents 8 and 9.<br>-Resident 9 self-administered all her medications.<br>-Resident 8 had "prescribed sprays in her room", but she was not sure if she was able to self-administer those medications.<br><br>Review of resident 8's medical record revealed:<br>*Her 5/4/24 Brief Interview of Mental Status (BIMS) score was a 15, indicating her cognition was intact.<br>*Her diagnoses included: chronic sinusitis, asthma, acute and chronic respiratory failure with hypoxia, and pain in unspecified shoulder.<br>*Her 6/21/24 Care Plan included:<br>-She "may self administer Systane eye drops and Fluticasone nasal spray and Nelipot rinse and Biotene moisturizing spray and Biofreeze."<br>-"Medications are kept in [resident 8's] room in | F 554 | All nursing staff are required to complete medication education with post test. All new hired nurses/CMAs will be required to complete medication storage training. Self-administration assessment has been created in Point Click Care and will trigger quarterly for the IDT team to re-evaluate residents' ability to self-administer medications.<br><br>Self-administration assessments and orders will be audited by DON or designee with each residents ARD x 3 months, two residents will be randomly audited each month x 3 months and PRN following. If desired outcome is not achieved/maintained, individual staff education to be completed as indicated. Findings will be reported at QAPI for 12 months.<br><br>Addendum<br>Resident 8 and 9 were assessed for their ability to self-administer medications. Resident 8 and 9 are capable of self-administration and will be reassessed quarterly. | |

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| F 554 | Continued From page 2<br>lock box that [resident 8] has the key."<br>*Her physician orders included:<br>-A 2/5/20 order for Biofreeze Gel 4% (menthol (Topical Analgesic)) apply to right upper back and shoulders as needed for pain. "May keep at bedside".ain<br>-A 2/1/13 order for Biotene Moisturizing Mouth Solution "May self administer, may keep at bedside."<br>-A 10/14/18 order for CeraVe Cream (Emollient) apply to calves and feet topically at bedtime for dry skin "May keep at bedside".<br>-A 8/4/23 order for Fluticasone Propionate Suspension 50 MCG/ACT 2 spray in both nostrils as needed.<br>--There was no self-administration order for this spray.<br>-A 3/7/24 order for Olopatadine HCl (hydrochloride) Solution instill 1 drop in both eyes one time a day for allergic conjunctivitis "unsupervised self-administration May keep at bedside and self-administer per order 3/7/24".<br>-A 10/15/18 order for Preparation H Cream Insert 1 application rectally as needed for itching QID PRN "May keep at bedside".<br>-A 3/7/24 order for Systane Ultra Solution Instill 1 drop in both eyes as needed for dry eyes "unsupervised self-administration May keep at bedside and self-administer per order 3/7/24".<br>*Her Medication Self-Administration Safety Screen completed on 11/2/22 indicated:<br>-Types of medication that were reviewed for self-administration included: inhalants, eye drops, eye ointments, and topical ointments/creams/patches.<br>-Medications assessed were: Voltaren gel, Flonase nasal spray, Olopatadine eye ointment, Systane eye drops, and Preparation H.<br>-It was determined she was able to keep those | F 554 | | |

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| F 554 | Continued From page 3<br>medications "Bedside with resident".<br>-The assessment included that an area marked "Physician Order" and "Resident may self administer medications UNSUPERVISED".<br>-The area of the assessment that required a physician order date was not completed.<br>*There was no additional self-administration of medication safety assessments completed.<br><br>2. Review of resident 9's medical record revealed:<br>*Her 4/25/24 BIMS score was a 15, indicating her cognition was intact.<br>*There was a 3/21/23 order for "unsupervised self-administration" of "Polyethylene Glycol Powder (Polyethylene Glycol 1450) Give 8.5 gram by mouth as needed for constipation".<br>-She was able to store the medication in her room.<br>*Her most recent self-administration of medication assessment was completed on 3/12/23.<br>*Her 6/20/23 care plan included the following:<br>-On 3/21/23 she was able to self-administer Miralax, eye drops and topical medications.<br>--She would receive medications from staff as directed.<br>--She would self-administer medications "without complications and appropriately."<br>-"Facility staff to set up medications and resident can self administer".<br>-Staff were to "observe for difficulties in self administering medications. Licensed Staff to assist Prn and ensure daily that medications taken correctly."<br><br>Interview on 6/21/24 at 11:25 a.m. with minimum data set coordinator/RN C regarding self-administration of medications by residents 8 | F 554 | | |

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| F 554 | Continued From page 4<br>and 9 revealed:<br>*Residents 8 and 9 were able to self-administer their medications.<br>*She had "never thought about" completing an additional self-administration of medication safety assessment for either resident.<br>*She confirmed resident 8 and 9 should have been assessed for safe self-administration of medications at least quarterly, and she would have been responsible to those assessments.<br><br>Review of the provider's 4/1/23 Self-Administration of Medications Policy revealed:<br>*"Purpose To allow those residents who are deemed able the right to keep specific medications at bedside and to self-administer these medications."<br>*"Is it the policy of [name of different provider] to evaluate for safety and suitability any resident who desires to self-administer their medications."<br>*"Initial screening tool for evaluating self-administration of medications will be performed by the clinical care coordinator (CCC) the first quarter following admission and/or after resident expresses desire to self-administer medications. Bedside use and self-administration may be implemented if it is determined, through the use of the screening tool, that the resident meets the requirements to self-administer medication, the MD will be notified and an order will be obtained for self-administration of medications.<br>-Appropriate documentation in the resident's record will reflect this decision as well as contact with the physician.<br>-Nurse receiving the physician order will update the plan of care and the eMAR [electronic medication administration record]." | F 554 | | |

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| F 554 | Continued From page 5<br>*"Self-administration of medications will be evaluated at least quarterly in conjunction with the MDS [minimum data set] assessment for nursing home residents."<br>*"Indicate on eMAR in "Administration Notes" that medications are self-administered by the resident. Monthly checks will be done on all self-administered medications." | F 554 | | |
| F 600 SS=G | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>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.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on the South Dakota Department of Health (SD DOH) Facility Reported Incident (FRI), observations, interviews, and record review, the provider failed to ensure:<br>*One of one sampled resident (10) who was mentally incapable of identifying safety risks was free from the potential of abuse and neglect by one of one sampled resident (37).<br>*One of one sampled resident (1) received necessary care related to pressure ulcers. | F 600 | This deficiency has the potential to impact all residents.<br><br>DON/Administrator reviewed and updated policy on Abuse and Neglect.<br><br>Resident 37 has been moved to another unit away from Resident 10's known areas of wandering.<br><br>Residents with known behaviors have been assessed for their risk to affect other residents, care plans updated accordingly. Behavior charting has been added to the nurses to TAR every shift to chart episodes of wandering and interventions taken to alert the IDT team of care plan changes needed. Residents risk for behaviors to affect other resident had been added to the quarterly behavior assessment. DON/MDS coordinator to review notes daily for behaviors that have the potential to affect other residents and update care plan accordingly.<br><br>Addendum<br>Wandering/Behavior charting every shift was added to resident 10. This is being reviewed/audited daily for new or increased behaviors or wandering by DON. Results of audits will be reported at QAPI. | 06/18/2024 |

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| F 600 | Continued From page 6<br>Findings include:<br><br>1. Review of the provider's 6/14/24 submitted SD DOH FRI revealed:<br>*On 6/13/2024 at 12:58 p.m. a suspicion/allegation of abuse/neglect regarding resident-to-resident inappropriate sexual behavior involving resident 10 and resident 37.<br>*At 9:01 p.m. licensed practical nurse (LPN) O contacted administrator (ADM) A and informed her of the incident between resident 10 and resident 37.<br>*Resident 10 was found in resident 37's room in her wheelchair next to resident 37 when certified nursing assistant (CNA) E walked by his room and saw resident 10 sitting in there.<br>*CNA E:<br>-Removed resident 10 from resident 37's room and brought her to her room<br>-Noticed that resident 10's blouse was unbuttoned, and her breasts were exposed.<br>*Notified LPN O At 8:58 p.m. of what he had seen.<br>*LPN O contacted administrator A for guidance.<br>*Administrator A advised LPN O to monitor resident 10 through the night.<br><br>Further information on the SD DOH FRI revealed:<br>*Administrator A had not notified law enforcement or the Department of Human Services (DHS) until after the surveyors had entered the building on 6/18/24.<br>*Both entities were to have been notified if there was reasonable cause to suspect abuse or neglect of any resident by any person.<br>*A conclusion summary indicated resident 37 had been monitored throughout the night of 6/13/24.<br>*Administrator A provided education to all staff on 6/14/24 to monitor residents 10 and 37 and move | F 600 | | |

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| F 600 | Continued From page 7<br>resident 10 if any interaction between her and resident 37 was happening.<br>*Administrator A instructed CNA E and LPN O to document on 6/13/24 what between residents 10 and 37.<br>*CNA E documentation revealed:<br>-"I noticed [resident 37] door was almost completely closed besides a crack."<br>-He knocked on the door and entered to find resident 10 by resident 37.<br>-He (resident 37) was sitting in his recliner with his feet down, leaning and facing toward resident 10 and she was also facing resident 37.<br>-They were about one foot apart from each other while "chatting a little bit."<br>-CNA E decided to take resident 10 out of resident 37's room to the hallway, then decided to take her to her room.<br>-"[I] noticed her shirt was on weird and completely unbuttoned with both her breasts exposed."<br>-"With notice, resident 10 has a crippled arm and is not able to unbutton her shirt herself."<br>*LPN O was called to resident 10's room by CNA E at 8:58 p.m.<br>-LPN O's documentation confirmed CNA E's documentation.<br>-LPN O added that resident 10 was not able to tell her or CNA E what or if anything had happened.<br>*LPN O completed resident 10's 6/13/24 incident report indicating:<br>-On 6/13/24 at 11:15 p.m. LPN O checked on resident 10.<br>-"She was restless, wide awake, legs hanging out of bed, and had her arms crossed over her chest."<br>-"When asked if she (resident 10) is ok, she quickly states ?no? [no]"<br>-LPN O assisted her in getting her legs back in bed and covered up. | F 600 | | |

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| F 600 | Continued From page 8<br>-"Resident keeps trying to say something to [the] nurse but is unable to get the words out.<br>-"Nurse sat with resident for about 5 minutes. She was able to relax some and close her eyes."<br>-At 1:45 p.m., "She was awake in bed. She appeared to be calm and comfortable."<br><br>2. Interview on 6/18/24 at 3:45 p.m. with ADM A regarding the FRI report regarding residents 10 and 37 revealed:<br>*They had notified the SD DOH of the event on 6/14/24.<br>*They had not notified law enforcement or the Department of Human Services (DHS) because they were waiting for SD DOH to tell them what to do.<br>-They were not done with their investigation.<br>*ADM A confirmed:<br>-Resident 37 had a Brief Interview for Mental Status (BIMS) score of 13, indicating he was cognitively intact.<br>-Resident 10 had a BIMS score of 99, indicating the resident chose not to participate for four or more items, or gave nonsensical responses.<br>-Resident 10 liked to go into residents 37 and 5's room and sit with them often.<br>-It occurred mostly after meals.<br>*Administrator A said resident 37 had a history of calling resident 10 inappropriate names and expressed not wanting her in his room at different times.<br>-She confirmed during the above 6/18/24 at 3:45 p.m. interview that resident 37 was being moved to another on 6/18/24 to put space between resident 10 and resident 37.<br><br>The following surveyor interviews were completed to support the above staff interviews regarding the resident-to-resident allegation: | F 600 | | |

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| F 600 | Continued From page 9<br><br>3. Interview on 6/20/24 at 4:25 p.m. with CNA E revealed:<br>*He had not seen resident 37 touch resident 10 on 6/13/24, but he (resident 37) quickly jolted back when CNA E walked into his room, so CNA E removed resident 10 from resident 37's room.<br>*CNA E attempted to ask resident 10 questions.<br>-She was cognitively impaired with dementia.<br>-CNA E asked her if resident 37 had touched her, and she said yes.<br>*LPN O had entered resident 37's room and asked him if he had a visitor.<br>-He denied having a visitor and then he "became frantic/hesitant after she asked him if resident 10 was in his room with him, and he admitted she was in his room."<br>*CNA E stated:<br>-"She could have been in resident 37's room for a while because [LPN O and CNA E] had been busy putting other residents to bed.<br>-He did not remember the exact time, but thought it was between 9:00 p.m. and 10:00 p.m.<br>-Resident 10 was one of the last people to go to bed.<br>-Resident 10 would go into the room shared by residents 37 and 5 often because she thought resident 5 was her son.<br>-He had never seen resident 10 on resident 37's side of the room before 6/13/24.<br>-Resident 5 was in the room at the time of the event but was not facing the same way as the other two residents.<br>-Resident 37 was sitting in a recliner/lift chair tilted forward and fully lifted.<br>--He was facing her, and she was facing him, and they were about one foot apart.<br>*After he had taken resident 10 to her room across the hall he realized: | F 600 | | |

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| F 600 | Continued From page 10<br>-Her shirt was unbuttoned all the way, and she was not able to unbutton it herself."<br>-She was not wearing a bra or an undershirt.<br>*CNA E stated: CNAs charted when residents had behaviors.<br>-He had never heard resident 10 and resident 37 talk to each other.<br>-Resident 37 had not used inappropriate verbal sexual remarks with other residents.<br>-He heard younger female staff state resident 37 had used inappropriate sexual remarks with younger female staff.<br>-On that night one of the female staff members had said resident 37 used inappropriate verbal remarks toward her.<br>-Another CNA also had inappropriate remarks made to her from resident 37 a few days before the event.<br>--He did not know the names of those female staff members.<br><br>4. Interview on 6/21/24 at 8:14 a.m. with LPN O revealed:<br>*She worked on the evening of 6/13/24.<br>*Around 9:00 p.m. CNA E came to get her and told her what he had seen.<br>*She was just told resident 10 required full assistance with unbuttoning of her clothes.<br>-She had never seen her unbutton her shirt.<br>*She was not told about resident 10's shoes being off.<br>- She had seen her take her shoes off before.<br>*CNA E had brought resident 10 to her room and pulled her shirt closed.<br>*LPN O texted administrator A and asked her to call her.<br>-She called back right away, and LPN O explained what had happened.<br>-Administrator A said to make sure she checked | F 600 | | |

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| F 600 | Continued From page 11 | F 600 | | |

on resident 10, documented, and to keep residents 10 and 37 separated.
*LPN O stated resident 10 wandered in her wheelchair often, most days going into resident 37's room, even when he was not there.
-She had documented that resident 37 had told resident 10 to "get the hell out of there" (his room) before.
-She had educated him to call for help to get her out of his room.
*LPN O had not seen resident 37 be inappropriate, but other staff had documented that he has made comments about slapping their butts but not that he had ever done it.
-She stated, "(Resident 37) had a side that can be inappropriate, not all the time but he has his moments."
-He had not been inappropriate with other residents that she was aware of.
*She did not know if she had access to the SD DOH reporting system. She would report to administrator A.

5. An interview on 6/21/24 at 10:00 a.m. was attempted with resident 5 (resident 37's roommate) regarding the event that took place on 6/13/24 in his room. Resident 5 was unable to participate in that interview.

6. Interview on 06/20/24 at 4:57 p.m. with resident 37 revealed:
*He was moved to a new, private room at the end of the 100 wing on 6/18/24 after an incident with resident 10.
*He saw resident 10 wheel herself past his room just before the surveyors entered his room for an interview.
-He was afraid she would see him here.
-He thought she would have seen him and would

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have wheeled into his room when she saw him, and he was glad she did not.
*She would come into his room when they both lived in the 200 hall, two or three times a week and stare out the window.
*She would sometimes go in the bathroom or remove his roommate's socks from his drawer.
*She would sometimes go through his refrigerator and try to take his pop.
-He would kick the refrigerator door and tell her to "Put that back."
*On 6/13/24 she came into his room in her wheelchair and tried take a Mountain Dew from his refrigerator.
-He would "ring my buzzer and she came to get her", referring last week when resident 10 came into his room.
-He had not recalled who came into the room to get her on that day.
-One time CNA R came to get her.
*He stated on the evening of 6/13/24:
-Resident 10 was in his room in front of his refrigerator taking off her shoes.
-She took off both of her shoes but not her socks.
-He helped her put her shoes back on.
-He lowered his chair down and reached forward to put her shoes on.
-He thought she must have had a sore foot because she said, "Oh that hurts."
-He said, "Her shirt was unbuttoned at the bottom, and she had started unbutton her shirt from the bottom up."
*He put his call light on a minute after taking the pop from her.
*She was in the room for about 5 minutes.
*"Her shirt was not unbuttoned at that time."
*He did not try to help her button her shirt.
*He had not known if she had anything else under her shirt.

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*He denied touching her.
*He denied she touched him.
*He denied that she was exposed.
*He denied calling resident 10 any names.
*He did not enjoy resident 10's visits.
*He felt roommate (resident 5) hardly knew she was there.
*He stated he was given a new room because resident 10 used to come into his room all the time and he was glad to have his new room.
*He stated resident 10 had not been in his room since he moved.

7. Interview on 6/21/24 at 9:22 a.m. with business office (BO)/social services designee (SSD) D regarding residents 10 and 37 revealed:
*Resident 10 wanders everywhere in a wheelchair.
*If you keep your door shut, she is pretty good.
*She did go into resident 5's room a lot because he looks like her son.
*There has never been a problem between her and resident 5, they both fall asleep in their chairs and seldom talk.
*On 6/20/24 resident 37 was worried that resident 10 was going to come into his new room as she had just wheeled herself past his room.
*BO/SSD D had not been aware of an incident of resident 37 calling resident 10 inappropriate names.
-She could see that might happen.
-His use and choice of words were 'crass'.
*Resident 37 sees a behavioral health services counselor.
*He can be very defensive.
*BO/SSD D had never heard him say anything sexual near residents but can be inappropriate with staff.
*BO/SSD D's social service (SS) consultant was

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| F 600 | Continued From page 14<br>not called regarding the 6/13/24 event.<br>*Administer A did the investigation, so BO/SSD had not done anything.<br>*BO/SSD D had not checked resident 10 the next day to monitor her emotional status.<br>*BO/SSD D had the "SS consultant information and could call her if I needed help."<br>-The SS consultant visited the provider quarterly, and if BO/SSD D needed her she would be able to come.<br>Review of the SSD job description included:<br>*Essential duties:<br>-Work with an interdisciplinary team to provide psychosocial support to residents, families, and or vulnerable populations so they can cope.<br>-Counsel residents, advise family, and assist in the development of their needs and concerns by means of visits, interviews, and care planning.<br>-Assess resident's needs throughout their stay at the facility to maintain a care plan that addresses social, emotional, and psychosocial needs. Continually assess resident needs while they are adjusting to their new home.<br>-Continually maintain contact with residents, and families, concerning all aspects of their residency.<br>-Be firm and be able to take responsibility and take charge of situations.<br>*BO/SSD D stated, "I had never visited with anyone about things like that."<br><br>8. On 6/20/24 at 4:50 p.m. resident 10 was observed as she wheeled herself up the 100 hall, unsupervised.<br>*Resident 10 had been at the end of that hall, where resident 37 had been moved to separate them.<br>*The surveyors voiced concern to administrator A as resident 10 was wheeling herself down the 100 hall where resident 37 had been moved. | F 600 | | |

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| F 600 | Continued From page 15<br>*Administrator A asked if the provider must take away resident 10's rights to be down the 100 hall.<br>*Education was provided to her to ensure resident 10's safety, rather than take away her rights.<br><br>Review of resident 37's 5/23/24 Long Term Care Progress Note by his attending physician indicated resident 37 had inappropriate sexual behaviors.<br>There was an incident where he spoke in a way that was inappropriate to high school CNA.<br><br>9. Review of the provider's 6/10/24 SD DOH FRI revealed:<br>*On 6/10/24 at 12:36 p.m. hospice registered nurse (RN) L contacted interim director of nursing (IDON) G and informed her that resident 1 had "open sores on her buttocks."<br>-Dressings had been provided on 6/7/24 by hospice to the provider's staff.<br>-The provider's staff did not use the dressings for resident 1 as "they just put her in wheelchair and applied cream to buttocks."<br>-Hospice RN H spoke with the provider's licensed practical nurse(LPN) I and stated to apply the dressing once resident 1 was placed back into her bed.<br>*On 6/10/24 after the conversation between hospice RN L and IDON G, IDON G notified resident 1's family that she had developed "pressure sores to her bilateral buttocks likely over the weekend."<br>-IDON G then had LPN J place the standing order dressings on the wounds.<br><br>Review of resident 1's medical record revealed:<br>*She was admitted on 1/4/24.<br>*She was admitted to hospice on 1/9/24. | F 600 | | |

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| F 600 | Continued From page 16<br>*On 6/6/24 two reddened areas were identified on her buttocks.<br>-On 6/7/24 hospice provided Optifoam (foam dressing with adhesive borders) dressings for the reddened area.<br>*Her family was notified on 6/10/24 of the pressure ulcers and their condition.<br>*On 6/11/24 a Wound Documentation assessment was completed which indicated the onset date as 6/6/24.<br>-The 6/11/24 Wound Documentation indicated there were currently six areas identified as pressure wounds.<br>-Areas identified and the measurements of each were:<br>--Two on her left buttock measured 6.0 centimeters (cm) by 8.0 cm. and the other measuring 2.5 cm by 2.0 cm.<br>--Two on her right buttock measured 7.0 cm by 7.0 cm and the other measuring 1.5 cm by 1.5 cm.<br>--One on her coccyx (tailbone) measured 1.7 cm by 0.8 cm.<br>--One on her left heel measured 2.9 cm by 2.0 cm.<br>*Her family requested an air mattress be placed on her bed.<br>-Hospice ordered that mattress.<br>*Wound care orders included: "Applied cavilon advanced [skin protectant] to peri wound area due to erythema [redness]. Applied heel mepilex [absorbent foam] dressing to buttocks to cover the entire area of the wound. Also applied a 4x4 mepilex to the middle of the dressing to ensure it was sealed. Applied betadine to left heel."<br>-Her primary care physician was notified.<br>*On 6/11/24 a hospice standing order for "Optifoam Gentle Heel Foam Dressing 9 x 9. Apply to buttock/coccyx area daily. Apply 4 x 4 | F 600 | | |

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| F 600 | Continued From page 17<br>foam dressing over coccyx area to seal." was entered in her orders.<br>-On 6/12/24 was the first time that order was documented in her treatment administration record as completed for the first time.<br>*She passed away on 6/14/24.<br><br>Interviews conducted during the survey dates of 6/18/24 through 6/21/24 confirmed resident 1 had developed pressure ulcers and had not received appropriate and timely treatment for those pressure ulcers.<br><br>Interview on 6/21/24 at 11:25 a.m. with administrator A regarding resident 1's pressure ulcer revealed:<br>*Resident 1 was on hospice.<br>*Two licensed practical nurses had been terminated due to this incident.<br>*Education on abuse and neglect had been provided to all staff.<br>*Her expectation would have been for the pressure ulcer to be checked on daily and documented in the resident's EMR.<br><br>Interim IDON G was unable to be contacted for an interview.<br><br>Refer to F686. | F 600 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, interview, and Centers | F 641 | This deficiency has the potential to impact all residents.<br>Administrator/DON has reviewed and updated policies and procedures. | 7/23/2024 |

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| F 641 | Continued From page 18<br>for Medicaid and Medicare (CMS) Resident Assessment Instrument (RAI) Manual, the provider failed to ensure the Minimum Data Set (MDS) assessments were coded accurately for:<br>*One of one resident (15) who had pressure ulcers.<br>*One of one resident (27) who did not have a catheter.<br><br>1. Review of resident 15's electronic medical record (EMR) revealed:<br>*She was admitted on 11/1/23.<br>*Weekly wound documentation completed on 5/6/24 indicated two "grade 2" coccyx pressure wounds.<br>-"Resident has two new open sores to coccyx- one on the left and right side."<br>*Her 5/11/2024 Quarterly Minimum Data Set (MDS) assessment, section M (Skin Conditions) indicated the resident had no unhealed pressure ulcers.<br><br>Interview on 6/20/24 at 2:47 p.m. with MDS/registered nurse (RN) C regarding resident 15's pressure ulcers revealed:<br>*She had completed resident 15's 5/11/24 MDS assessment.<br>*She had not reviewed the weekly wound documentation completed on 5/6/24 before completing the MDS.<br>*She confirmed resident 15 had two pressure wounds discovered on 5/6/24.<br>*She stated, "The MDS was not coded correctly. I would have expected that to be on there."<br><br>Review of the October 2023 CMS RAI Version 3.0 Manual Section M, Page M-1 revealed:<br>"Steps for Assessment 1. Review the medical record, including skin care flow sheets or other | F 641 | Inaccurate MDS has been updated and resubmitted by MDS coordinator.<br><br>Review of residents MDS have been audited and no other inaccuracies found during audit. Schedule for residents' assessment due quarterly, biannually, and annually have been created for IDT team to follow to ensure they are completed in a timely manner.<br><br>MDS and Assessment audits will be completed by DON or designee with each residents ARD x3 months, two residents will be randomly audited each month x 3 months and PRN following. If desired outcome is not achieved/maintained, individual staff education to be completed as indicated and review of process will be completed.<br><br>Addendum<br>MDS coordinator or designee will present findings from these audits at the monthly QAPI committee for review for 12 months. | |

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| F 641 | Continued From page 19<br>skin tracking forms, nurses' notes, and pressure ulcer/injury risk assessments. 2. Speak with the treatment nurse and direct care staff on all shifts to confirm conclusions from the medical record review and observations of the resident. 3. Examine the resident and determine whether any ulcers, injuries, scars, or non-removable dressings/devices are present."<br>2. Review of resident 27's 5/4/2024 Quarterly Minimum Data Set (MDS) assessment, section H (Bladder and Bowel) revealed she:<br>*Was admitted on 2/17/23.<br>*Had an indwelling urinary catheter.<br><br>Interview on 6/19/24 at 2:00 p.m. with MDS/RN C regarding resident 27 revealed:<br>*She did not have a catheter.<br>-Had not had a catheter since she was admitted.<br>*MDS/RN C:<br>-Had completed resident 27's 5/4/24 MDS assessment.<br>-Had not known section H had been marked to indicate she had a catheter.<br><br>Review of the October 2023 CMS RAI Version 3.0 Manual Section H, Page H-2 revealed:<br>*"Care planning should be based on an assessment and evaluation of the resident's history, physical examination,physician orders, progress notes, nurses' notes and flow sheets, pharmacy and lab reports, voiding history, resident's overall condition, risk factors and information about the resident's continence status,<br>catheter status, environmental factors related to continence programs, and the resident's response to<br>catheter/continence services.<br>*"Steps for assessment" | F 641 | | |

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| F 641 | Continued From page 20<br>-"Examine the resident to note the presence for any urinary or bowel appliances."<br>-"Review of the medical record, including bladder and bowel records, for documentation of current or past use of urinary or bowel appliances."<br>3. Interview on 6/21/24 at 11:25 a.m. with MDS/RN C regarding MDS assessment completion revealed:<br>*She was responsible to complete and ensure the MDS was accurate for each resident.<br>*Her training had included basic training through online resources.<br>*When she had questions she would review the RAI manual for answers. | F 641 | | |
| F 657 SS=E | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s).<br>An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in | F 657 | This deficiency has the potential to impact all residents.<br><br>Administrator/DON/MDS coordinator reviewed and updated policy and procedures. Care Plans found to be inaccurate have been corrected.<br><br>Complete Care plan audit and update will be completed for all residents by DON/MDS coordinator within 30 days of POC. Schedule has been implemented for resident care plans to be updated and reviewed with resident's care conference by DON and/or MDS coordinator.<br><br>Care Plan audits will be completed by DON with each residents ARD x 3 months, two residents will be randomly audited each month x 3 months and PRN following. If desired outcome is not achieved/maintained, individual staff education to be completed as indicated and review of process will be completed. | 7/23/2024 |

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| F 657 | Continued From page 21<br>disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and policy review, the provider failed to review and revise comprehensive care plans to ensure care needs were accurately reflected for six of twelve sampled residents (3, 10, 16, 23, 26, and 37). Findings include:<br><br>1. Interview on 6/18/24 at 11:14 a.m. with administrator (ADM) A during the entrance conference revealed there was one resident (16) who received dialysis treatments and one resident who smoked cigarettes (26).<br><br>Review of resident 16's medical record revealed:<br>*He received dialysis treatments two days a week.<br>*His care plan indicated "Fluids as ordered. Restrict or give as ordered."<br><br>Interview on 6/19/24 at 10:26 a.m. with certified nursing assistant (CNA) R regarding resident 16 and care plans revealed:<br>*If she observed any bleeding at resident 16's dialysis site on his arm, she would report it to the nurse.<br>*He had been on a fluid restriction, and she thought "they took it [the fluid restriction] away" but she was not sure.<br>-She had seen him have a glass of water in his room, so she had given him water during a routine | F 657 | Addendum<br>Resident 3 - Care plan updated to reflect the use of a seat belt on her wheelchair. closet care plan updated and devise assessment was completed.<br>Resident 10 - comprehensive and closet care plan was updated to reflect current behavior monitorin gin place and encouraging resident to attend activities to prevent wandering to other residents' rooms.<br>Resident 16 - Care plan updated to reflect regular fluids as ordered, no fluid restriction required at this time. Discontinued on 10/10/2024.<br>Resident 23 - Residents comprehensive and closet care plan to the floor and a fall mat beside the bed when resident is resting. Nursing is to remove the fall mat and raise the bed when resident 23 appears restless or anxious.<br>Resident 26 - Resident has been discharged.<br>Resident 37 - Hourly checks were removed from care plan as this is no longer required. | |

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| F 657 | Continued From page 22<br>water pass.<br>*She stated CNAs received information about changes in resident's care through the use of a communication book, verbal report at change of shift, and "other CNAs tell me."<br>*She stated she had memorized what care the residents needed and would review a new resident's care plan when they were admitted.<br><br>Interview on 6/19/24 at 3:48 p.m. with registered nurse (RN) N regarding resident 16's fluid restriction revealed:<br>*She thought he was on a fluid restriction.<br>*She was not sure what the fluid restriction amount was.<br>*She did not monitor or document his fluid restriction.<br>*She stated, "He doesn't drink all of what is put in front of him, so I don't worry about it."<br><br>Interview on 6/20/24 at 10:54 a.m. with minimum data set coordinator/registered nurse (MDS/RN) C regarding resident 16 revealed:<br>*He was not on fluid restrictions or a specialized diet as the dialysis provider had discontinued it on 10/10/23.<br>*She confirmed his care plan indicated his fluids were as ordered or restricted as ordered.<br>*She agreed his care plan for fluids was not individualized to reflect his current needs.<br><br>2. Review of resident 26's medical record revealed:<br>*His smoking safety screen was completed on 4/16/24 and indicated:<br>-He had or shown signs of dementia or other cognitive impairment.<br>-He smoked 10 or more cigarettes each day.<br>-He was able to demonstrate safety with smoking. | F 657 | | |

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| F 657 | Continued From page 23<br><br>Interview on 6/19/24 at 10:26 a.m. with CNA R regarding resident 26 revealed he smoked independently.<br><br>Review of his 6/20/24 care plan included:<br>*A 4/16/24 revised focus area that he smoked cigarettes and was at risk for injury related to smoking.<br>*Staff were to assist him outside to smoke and ensure clothing was appropriate for weather.<br>*The charge nurse was to provide him 8 cigarettes each day in the morning, and he was allowed to smoke independently as long as maintained his safety awareness.<br>*Staff were to ensure resident 26 was aware/compliant with the facility's smoking policy and his plan.<br>*Staff were to report burns to himself or his clothing.<br>*A smoking assessment would be completed quarterly and PRN (as needed) for any changes in his condition.<br><br>Interview on 6/20/24 at 11:25 a.m. with MDS/RN C regarding resident 26's smoking and his care plan revealed:<br>*He was assessed and was determined to be safe to smoke on his own on 4/16/24.<br>*She confirmed his care plan indicated he was not safe to smoke on his own.<br>*She stated his care plan was "not supposed to be that way".<br>*She was responsible for ensuring his care plan was accurate.<br><br>3. Observation and interview on 6/18/24 at 2:31 p.m. with CNA P regarding resident 23 and care plans revealed: | F 657 | | |

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| F 657 | Continued From page 24<br>*Her bed was positioned low to the floor.<br>*A fall mat was in the room but had not been placed at her bedside.<br>*CNA P stated resident 23 was mostly non verbal, had several falls recently, and the fall mat was used "only when she is sleeping."<br>*She used the residents' care plans to know "what care the residents need."<br><br>Observation of an index card dated 6/4/24 located on resident 23's closet door revealed:<br>*The resident was independent with transfers.<br>*Fall risk interventions included "bed to floor" and "fall mat @ NOC [at night]."<br><br>Review of resident 23's electronic medical record (EMR) revealed:<br>*Her Morse Fall Scale assessment completed on 3/29/24 indicated she was at high risk for falls and she had at least 14 documented falls in the past 90 days.<br>*Her current care plan included:<br>-"TRANSFER: Supervision to limited assist of 1 with walker."<br>*It did not include her bed was to have been positioned low to the floor or the use of a fall mat at night.<br><br>Interview on 6/20/24 at 9:44 a.m. with MDS/RN C regarding resident 23's care plans revealed:<br>*She had been aware of resident 23's frequent falls and stated, "Interventions tried included redirection."<br>*Most of the falls were "with wandering and could be due to discomfort or anxiety."<br>*She had experienced a gradual decline since hospice started 10/23/23. Her family wanted her to continue to walk despite falls as it limited her anxiety and reduced her need for medication. | F 657 | | |

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*Her bed was "kept in the lowered position close to the floor with a fall mat during the night or when she is sleepy and may roll out of bed. During the day the fall mat was not always used due to the increased fall risk associated with the mat if she wanted to get up."
*She would have expected staff to know what interventions had been in place because they "would be in the care plan that is kept on the closet door."
Those "closet" care plans were updated monthly to reflect the information that was on residents' care plans.
*It was her responsibility to update care plans.

4. Observation and interview on 6/18/24 at 4:42 p.m. with resident 3 revealed:
*She was seated in her wheelchair with a seat belt around her waist and connected to the wheelchair.
*She stated the seat belt was to keep her in the chair, "I fall easily". She was able to unclasp the seat belt.
*Her closet care plan did not include she used a seat belt.

Review of resident 3's current care plan revealed it did not include she had used a seat belt.

Interview on 6/19/24 at 11:25 a.m. with MDS/RN C regarding resident 3's seat belt confirmed the use of the seat belt was not included on her care plan.

5. Review of resident 10's EMR including her updated 6/18/24 care plan revealed resident 10:
*Was considered a vulnerable adult due to a limited mobility.
*She wandered the halls in her wheelchair,

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| F 657 | Continued From page 26<br>entering other resident's room.<br>*Staff were to remove her physically from any potentially harmful situations while reassuring her.<br>*A new intervention in her care plan was to ensure she would be observed hourly, and she stayed out of resident 37's room and other rooms for her safety.<br><br>Review of resident 10's closet care plan on 10/21/24 at 10:30 a.m. revealed:<br>*It was last updated on 6/4/24 before the event.<br>*The closet care plan had not been updated to include caregivers were to ensure she would be observed hourly, and she stayed out of resident 37's room and other rooms for her safety.<br><br>6. Review of resident 37's EMR including his updated 6/18/24 care plan revealed resident 37:<br>*Was considered a vulnerable adult due to recent declines in ADL function, seizures, and ataxia (impaired balance or coordination).<br>*Staff were to remove him physically from anything potentially harmful.<br>*A new intervention in his care plan was to ensure he would be observed hourly and redirected.<br><br>Review of resident 37's closet care plan on 6/21/24 at 10:30 a.m. revealed:<br>*It was last updated on 6/4/24.<br>*It had not been updated to include staff were to ensure he would be observed hourly and redirected.<br><br>7. Interview on 6/20/24 at 11:25 a.m. with MDS/RN C revealed:<br>*Any staff member could update a resident's care plan.<br>*She was responsible for ensuring all care plans were updated with the resident's current care | F 657 | | |

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| F 657 | Continued From page 27<br>needs.<br><br>8. Interview on 6/20/24 at 1:30 p.m. and again at 2:00 p.m. with MDS/RN C regarding care plans revealed:<br>*The nurses had access to the care plan.<br>*The CNAs and temporary staff could look at the "closet care plans" located on each resident's closet door.<br>*The closet care plans were index cards with the necessary information for caregivers to provide care to the residents.<br>*The closet care plans were updated monthly.<br><br>The documentation in the care plans did not reflect or support the information provided by MDS/RN C, as the care plans had not been updated.<br><br>Review of the provider's reviewed 9/18/19 Care Plan Policy and Procedure revealed:<br>*The care plan was the basic responsibly of the MDS/RN or designee.<br>*Care plans included "goals and/or expected outcomes, specific nursing interventions so that any nursing staff member is able to quickly identify a residents individual needs and to decrease the risk of incomplete, incorrect, or inaccurate care, and to enhance continuity of nursing care."<br>*"Care plans will be reviewed quarterly, annually, and with any significant change in resident condition."<br>*"Short term changes to the care plan would be added as necessary to the Short Term Care Plan."<br>*"Each discipline will update the care plan as changes occur between assessments and scheduled care | F 657 | | |

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| F 657 | Continued From page 28<br>conferences."<br>*"Care plans were to be written by exception for Resident Centered Care Plan Facility Standards and Short Term Care Plans. They include measurable outcomes and identify interventions that were specific to the individual resident with defined time frames and parameters. Target dates are through next review period unless otherwise specified."<br><br>Review of the providers' April 3, 2023 Comprehensive Care Plan policy revealed "Each Resident's care plan will be updated if a goal has been met or if a new focus arises. If a change is made on a paper copy of a resident's care plan you must date and initial by the change."<br><br>Review of the provider's undated Fall Policy revealed: "The team will discuss root causes for any fall, formulate a plan to prevent further falls, and ensure care plan and staff are updated on all plans to prevent falls." | F 657 | | |
| F 686 SS=G | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent | F 686 | This deficiency has the potential to impact all residents.<br><br>Lack of communication and documentation regarding residents that require frequent repositioning due to the potential for development of pressure injuries. Residents at high risk for pressure injuries should have been identified and placed on a documented repositioning program alongside weekly skin assessments and quarterly risk for pressure injury assessments. | 7/23/2024 |

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| F 686 | Continued From page 29<br>new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of the South Dakota Department of Health (SD DOH) Facility Reported Incident (FRI), record review, interview, and observation, the provider failed to ensure two of two sampled residents (1 and 4) received necessary care and treatment in a timely manner for the prevention of pressure ulcers. Findings include:<br><br>1. Review of the provider's 6/10/24 SD DOH FRI revealed:<br>*On 6/10/24 at 12:36 p.m. hospice registered nurse (RN) L contacted interim director of nursing (IDON) G and informed her that resident 1 had "open sores on her buttocks."<br>-Dressings had been provided on 6/7/24 by hospice to the provider's staff.<br>-The provider's staff did not use the dressings for resident 1 as "they just put her in wheelchair and applied cream to buttocks."<br>-Hospice RN H spoke with the provider's licensed practical nurse(LPN) I and stated to apply the dressing once resident 1 was placed back into her bed.<br>*On 6/10/24 after the conversation between hospice RN L and IDON G, IDON G notified resident 1's family that she had developed "pressure sores to her bilateral buttocks likely over the weekend."<br>-IDON G then had LPN J place the standing order dressings on the wounds.<br><br>Review of resident 1's medical record revealed:<br>*She was admitted on 1/4/24.<br>*She was admitted to hospice on 1/9/24.<br>*On 6/6/24 two reddened areas were identified on | F 686 | Residents with current pressure injuries and at high risk for the development of pressure injuries have been placed on a frequent repositioning program, which will be documented on an automatic task on the residents ADL charting in POC as of 6/21/24 by DON.<br><br>All residents will be assessed for risk of pressure injuries on admission, quarterly, and with changes in conditions. An individualized plan of care will be created and implemented by the wound care certified nurse within 48 hours of admission.<br><br>Current polices and procedures regarding pressure injuries and repositioning reviewed by DON/MDS coordinator on 6/25/2024. Education on repositioning and offloading including techniques to prevent pressure injuries implement for nursing staff on 7/5/24. Education to be reviewed and quiz to be completed for Nurses, CMAS, and CNA's. New hires for nursing staff will be required to complete the quiz as part of the new hire orientation.<br><br>Repositioning/offloading documentation to be audited by DON or designee twice weekly x 4 weeks, once weekly x 2 weeks and monthly following. Audited findings will be reported at QAPI for 12 months. New skin issues will be reviewed each morning with staff at stand up meeting. If desired outcome is not achieved/ maintained individual staff education to be completed as indicated and review of process will take place. | |

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| F 686 | Continued From page 30<br>her buttocks.<br>-On 6/7/24 hospice provided Optifoam (foam dressing with adhesive borders) dressings for the reddened area.<br>*Her family was notified on 6/10/24 of the pressure ulcers and their condition.<br>*On 6/11/24 a Wound Documentation assessment was completed which indicated the onset date as 6/6/24.<br>-The 6/11/24 Wound Documentation indicated there were currently six areas identified as pressure wounds.<br>-Areas identified and the measurements of each were:<br>--Two on her left buttock measured 6.0 centimeters (cm) by 8.0 cm. and the other measured 2.5 cm by 2.0 cm.<br>--Two on her right buttock measured 7.0 cm by 7.0 cm and the other measured 1.5 cm by 1.5 cm.<br>--One on her coccyx (tailbone) measured 1.7 cm by 0.8 cm.<br>--One on her left heel measured 2.9 cm by 2.0 cm.<br>*Her family requested an air mattress be placed on her bed.<br>-Hospice ordered that mattress.<br>*Wound care orders included: "Applied cavilon advanced [skin protectant] to peri wound area due to erythema [redness]. Applied heel mepilex [absorbent foam] dressing to buttocks to cover the entire area of the wound. Also applied a 4x4 mepilex to the middle of the dressing to ensure it was sealed. Applied betadine to left heel."<br>-Her primary care physician was notified.<br>*On 6/11/24 a hospice standing order for "Optifoam Gentle Heel Foam Dressing 9 x 9. Apply to buttock/coccyx area daily. Apply 4 x 4 foam dressing over coccyx area to seal." was | F 686 | Addendum<br>All licensed nurses were required to review and sign off on evidence-based practices on care and treatment outlined in the pressure injury policy. | |

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entered in her orders.
-On 6/12/24 was the first time that order was documented in her treatment administration record as completed for the first time.
*She passed away on 6/14/24.

Interview on 6/19/24 at 1:14 p.m. with hospice registered nurse (RN) H regarding resident 1 revealed:
*The hospice certified nursing assistant (CNA) K had notified her on 6/7/24 that she was concerned about resident 1's "bottom".
*She kept wound dressings in her car and went to gather them.
*When she returned with the dressings, the facility staff had already assisted resident 1 from her bed to her wheelchair.
*Hospice RN H asked licensed practical nurse (LPN) I to evaluate resident 1's bottom after lunch that day.
*When hospice RN H returned on 6/10/24 she was informed the dressings were not applied over the weekend.
-Hospice did not inform the family of the wound as the provider was the primary caregiver.
*The provider managed routine and regular dressing changes of wounds and completed measurements.
-Hospice would record those measurements in their notes.
*During a hospice nurse visit, contact would be made with the provider's nurse on duty and information would be shared by verbal reports.

Interview on 6/19/24 at 2:10 p.m. with hospice RN L regarding resident 1 revealed:
*Resident 1 previously had skin breakdown "off and on for a few months but was healed before she started to decline."

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| F 686 | Continued From page 32<br>*On 6/6/24 hospice CNA K had provided her pictures of resident 1's skin breakdown of her upper right hip area and her "bottom".<br>-Hospice RN L had informed hospice CNA K by telephone to have the facility use Optifoam and reposition her often.<br>*On 6/7/24 hospice RN H was notified there was no Optifoam at the facility.<br>-Hospice RN H brought Optifoam dressings to the facility and gave them to LPN I.<br>*Hospice RN K came to the facility on 6/10/24 and LPN J reported to her that resident 1's buttocks were "much worse."<br>-LPN J told her that the Optifoam was not applied over the weekend and did not think that resident 1 had been repositioned.<br>*Hospice RN L notified IDON G and requested that she call resident 1's family and notify them that the recommendations hospice made on 6/7/24 had not been followed.<br>*Resident 1's daughter then came to facility and took pictures resident 1's buttocks, sent them to hospice RN L and she identified an area as a Stage III pressure ulcer.<br>*Hospice RN L stated that the hospice agency does not manage pressure ulcer care.<br>-They would make recommendations and assist the provider's licensed nurses with changing of the dressings when they were at the facility.<br>-The hospice agency had not required physician orders for Optifoam.<br>*An order on 6/12/24 "Optifoam heel" dressing order was by the provider's consulting wound nurse.<br>*RN L stated the typical hospice communication with the provider's nurses included verbal contact when the hospice nurse arrived, the hospice nurse would visit the resident, and discuss with the provider's nurse again regarding any | F 686 | | |

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| F 686 | Continued From page 33<br>concerns they had found.<br>*She thought the communication between the provider and the hospice agency was poor.<br>-The hospice agency would find information regarding the hospice resident through review of the provider's medical records for that resident.<br>*Hospice RN L stated, "She [resident 1] had a history of just being pushed to the side" and she was very disappointed in the provider's management of her pressure ulcers.<br><br>Interview on 6/19/24 at 3:49 p.m. with hospice CNA K regarding resident 1's pressure ulcer revealed:<br>*On 6/6/24, in the afternoon, she had provided hospice care to resident 1.<br>-During this visit, she found resident 1 "in her bed soaking wet with urine although she had a catheter in place."<br>--The catheter was removed from underneath of her leg, and it stopped leaking.<br>-While providing cares, she identified that resident 1 had redness to her buttocks.<br>--There had been two areas on the right buttock, "about as long as her thumb and the other one higher up by her "butt crack" and a little longer than the first one."<br>-She notified hospice RN L at that time and was instructed to notify the facility nurse on duty.<br>*On 6/10/24 hospice CNA K has shown by LPN J resident 1's buttocks.<br>-CNA K stated she was "disturbed and astounded" by the change in the appearance of her buttocks.<br>-She had notified hospice RN L of that change.<br>*On 6/11/24 IDON G and administrator (ADM) A had called her and asked her who had seen resident 1's pressure ulcer and what had happened, she provided them with same | F 686 | | |

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| F 686 | Continued From page 34<br>information as above.<br><br>Interview on 6/19/24 at 10:26 a.m. with CNA R regarding resident 1 revealed:<br>*She had assisted hospice CNA K in repositioning her on 6/9/24.<br>*She had been told that resident 1 had "sores" and to reposition her more often.<br>-Resident 1 had refused a couple of times.<br><br>Interview on 6/21/24 at 11:25 a.m. with ADM A regarding resident 1's pressure ulcer revealed:<br>*Resident 1 was on hospice.<br>*Two licensed practical nurses had been terminated due to this incident.<br>*Education on abuse and neglect had been provided to all staff.<br>*Her expectation would have been for the pressure ulcer to be checked on daily and documented in the resident's EMR.<br><br>Interim IDON G was unable to be contacted for an interview.<br><br>2. Observation on 6/19/24 at 10:30 a.m. of resident 4 revealed:<br>*She had been in the hallway sitting in a wheelchair (w/c).<br>*Her feet had been resting on the foot pedals and were covered with small foam boots.<br>*She was alert, answered only when spoken to, and had denied any foot pain.<br><br>Observation on 6/20/24 at 2:00 p.m. of resident 4 revealed she had been:<br>*Sitting in a recliner with legs elevated and with her feet crossed at the calf.<br>*Wearing small foam boots. | F 686 | | |

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| F 686 | Continued From page 35<br>Observation on 6/18/24 at 1:30 p.m. of resident 4 revealed:<br>*She had been lying in bed on her left side with foam boots on.<br>*No other pressure-relieving measures were in place.<br><br>3. Review of resident 4's 8/20/23 through 6/21/24 electronic medical record (EMR) revealed:<br>*She was admitted on 1/24/23.<br>*Her diagnoses included the following: Alzheimer's disease and dementia (forgetfulness), psychotic disturbance, major depression with mood disturbance, Type 2 diabetes with neurological complication, degenerative joint disease, and malnutrition.<br>*She had poor memory recall and was unable to participate in decision-making for her care.<br>*She was dependent upon the staff for:<br>-The development of her plan of care and to ensure the interventions were implemented for quality of care.<br>-Assistance with all activities of daily living (ADLs) to include bed mobility, repositioning, and positioning pressure relieving devices.<br>*On 2/10/24 she was admitted to Hospice for end-of-life care.<br>*While under the care of the provider she had acquired seven pressure ulcers.<br>*She had:<br>-One stage 2 pressure ulcer (partial thickness loss) located on her right lateral ankle had worsened to a stage 3 (full thickness skin loss). That wound had been identified on 12/28/23.<br>-A callous formation on her right mid-lateral foot that was identified on 2/21/24 and had worsened to a stage 3 pressure injury.<br>-A deep tissue pressure injury was identified on 3/4/24 to the right lateral foot. It was a deep | F 686 | | |

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| F 686 | Continued From page 36<br>purple/brown color and unstageable.<br>-Two large intact blisters on her left lateral foot that were identified on 4/14/24.<br>-An unstageable pressure ulcer located by her right little toe that was black in color and was identified on 5/30/24.<br>-An open pressure area to her left buttock/sacrum was identified on 4/11/24.<br>*Hospice and a wound nurse had been involved with the care and treatment of her wounds.<br>-The wound nurse was not available for an interview.<br><br>Review of resident 4's 8/20/23 through 6/21/24 progress notes revealed:<br>*On 12/3/23 at 9:38 p.m. the nurse documented, "Nurse was at the nurses station when a loud noise was heard and resident began yelling. Nurse went to room and found resident sitting on the floor of her room near her sink. She was incontinent of stool and had some blood coming from a spot on her R [right] outer ankle."<br>*On 12/28/23 the director of nursing (DON) B documented, "During bath skin assessment, it was noted that resident has a new pressure injury to her right ankle. See wound assessment for details."<br>*Her Braden score fluctuated between 16 and 18 and indicated she was at risk for skin breakdown.<br>-"She had a potential problem with friction and shearing due to moving feebly and/or requires minimal assistance."<br>*She had pressure-reducing devices for her chair and bed.<br>-There was no documentation of a repositioning plan.<br>*On 1/23/24 the Minimum Data Set coordinator (MDS)/RN C documented, "Charge nurse reported that resident's ankle wound looks worse | F 686 | | |

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| F 686 | Continued From page 37<br>today and has eschar [dead tissue that sloughs off healthy skin after an injury] in the wound bed. FNP [practitioner's name] saw resident today to evaluate the wound. Orders received.....If no improvement in wound bed by Thursday afternoon, schedule appointment with [practitioners name] on Friday for the area to be debrided."<br>*On 1/24/24 it was decided with the help of hospice to change the treatment and not debride the wound.<br>*On 2/21/24 DON B spoke with the hospice nurse and confirmed the wound appeared to be larger based on the measurements completed the day before.<br>-There was no documentation to support the callous formation on the lateral side of her right foot had been identified.<br>*On 3/4/24 MDS/RN C documented, "Wound to right lateral ankle dressing change noted. Slough covers 95% of the wound bed, edges are round, and wound appears to be larger. Resident also has a DTI [deep tissue injury] to lateral edge of right foot. It is dark purple in color. It is pea-size. Resident shoes were removed and gripper socks applied."<br>-On 3/8/24 the wound had worsened, and MDS/RN C documented: "Dressing change completed to right lateral ankle. Wound appears larger and now measures 3.1 x [by] 2.5 x 0.4. There is a small necrotic dark are [area] at 12 o'clock that measures 0.4 x 0.6."<br>-On 3/9/24 both of the wounds had worsened, and MDS/RN C documented: "Wound care provided to right lateral ankle this morning because resident had the dressing off. The wound appears swollen and red and warm to the touch. The wound base is 100% green/yellow slough, there is a necrotic area at 12 o'clock that | F 686 | | |

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| F 686 | Continued From page 38<br>appears larger than yesterday and then redness and the skin is boggy just above and to the right of necrotic area. Swelling noted to distal end of wound when leg is elevated. Hospice nurse updated this morning. TED hose left off the foot so no pressure is applied to area. New wound care orders received from Hospice."<br>*On 3/17/24 the charge nurse documented: "Wound dressing changed to R [right] lateral ankle per orders. Peri-wound has increased redness and inflammation. Fax sent to PCP [primary care provider] requesting to consider ABX [antibiotic] tx [treatment].<br>-The physician ordered an antibiotic to be given every 6 hours for 10 days due to right lateral ankle inflammation.<br>*On 4/11/24 DON B documented: "Upon assisting resident to the bathroom, it was noted that resident has an open pressure area to her left buttock/sacrum. Applied a thick layer of calmoseptine over it."<br>-Twelve days later, on 4/23/24, DON B documented that the wound on the left buttocks had closed.<br>-There was no other documentation in the EMR to support the size, appearance, drainage, and pressure relieving measures put in place to promote healing of that wound.<br>*She had a care conference review on 4/11/24.<br>-She had started to decline further and was sleeping more.<br>*On 4/14/24 the nurse documented: "Resident has a large fluid filled blister to lateral left heel and a medium sized blister to the medial left heel, both intact. Right ankle is larger in size, with foul smelling drainage. Peri-wound bright red, swollen and warm to touch. Wound to lateral right foot open with slough and necrotic tissue. Per-wound bright red, swollen and warm to touch." | F 686 | | |

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| F 686 | Continued From page 39<br>-The physician was called, and orders were given to start another antibiotic.<br>*On 4/15/24 the nurse and DON consulted with the Hospice nurse regarding the resident's wounds.<br>-They had decided to discontinue all wound care and provide comfort care for wounds due to poor circulation.<br>*On 4/18/24 the physician was notified of the current status of wound care and the physician advised to continue the wound care to the right ankle to maintain current status. They were to paint the left lateral and medial heel wounds with betadine.<br>-These orders were received three days after the discontinuation of wound care had been decided.<br>*On 4/28/24:<br>-Was the first documentation to support a comprehensive skin and positioning evaluation had been completed for her.<br>-Her Braden score had dropped to 12 and identified her as high risk for skin breakdown.<br>--That was the first Braden score that supported her at high risk due to her gradual failing condition that was identified when she was admitted to Hospice care on 2/10/24.<br>-That was the first documentation that indicated:<br>--Pressure-relieving approaches and interventions were implemented.<br>--A turning and repositioning program had been implemented.<br><br>Review of resident 4's weekly wound documentation revealed there were five separate wounds assessed and documented on weekly versus the seven that had been identified in the progress notes from 12/28/23 through 4/28/24.<br><br>Review of resident 4's "closet" care plan | F 686 | | |

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| F 686 | Continued From page 40<br>revealed:<br>*Those care plans were placed in the residents' closets for the certified nursing assistants and temporary staff use for providing care.<br>*On 1/3/24 a closet care plan was placed in her closet.<br>-She needed the assistance of one staff member with a walker and transfers.<br>-Her only indicated special need was oxygen.<br>*The closet care plan was not updated until 5 months later on 6/4/24.<br>-She was non-ambulatory and needed the assistance of two staff members with transfers.<br>-She was to be repositioned on rounds and was to be provided with offloading.<br>--There was no documentation on what should have been should have been offloaded.<br>-"Pressure ulcer" was marked.<br>-Special needs included: "Heel boots/gripper sock at all times. O2 [oxygen] at night - HOSPICE."<br><br>Review of resident 4's ongoing comprehensive care plan revealed:<br>*Focus area: "ADL [activities of daily living] Self Care Performance Deficit..."<br>-Was created on 1/25/23 and revised on 2/10/23.<br>*Goals: "Will maintain current level of function through the review date." "Will not develop complications of immobility." With a target date of 7/27/24.<br>*Interventions:<br>-"Dressing: [Resident name] requires assistance of 1 with cue with dressing/undressing."<br>-"Oral Care: Independent after set up."<br>*A 1/25/23 focus area that was revised on 11/28/23 indicated: "....has limited physical mobility as e/b [evidenced by] shuffling gait r/t dementia and Alzheimer's." "....will participate in restorative program." | F 686 | | |

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| F 686 | Continued From page 41<br>*Goals: "Will maintain current level of mobility through review date."<br>-"Will remain free of complications related to immobility including....skin-breakdown."<br>--Was created on 2/10/23 and has a target date of 7/27/24.<br>*Interventions:<br>-"Ambulation: .....requires walker and 1 assist."<br>-"Ambulatory status: "1 assist with gait belt and walker for ambulation. When not walking with staff must use a wheelchair."<br>--"Encourage reposition/position changes during rounds."<br>--"Transfer: Can transfer independently with walker in room and with supervision when on the unit."<br>*Focus area: "[Resident's name] has the potential for a Nutritional problem r/t dementia and Alzheimer's, and episodes of dysphagia needing nectar thick liquids."<br>-Was created on 1/25/23 and revised on 2/10/23.<br>-The focus area had not been updated to include her declining condition and wound care nutritional support requirements.<br>*Focus area: "[Resident's name] has potential for impairment to skin integrity r/t cardiac history, fall risk and dementia."<br>-Was created on 2/10/23 and revised on 4/25/23.<br>*Goal: "Will be free from skin alteration/injury through the review date.<br>-Target date was 7/27/24.<br>*Interventions:<br>-"Reposition frequently." No documentation on how frequently she was to have been repositioned.<br>-Required a pressure-relieving mattress when in bed/chair.<br>-No documentation on other pressure relieving measures to promote the health of her skin. | F 686 | | |

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| F 686 | Continued From page 42<br>*Focus area: "[Resident's name] has Pressure injury to Right Lateral Ankle, Right Lateral foot and Bilateral heels r/t Braden score of 10 - 12 (high risk), immobility, terminal diagnosis,"<br>-Was initiated on 4/28/24 and created/revised on 5/5/24. That had been four months after the identification of her first pressure ulcer.<br>-It did not include all seven of her pressure ulcers.<br>*Goals: "Will participate with repositioning." "Pressure injury will show signs of healing and will remain free from infection by/through review date." "Will have intact skin, free from redness, blisters or discoloration by/through review date."<br>-These goals were created on 5/5/24 and had a target date of 7/27/24.<br>-Interventions: "Pressure relieving support surfaces in bed and chair: Standard reduction necessary to reduce pressure and to improve comfort level in relation to positioning/repositioning in bed and chair."<br><br>4. Interview on 6/20/24 at 2:44 p.m. with MDS/RN C regarding resident 4's pressure ulcers, pressure ulcer care, and the documentation of the pressure ulcer care was difficult to follow revealed:<br>-She stated she would bring the timeline and care provided together so the surveyor could review it.<br>-She stated resident 4's physician would be visiting resident 4 on 6/20/24 and she would discuss the pressure ulcers and possible changes in her pressure ulcer care and the two pressure ulcers on her right lateral foot had worsened and were red in color.<br><br>5. Interview on 6/21/24 at 11:30 a.m. with MDS/RN C regarding the pressure ulcers revealed:<br>-She had not put together the documentation of | F 686 | | |

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| F 686 | Continued From page 43 | F 686 | | |

the timeline of the pressure ulcer care.
-She had discussed with resident 4's physician and was told he was not going to change her ulcer orders.
-She stated the new director of nurses (DON) was wound certified and MDS/RN C felt that the wound care would be changing for the better.
*She stated:
-Hospice cannot provide an air bed because she did not meet the hospice guidelines.
-The provider could provide an air bed, but she was scared the resident would break a hip because she moved in bed.
-Resident 4 had used her own mattress when the pressure ulcers started.
-She accepted a provider pressure relief mattress, and it did provide better relief than her mattress.
-She had long pressure relief boots, but she was too hot in them, and she would take them off.
--She had accepted the small foam boots.
-The first thing resident 4 would do when she would lie in bed was to place her feet sideways, so they are lateral to the mattress, and she felt that caused pressure ulcers.

Review of the provider's undated Charting Expectations policy revealed:
*Rounds:
-"The night CNA and the night nurse are expected to do rounds on residents at 1:00 a.m. AND 4:00 a.m. You cannot skip a round as that can be considered neglect....."

Review of the provider's 10/01/21 Pressure Ulcer Prevention policy revealed:
*Purpose:
-"To promote the prevention of pressure ulcer development."

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| F 686 | Continued From page 44<br>-"To promote the healing of pressure ulcers that are present including prevention of infection to the extent possible."<br>-"To prevent the development of additional pressure ulcer."<br>*Policy:<br>-"It is the policy of [facility name] to prevent a resident who enters the facility without pressure sores from developing pressure sores unless the individual's clinical condition demonstrates that they were unavoidable and to provide necessary treatment and services to a resident having pressure sores to promote healing, prevent infection and prevent new sores from developing."<br><br>Review of the provider's 9/18/19 Care Plan Policy and Procedure revealed:<br>*Purpose:<br>-"Care plans will be developed by an interdisciplinary team with participation of the resident, family, and/or representative..."<br>-"Care plans include active and historical diagnoses, goals and/or expected outcomes, specific nursing interventions so that any nursing staff member is able to quickly identify a resident's individual needs and to decrease the risk of incomplete, incorrect, or inaccurate care, and to enhance continuity of nursing care."<br>*General instructions:<br>-"Care Plans will be reviewed quarterly, annually, and with any significant change in resident condition." | F 686 | | |
| F 698 SS=D | Dialysis<br>CFR(s): 483.25(l)<br><br>§483.25(l) Dialysis.<br>The facility must ensure that residents who | F 698 | | |

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| F 698 | Continued From page 45<br>require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review and policy review the provider failed to ensure one of one sampled resident (16) who required dialysis treatment was monitored for abnormalities upon returning from his dialysis treatment. Findings include:<br><br>1. Interview on 6/19/24 at 8:27 a.m. with administrator A revealed resident 16 received dialysis two days per week.<br><br>Review of resident 16's medical record revealed:<br>*A 12/4/23 physician's order for, "Upon return from dialysis: Assess Vital Signs and fistula [a connection between an artery and a vein for dialysis treatment] for bleeding, bruising or other abnormalities prior to resident returning to his room. Document V/S [vital signs] and fistula site. Any abnormal findings or concerns a progress note must be made and faxed to PCP [primary care provider]."<br>*There was no documentation in his treatment administration records that monitoring had occurred for four of sixteen opportunities from April 19, 2024 through June 10, 2024.<br>-Those dates had included 4/19/24, 5/13/24, 5/20/24, and 6/10/24.<br><br>Interview on 6/20/24 at 10:41 with minimum data set coordinator/registered nurse C regarding monitoring of resident who received dialysis revealed:<br>*The charge nurse who worked that day was | F 698 | This deficiency has the potential to impact one resident.<br><br>Pre and Post Dialysis assessments have been added to the dialysis residents TAR for nurses to complete on designated dialysis days including vital signs, Bruit and thrill, visual assessment of fistula and pain. This was added to the TAR on 7/5 by Director of Nursing.<br><br>Future residents in need of hemodialysis will be required to have pre and post dialysis assessments on their plan of care at admission.<br><br>DON/Administrator or designee will review policy and procedures for Dialysis.<br>Policy has been implemented for the documentation and assessment of dialysis residents upon leaving and returning to the facility from Hemodialysis on 7/5/2024 by Director of Nursing.<br><br>Staff education has been provided to all nurses. Nurses to complete policy review of procedure with a post test. New hire nurses will be required to complete this as part of orientation and all nurses will complete dialysis competencies yearly.<br><br>Pre and post dialysis assessments will be audited by DON or designee twice weekly x 4 weeks, weekly x2 weeks, and monthly for 12 months. Findings will be reported at QAPI for 12 months. | 07/23/2024 |

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| F 698 | Continued From page 46<br>responsible to ]have monitored and documented in that resident's electronic medical record.<br>*She had no knowledge of why the monitoring of resident 16 had not been completed.<br>*Resident 16 went for dialysis two days each week.<br>*She said licensed practical nurse (LPN) J should have completed and documented the monitoring for three of the four days that it had not been done for resident 16.<br>-LPN J's "documentation had been a problem."<br>--She was no longer employed there.<br><br>Review of the provider's 10/29/24 Dialysis policy revealed:<br>*[The provider] "will ensure resident follows dialysis schedule as ordered by the physician."<br>*"Nurses will monitor dialysis catheter and/or AV [arteriovenous] fistula site every shift for signs and symptoms of infection an/or malfunction. All concerns will be reported to the dialysis center, nephrologist, surgeon, and/or primary care physician." | F 698 | | |
| F 700 SS=D | Bedrails<br>CFR(s): 483.25(n)(1)-(4)<br><br>§483.25(n) Bed Rails.<br>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.<br><br>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>§483.25(n)(2) Review the risks and benefits of | F 700 | This deficiency has the potential to impact all residents.<br><br>Lack of schedule for assessments to be completed timely was found to be the root cause of inaccuracy.<br><br>Reviewed bed rails policy and procedures.<br>All staff responsible for bed rails will be educated on the protocol of bed rails.<br>Resident rooms have been audited for the use of bed rails. | 07/23/2024 |

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| F 700 | Continued From page 47<br>bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br><br>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and policy review the provider failed to ensure two of two sampled residents (2 and 8) who used bed side rails were appropriately assessed and documentation accurately reflected the type of bed side rail in use. Findings include:<br><br>1. Observation and interview on 6/19/24 at 9:03 a.m. with resident 8 revealed:<br>*She was in her bed, eating breakfast.<br>*The side rails on both sides of the upper one-half of her bed were in the up position.<br>*She indicated she had started using the side rails in 2023 to assist her in turning while in bed after she had fractured her her hip.<br><br>Review of resident 8's medical record revealed:<br>*Her 5/4/24 Brief Interview of Mental Status (BIMS) score was a 15, which indicated her cognition was intact.<br>*An 8/12/20 physician order for "OK to use ¼ side rail/grab bar for assist with bed mobility and turning."<br>*A Physical Device Evaluation completed on 4/9/23 included:<br>-"Rails on Bed", "1/2 side rail", "bilateral" (both sides), and "Pain medications work well but | F 700 | Assessments and consent forms have been completed for all residents with bed rails. DON/ MDS coordinator or designee will ensure that bed rails consents are completed on all residents determined to need a bed rail. Maintenance Director will ensure that the bed rails are removed when residents are discharged.<br><br>Trigger for assessment completion have been turned on for assessments in point click care due quarterly, biannually and annually for IDT team to follow to ensure they are completed in a timely manner.<br><br>Assessment audits will be completed by DON with each residents ARD x 3 months, two residents will be randomly audited each month x 3 months and PRN following. If desired outcome is not achieved/maintained individual staff education to be completed as indicated and review of process will be completed. Findings will be reported to QAPI for 12 months. | |

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| F 700 | Continued From page 48<br>resident requests side rails to help reposition in bed".<br>*There were no other Physical Device Evaluations completed for the use of side rails after that.<br>*Her 6/20/24 care plan included she used an "assistive device 1/4 side rail/grab bar on both sides of bed to assist with reposition and turn in bed. Is not able to pull any of her own weight. Uses bar to hold while turning."<br><br>2. Observation on 6/18/24 at 4:22 p.m. and again on 6/19/24 at 1:40 p.m. of resident 2 revealed:<br>*He was in his bed lying on his right side, with his eyes closed.<br>*A side rail attached to the right, upper half of his bed was in the up position.<br><br>Review of resident 2's medical record revealed:<br>*A 1/18/24 physician order for a "U-shaped grab or 1/4 Side to bed on right side to assist resident in maintaining independence and assist in repositioning self."<br>*An Assistive Device Assessment completed on 1/18/24 had "Bed Assist Bar", and "Alternatives to Restraints Attempted" was marked as "Not Applicable".<br>*A Physical Device Assessment completed on 1/29/24 included the use of "Rails on Bed", "U type grab bar", "Location on bed" was marked as (right side] checked, the "Device will be used for" area had mobility enabler/enhancer, positioning, and safety checked.<br>*There were no other Assistive Device Assessments or Physical Device Assessments completed.<br>*His 6/20/24 care plan included that he used a "U-shaped grab bar to right side head of bed to aid in transfers and repositioning". | F 700 | | |

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| F 700 | Continued From page 49<br><br>3. Interview on 6/19/24 at 10:26 a.m. with certified nursing assistant R regarding resident's side rail use revealed:<br>*Resident 8 used her side rail to help her turn and hold herself in position when care was provided to her.<br>-She had used this side rail for "at least a year."<br>*Resident 2 used his side rail to turn, sit up in bed, to hold his television remote, towels, and his call light.<br><br>4. Interview on 06/20/24 at 5:48 p.m. with minimum data set coordinator (MDS)/registered nurse (RN) C regarding resident assessments for safe and appropriate side rail use revealed:<br>*Those assessments were to be completed on a quarterly basis.<br>*Residents 2 and 8 did not have current assessments for side rail use completed and she:<br>-Was responsible for the completion of those assessments.<br>-Did not know why she had not completed them.<br><br>5. Review of the provider's undated Restraint policy revealed:<br>*"Physical restraints are any manual method or physical or mechanical device, material, or equipment attached to or near your body so a resident can't remove the restraint easily. Physical restraints, prevent freedom of movement or normal access to one's own body."<br>*"Physical or chemical restraints are not to be used, unless it's necessary to treat medical symptoms."<br>*"The following items are considered restraints:<br>-*Side rails".<br>*"To properly use one of the previous items to assist a resident in maintaining independence, | F 700 | | |

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| F 700 | Continued From page 50<br>the resident and the device must be assessed for the following:"<br>-"The resident is able to remove the device without assistance from staff."<br>-"The device has to assist resident in maintaining independence."<br>-"Device must be approved by resident, family, and IDT committee."<br>-"Device must be in care plan and reviewed quarterly (or sooner if issues).<br>*"Siderails: Side rails can be used on a bed to increase a resident's mobility, ability to reposition self, and to maintain independence. Side rails can also be a hazard and detrimental to a resident and cause injury."<br>*"Procedure to Implement a Device that can be considered a Restraint:"<br>-"All devices must be added to the care plan and assessed quarterly for resident's ability to independently use device and the safety of the device." | F 700 | | |
| F 727 SS=F | RN 8 Hrs/7 days/Wk, Full Time DON<br>CFR(s): 483.35(b)(1)-(3)<br><br>§483.35(b) Registered nurse<br>§483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.<br><br>§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.<br><br>§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. | F 727 | This deficiency has the potential to impact all residents.<br><br>Facility to reapply for waiver for RN coverage or ensure an RN is in the facility at least 8 hours daily.<br><br>An audit of RN hours and current staffing to be completed by Administrator/DON. Administrator/DON to ensure adequate RN coverage in the facility and/or waiver is in place.<br><br>Administrator/DON or designee to audit RN coverage weekly x 3 months, monthly x 3 months and quarterly x 6 months. Findings will be reported at QAPI for 12 months. | 07/23/2024 |

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| F 727 | Continued From page 51<br>This REQUIREMENT is not met as evidenced by:<br>Based on Payroll Based Journal (PBJ) reports, interview, and record review, the provider failed to ensure there was a registered nurse (RN) working for eight consecutive hours per day for 36 days in Federal Fiscal Quarters 1 (October, November, and December 2023) and Quarter 2 (January, February, and March 2024), and one day from June 6th, 2024, through June 14, 2024. Findings include:<br><br>1. Review of the provider's Federal Fiscal Quarter 1 (October, November, and December 2023) PBJ Certification and Survey Provider Enhanced Reporting (CASPER) report revealed the following:<br>*There were no eight consecutive hours worked by an RN on the following days:<br>-October 14th, 22nd, and 28th.<br>-November 10th, 11th, 12th, 14th, 24th, 25th, and 26th.<br>-December 3rd, 9th, 10th, 14th, 15th, 17th, 18th, 22nd, 23rd, 24th, 25th, and 31st.<br><br>Review of the provider's Federal Fiscal Quarter 2 (January, February, and March 2024) PBJ CASPER report revealed the following:<br>*There were no eight consecutive hours worked by an RN on the following days:<br>-January 1st, 6th, 7th, 8th, 13th, 20th, and 27th.<br>-February 1st, 3rd, 4th, 11th, 17th, 18th, 24th, and 25th.<br>-March 1st, 2nd, 3rd, 16th, 17th, 23rd, 24th, 25th, 30th and 31st.<br><br>Review of provider's timecards and nurse schedules for the time frames above revealed:<br>*There were no eight consecutive hours worked | F 727 | | |

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| F 727 | Continued From page 52<br>by an RN on the following days:<br>-October 14th, 18th, 22nd, and 28th.<br>-November 4th, 10th, 11th, 12th, 25th, and 26th.<br>-December 3rd, 8th, 9th, 21st, 23rd, 24th, 27th, 29th, and 31st.<br>-January 13th, 14th, and 20th.<br>-February 1st, 2nd, 3rd, 4th, 18th, 23rd, and 24th.<br>-March 2nd, 16th, 17th, 23rd, 24th, 30th, and 31st.<br><br>Additional review of the provider's time cards and nurse schedules from 6/6/24 through 6/14/24 revealed the were no eight-hour consecutive hours worked by an RN on 6/8/24.<br><br>Interview on 6/21/24 at 11:30 a.m. with administrator (ADM) A confirmed there were 37 days that had no eight consecutive hours worked by an RN.<br><br>Interview on 6/21/24 at 11:35 a.m. with Minimum Data Set coordinator (MDS)/registered nurse (RN) C regarding the PBJ revealed:<br>*She had been responsible for submitting PBJ data to the Centers for Medicare and Medicaid Services (CMS) until January 1, 2024, ADM A was then responsible to submit the data.<br>-The information was entered manually, as their time clock system information did not carry over into the PBJ system.<br>*She had not been able to access those Reports online.<br><br>Continued interview on 6/21/24 at 2:07 p.m. with ADM A regarding having an RN work for eight consecutive hours each day revealed:<br>*The provider was licensed to provide skilled nursing care and did not have a nurse waiver.<br>*She confirmed there was not always a registered | F 727 | | |

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| F 727 | Continued From page 53<br>nurse for eight consecutive hours each day at the facility.<br>-When an RN was not in the facility, a physician and an RN were available by phone.<br>*She stated there were no residents in the facility that required an RN for care.<br>-She stated, "If that were needed [an RN], we would have RNs available, the Hospice nurse is also an RN and available when she is here."<br>*The provider was advertising with online employment companies, Facebook, local television stations, and the local newspaper.<br>*The staffing for weekends was "Based upon residents we have and acuity level [of the residents]. | F 727 | | |
| F 761 SS=E | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and | F 761 | This deficiency has the potential to impact all residents.<br><br>Administrator/DON have reviewed and updated storage of prescription medications/ outdated medication policy.<br>All medications found in residents room without self-administration and bedside order have been removed.<br><br>Resident's orders and rooms (with resident permission) have been audited for medications out of compliance by DON and MDS coordinator.<br>All nursing staff are required to complete medication storage education with a post test.<br>All new hire nurses/CMA's will be required to complete medication storage training.<br><br>Pharmacists to be included in reviewing expired medications and providing input to the on-going audits. | 07/23/2024 |

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| F 761 | Continued From page 54<br>Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>A. Based on observation, interview, and policy review, the provider failed to ensure:<br>*As needed (PRN) medications stored in blister pack cards with pharmacist-determined expiration dates had been monitored for expiration and removed for destruction for three of three sampled residents (14, 22, and 31) in one of one medication cart.<br>*Four of four medications had opened or expiration dates indicated, for three of three sampled residents (7, 15, and 33) in one of one medication cart.<br>Findings include:<br><br>1. Observation, medication review, and interview on 6/20/24 at 11:38 a.m. with registered nurse (RN) N of one of one medication cart revealed:<br>*PRN blister pack cards (medication cards) with expired medications for three residents (14, 22, and 31):<br>-Resident 14's acetaminophen was dispensed from the pharmacy on 6/10/23 and expired on 6/8/24.<br>-Resident 22's loperamide caplets were dispensed from the pharmacy on 9/14/23 and expired on 4/30/24.<br>-Resident 31's acetaminophen was dispensed from the pharmacy on 4/5/23 and expired on 4/4/24.<br><br>*Four of four medications had no opened date or expiration date stickers, for three of three | F 761 | Self-Administration assessments and orders will be audited by DON or designee with each residents ARD x 3 months, two residents will be randomly audited each month x 3 months and PRN following. Medication Cart and Medication room will be audited by DON or designee twice weekly x 4 weeks, once weekly x 2 weeks and as needed following. If desired outcome is not achieved/maintained, individual staff education to be completed as indicated.<br><br>Addendum:<br>DON or designee will present findings from these audits at the monthly QAPI committee for review for 12 months. | |

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| F 761 | Continued From page 55<br>sampled residents (7, 15, and 33):<br>-Resident 7's two bottles of fluticasone propionate (nasal spray) were dispensed on 11/16/23. The bottles had no opened date or expiration date indicated.<br>-Resident 15's Ozempic injection pen (for diabetes) had no opened date or expiration date indicated.<br>-Resident 33's bottle of PRN fluticasone propionate was dispensed on 12/26/22.<br>--The bottle had no opened date or expiration date indicated.<br><br>Interview during the above observations with RN N revealed she confirmed:<br>*Those medications were outdated and should have been removed from the medication cart.<br>*The provider normally would mark the medications with an opened date.<br><br>Review of the provider's undated Medication Storage In The Facility policy revealed:<br>*Expiration dates of dispensed medications should be determined by the pharmacist at the time of dispensing.<br>*Certain medications or package types, once opened, require an expiration date shorter than the manufacturer's expiration date to insure medication purity an potency.<br>*Drugs re-packaged by the pharmacy staff would generally carry an expiration date as follows:<br>-The pharmacist determines the exact date based upon a number of factors as well as applicable law or regulation.<br>-Blister pack cards six months from the date of dispensing (when the manufacturer's expiration date is longer than six months). If the manufactures expiration date on the label will be the manufacturer's date. | F 761 | | |

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| F 761 | Continued From page 56<br>*When the original seal of the a manufacturers's is initially broken the container or vial would be dated.<br>-The nurse should place a "date opened" sticker on the medication and enter the date opened and the new date of expiration '(note: the best stickers to affix containers both a "date opened" and "expiration" notation line)"<br>The expiration date of the container would be 30 days unless the manufacturer recommended another date or regulations/guidelines.<br>*No expired medication would be administered to a resident.<br>*All expired medications would be removed from the active supply and destroyed in the facility, regardless of amount remaining.<br>*Disposal of any medications prior to the expiration dating would be required if contamination or decomposition is apparent.<br>Nursing staff should consult with the dispensing pharmacist of any questions related to medication expiration dates.<br>B. Based on observation, interview, and policy review, the provider failed to ensure prescription personal care products in one of one resident tub rooms were:<br>*Securely stored in accordance with accepted professional principles.<br>*Discarded when expired.<br>Findings include:<br><br>Observation on 06/20/24 at 8:34 a.m. of the cabinets in the tub room revealed they contained the following prescription products:<br>*Two bottles of Selsun Blue shampoo with prescription labels.<br>-One was resident 2's bottle and was dated 5/8/23.<br>-One was a resident's who had been discharged | F 761 | | |

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| F 761 | Continued From page 57<br>from the facility on 1/16/24 and was dated 12/28/23.<br>*One bottle of resident 11's prescription "anti-itch lotion" was dated 8/23/22 and had a manufacturer's expiration date of 3/24.<br>*Two tubes of resident 16's prescription labeled Desitin (skin protectant).<br>-One was dated 3/23/23, one was dated 3/2/24.<br>*A bottle of resident 11's prescription labeled Nystatin (antifungal) powder dated 12/30/21 and had a manufacturer's expiration date of 3/23.<br><br>Interview on 6/21/24 at 9:57 a.m. with MDS coordinator/RN C revealed:<br>*She confirmed no staff worked that day who completed baths.<br>*The items stored in the tub room were used during resident baths.<br>*She was unaware that prescription items and expired items had been stored in the tub room.<br>*She would have expected:<br>-Prescription items to have been stored in the locked medication cart or the locked medication room.<br>-Expiration dates on prescription products to have been monitored by the nurse on duty and discarded when expired. | F 761 | | |
| F 848 SS=F | Binding Arbitration Agreements<br>CFR(s): 483.70(n)(2)(iii)(iv)(6)<br><br>§483.70(n)(2) The facility must ensure that:<br>(iii) The agreement provides for the selection of a neutral arbitrator agreed upon by both parties; and<br>(iv) The agreement provides for the selection of a venue that is convenient to both parties.<br><br>§483.70(n)( (6) When the facility and a resident | F 848 | | |

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| F 848 | Continued From page 58<br>resolve a dispute through arbitration, a copy of the signed agreement for binding arbitration and the arbitrator's final decision must be retained by the facility for 5 years after the resolution of that dispute on and be available for inspection upon request by CMS or its designee.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, Arbitration Agreement review, and record review, the provider failed to ensure the Arbitration Agreement:<br>*Included the arbitration organizations name and how to contact that organization.<br>*Provided for a location that was convenient for both parties for an arbitration dispute.<br>Findings include:<br><br>1. Interview on 6/18/24 at 11:14 a.m. with administrator A revealed the provider had an Arbitration Agreement that was reviewed and requested to be signed by newly admitted residents or their representative.<br><br>Review of the provider's Arbitration Agreement revealed the following:<br>*"Location of Arbitration - The Arbitration will be conducted at a site selected by [provider] which shall be either at [the provider] or somewhere within a reasonable distance of [the provider]."<br>*"Time limitation for Arbitration - any request to arbitrate a Dispute must be submitted to [initials of the arbitration agency] (2) years from the date the event giving rising to the dispute occurred."<br>*The agreement provided the initials of the name of the arbitration agency, but did not specify what those initials meant.<br>*The agreement did not provide for a way to contact that arbitration agency. | F 848 | This deficiency has the potential to impact all residents.<br><br>Administrator and Social Services Consultant discussed Binding Arbitration Agreement on 7/16/2024.<br><br>Binding Arbitration Agreement has been updated as of 7/16/2024. The agreement now states that the arbitration shall be conducted by one neutral arbitrator mutually selected by both parties at a mutual location.<br><br>Administrator or designee will audit any new admissions to ensure that the Binding Arbitration Agreement is being explained to new admissions and if signed, to ensure that the updated agreement is being signed. Administrator or designee will audit weekly x 4 weeks and once monthly x 3 months.<br><br>Addendum:<br>For any residents who have previously signed Arbitration Agreement that does not meet the regulatory requirement, will be offered to sign a new agreement.<br>Administrator or designee will present findings from these audits at the monthly QAPI committee for review for 12 months. | 07/23/2024 |

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| F 848 | Continued From page 59<br>Interview on 6/20/24 at 9:28 a.m. with administrator A regarding the Arbitration Agreement revealed:<br>*All current residents or their representative had signed an arbitration agreement.<br>*She was not aware of who had developed and approved the agreement.<br>*Business office/social service designee (BO/SSD) D was responsible for having residents sign the agreement.<br><br>Interview on 6/20/24 at 10:32 a.m. with BO/SSD D revealed:<br>*She was responsible to have new residents sign the arbitration agreement.<br>*She was not aware of who had developed and approved the agreement.<br>*She confirmed:<br>-The location for a dispute was for the provider to determine and not both parties.<br>-The agreement provided the initials of the name of the arbitration agency, but did not specify what those initials meant.<br>-The agreement did not provide for a way to contact that arbitration agency.<br>*She stated the resident or resident's representative could search the Internet on their phone to obtain the name and how to contact that arbitration agency.<br><br>Interview on 6/21/24 at 7:55 a.m. with administrator A regarding the Arbitration Agreement revealed she:<br>*Agreed agreement should have had the arbitration agency name spelled out and a way to contact them.<br>*Agreed facility should not have been independent in selecting the location for an arbitration dispute. | F 848 | | |

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| F 848 | Continued From page 60<br>*Stated not all residents had signed the arbitration agreement, and was not sure why some had not.<br>*To her knowledge, no disputes had occurred.<br><br>Review of the provider's listing of residents revealed 26 of 34 of the current residents had signed an Arbitration Agreement. | F 848 | | |
| F 851 SS=F | Payroll Based Journal<br>CFR(s): 483.70(q)(1)-(5)<br><br>§483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format.<br>Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.<br><br>§483.70(q)(1) Direct Care Staff.<br>Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).<br><br>§483.70(q)(2) Submission requirements.<br>The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:<br>(i) The category of work for each person on direct care staff (including, but not limited to, whether | F 851 | Unable to timely correct past staffing data into PBJ for Federal Fiscal Quarter 1 and Federal Fiscal Quarter 2.<br><br>This deficiency has the potential to impact all residents.<br><br>Administrator will be re-educated on the importance of correctly inputting staffing records into PBJ so infractions do not trigger false alarms.<br><br>Administrator or designee will audit the effectiveness of staffing entries using the CASPER Report 1705D when it becomes available once per quarter for two quarters. Administrator or designee will present the audit findings at monthly QAPI meetings for review. | 07/23/2024 |

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| F 851 | Continued From page 61<br>the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);<br>(ii) Resident census data; and<br>(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).<br><br>§483.70(q)(3) Distinguishing employee from agency and contract staff.<br>When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.<br><br>§483.70(q)(4) Data format.<br>The facility must submit direct care staffing information in the uniform format specified by CMS.<br><br>§483.70(q)(5) Submission schedule.<br>The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.<br>This REQUIREMENT is not met as evidenced by:<br>Review of the provider's PBJ CASPER reports revealed the following items triggered:<br>*Federal Fiscal Quarter 1 and Federal Fiscal Quarter 2:<br>-No registered nurse (RN) hours for eight consecutive hours each day for more than four days.<br>-No 24-hour nurse coverage each day for more | F 851 | | |

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| F 851 | Continued From page 62<br>than four days.<br>-The weekend staffing metric was suppressed, meaning the data submitted was excessively low.<br><br>Interview on 6/21/24 at 11:30 a.m. with administrator A regarding PBJ reporting revealed:<br>*Minimum Data Set Coordinator(MDS)/registered nurse (RN) C had been responsible to submit the PBJ data to CMS.<br>*The time clock system was not able to automatically upload the payroll data to the PBJ system.<br>-The information had to be entered manually.<br>*Administrator A had recently gained access to the PBJ online reporting site, and the time clock had uploaded the data successfully.<br>*She confirmed the data for Federal Fiscal Year 2024 for Quarter's 1 and 2 had not been submitted accurately.<br><br>Interview on 6/21/24 at 11:35 a.m. with MDS/RN C regarding PBJ reporting revealed:<br>*She had been responsible to submit PBJ data to CMS until January 1, 2024, administrator A was then responsible to submit the data.<br>-The information was entered manually, as their time clock system information did not automatically transfer into the PBJ system.<br>*She had not been able to access the validation reports after submission.<br><br>Continued interview on 6/21/24 at 2:07 p.m. with administrator A regarding PBJ Data submission revealed:<br>*She confirmed there was not always an RN for eight consecutive hours each day at the facility.<br>*She confirmed there was no nurse waiver.<br>*She stated there were no residents in the facility that required a RN for care, "if that were needed | F 851 | | |

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| F 851 | Continued From page 63<br>(an RN), we would have RNs available, the Hospice nurse is also an RN and available when she is here."<br>*She confirmed there had been a licensed nurse in the facility at least 24 hours each day and that the PBJ submitted was inaccurate.<br>*When asked about how staff were scheduled for the weekend hours she stated, "Based upon residents we have and acuity level [of the residents].<br>*When asked if the PBJ data was accurate for low weekend staffing, she declined to answer.<br><br>Refer to F727. | F 851 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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 | F 880 | This deficiency has the potential to impact all residents.<br><br>Hand hygiene related to wound care was found to be caused by a lack of knowledge in a traveling RN.<br><br>Hand hygiene related to wound care/dressing changes written education to be completed with traveling RN prior to her next shift at Diamond Care Center.<br>Nursing staff are required to complete hand hygiene education with post test. All new hires will be required to complete hand hygiene training.<br><br>DON audited dressing changes with charge nurses on 7/1 and 7/3 with no other noncompliance found.<br><br>Hand hygiene audits will be completed by DON or designee twice weekly x 4 weeks, weekly x 2 weeks and monthly. Findings will be reported at QAPI for 12 months. If desired outcome is not achieved/maintained, individual staff education to be completed as indicated. | 07/23/2024 |

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| F 880 | Continued From page 64<br>accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. | F 880 | | |

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| F 880 | Continued From page 65<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and policy review, the provider failed to follow acceptable infection control practices during two of two observed dressing changes for two of two sampled residents (4 and 15) by registered nurse (RN) N. Findings include:<br><br>1. Observation on 6/20/24 at 11:29 a.m. with registered RN N during a dressing change for resident 15 who was on enhanced barrier precautions (EBP) revealed she:<br>*Put on a gown and a pair of gloves while in the hallway outside resident 15's room and with those gloved hands she:<br>-Picked up a basket of supplies from the shelf in the hall.<br>-Entered the room and turned the light switch on<br>-Moved the resident's personal items off the bedside table.<br>-Placed a paper towel on the bedside table and placed the basket on that paper towel.<br>-Touched the bed control to raise the bed.<br>-Moved blankets to uncover the resident.<br>-Opened the resident's brief to view the pressure area and then closed the brief.<br>-Covered the resident.<br>-Uncovered the resident's foot and removed the resident's sock.<br>-Sprayed "wound spray" on several pieces of gauze.<br>-Sprayed the resident's toe with the wound spray, touched a darkened area on the resident's toe with the wet gauze, and then touched that | F 880 | | |

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| DIAMOND CARE CENTER | 901 N MAIN AVE BRIDGEWATER, SD 57319 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 66<br>darkened area directly with those same gloved hands.<br>*Removed and discarded those gloves then washed her hands.<br>*Opened the bathroom door, gathered new gloves, closed the door, moved the curtain, and then put on those gloves. With those gloved hands she:<br>-Moved the bedside table closer to the bed.<br>-Opened a package of betadine swabs and wiped the resident's toe with the swab.<br>-Took a gauze pad from the basket and placed it on the barrier next to the basket.<br>-Attempted to wet the gauze with betadine.<br>--Touched the gauze pad directly with those gloved fingers.<br>---Placed that gauze pad on the resident's toe.<br>*Removed those gloves and discarded them.<br>*Without washing her hands, she used tape to secure the gauze in place and directly touched the resident's toe while she held the gauze in place.<br>*Placed the sock back on the resident's foot and covered her without wearing any gloves.<br>*Left the room with the basket of supplies.<br><br>Interview on 6/20/24 at 4:36 p.m. RN N regarding the above dressing change revealed she:<br>*Was an agency nurse and had worked in this facility "on and off for the past five years."<br>*Stated she had completed all "dirty tasks" while wearing one pair of gloves and all "clean tasks" while wearing a second pair of gloves.<br>*Preferred not to use hand sanitizer and elected to wash her hands when necessary.<br>*Stated that all residents with wounds are on EBP and that gloves and gowns are required for all "hands-on care."<br>*Confirmed that she had removed her gloves to | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435114 | A. BUILDING _____ B. WING _____ | C 06/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND CARE CENTER | 901 N MAIN AVE BRIDGEWATER, SD 57319 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 67<br>apply the tape to the gauze and toe because "the tape would have stuck to my gloves."<br>-Acknowledged that applying tape to the gauze and the resident's toe would have been considered hands-on care.<br>*Was unable to identify the missed opportunities for changing her gloves and performing hand hygiene.<br>*Stated she received ongoing educational training from the staff agency she worked for.<br><br>Interview on 6/21/24 at 9:57 a.m. with Minimum Data set (MDS)/RN C regarding the above dressing change revealed:<br>*She would have expected RN N to complete hand hygiene (wash her hands) before putting on gloves and after removing them.<br>*There had been several missed opportunities for RN N to have performed hand hygiene and to have changed her gloves during the observed dressing change.<br>*Agency staff had been provided orientation when they first came to the facility.<br>-Orientation did not include hand washing or glove use.<br>*Agency staff are expected to follow the facility's policies.<br>*She would have expected the staffing agency to provide specific ongoing training on handwashing and glove use that was to the national standard.<br>*She stated if staff chose not to use hand sanitizer then they should have washed their hands when hand hygiene was expected.<br>2. Observation on 6/20/24 at 2:15 p.m. with registered nurse (RN) N during dressing changes for resident 4 who was on enhanced barrier precautions (EBP) revealed she:<br>*Put on a gown and then gloves while in the hallway outside the resident room and with those | F 880 | | |

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| | 435114 | A. BUILDING _____ B. WING _____ | C 06/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| DIAMOND CARE CENTER | 901 N MAIN AVE BRIDGEWATER, SD 57319 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 68<br>gloved hands she:<br>-Picked up a basket of supplies from the shelf in the hall.<br>-Entered the room and turned the light switch on.<br>-Moved the resident's items off the bedside table.<br>-Placed a paper towel on the bedside table and placed the basket on that paper towel.<br>-Moved the blankets to uncover the resident.<br>-Touched the resident's brief.<br>-Touched the resident's bottom to expose the pressure area.<br>-Closed the resident's brief and covered the resident.<br>-Uncovered the resident's foot and removed her sock.<br>-Used "wound spray" to spray several pieces of gauze.<br>-Sprayed the resident's toe with the wound spray and touched a darkened area on the resident's toe first with the wet gauze and then directly with those gloved hands.<br>*Removed those gloves for the first time and washed her hands.<br>*Opened the bathroom door to get gloves, closed the door, moved the curtain, and then put on those gloves. With those gloved hands she:<br>-Moved the bedside table closer to the bed,<br>-Opened a package of betadine swabs and wiped the resident's toe with the swab.<br>-Took a gauze pad from the basket and placed it on the barrier next to the basket.<br>-She attempted to wet the gauze with betadine.<br>--She touched the gauze pad directly with those gloved fingers.<br>---Then placed that gauze pad on the resident's toe.<br>*Removed those gloves and discarded them.<br>*Without performing hand hygiene, she used tape to secure the gauze in place directly touching the | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435114 | A. BUILDING _____ B. WING _____ | C 06/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| DIAMOND CARE CENTER | 901 N MAIN AVE BRIDGEWATER, SD 57319 |

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|---|---|---|---|---|
| F 880 | Continued From page 69<br>resident's toe.<br>*Placed the sock back on the resident's foot and covered her without wearing any gloves.<br>*Left the room with the basket of supplies.<br><br>Interview on 6/20/24 at 4:36 p.m. RN N regarding the above dressing change revealed she:<br>*Was an agency nurse and had worked in this facility "on and off for the past five years."<br>*Stated she had completed all "dirty tasks" while wearing one pair of gloves and all "clean tasks" while wearing a second pair of gloves."<br>*Preferred not to use hand sanitizer and elected to wash her hands when necessary.<br>*Stated that all residents with wounds are on EBP and that gloves and gowns were required for all "hands-on care."<br>*Confirmed that she had removed her gloves to apply the tape to the gauze and toe because "the tape would have stuck to my gloves."<br>-Acknowledged that applying tape to the gauze and the resident's toe would have been considered hands-on care.<br>*Was unable to identify the missed opportunities for changing her gloves and performing hand hygiene.<br>*Received ongoing educational training from the staff agency she worked for.<br><br>Interview on 6/21/24 at 9:57 a.m. with Minimum Data set (MDS) coordinator/registered nurse (RN) C regarding the above dressing change revealed:<br>*She would have expected RN C to complete hand hygiene before putting on gloves and after removing them.<br>*There had been several missed opportunities for RN N to have performed hand hygiene and to have changed her gloves during the dressing | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 435114 | A. BUILDING _____ B. WING _____ | C 06/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND CARE CENTER | 901 N MAIN AVE BRIDGEWATER, SD 57319 |

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| F 880 | Continued From page 70 | F 880 | | |

change.
*Agency staff had been provided orientation when they first came to the facility.
-Orientation did not include hand washing or glove use.
*Agency staff are expected to follow the facility's policies.
*She expected the staffing agency to provide specific ongoing training on handwashing and glove use that was to the national standard.
*If staff chose not to use hand sanitizer then they needed to wash their hands when hand hygiene is expected.

Review of the provider's undated Hand Hygiene policy revealed:
*Staff must perform hand hygiene:
-"Immediately before and after resident care."
-"Immediately before putting PPE [personal protective equipment] and immediately after removing PPE."
*"The use of gloves does not replace handwashing or the use of alcohol-based hand sanitizer."

Review of the provider's undated Personal Protective Equipment policy revealed:
*"Wear gloves for all resident care/contact and/or tasks where the potential for contact with blood or body fluid may exist."
*"Remove gloves before touching equipment such as telephones, charts, computers, monitors, doorknobs, refrigerator handles, food, pens, pencils etc."

Review of the provider's 4/1/2024 Enhance Barrier Precautions policy revealed:
*"Enhanced Barrier Precautions involve gown and glove use during high-contact resident care

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|---|---|---|---|
| | 435114 | A. BUILDING _____ B. WING _____ | C 06/21/2024 |

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| DIAMOND CARE CENTER | 901 N MAIN AVE BRIDGEWATER, SD 57319 |

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| F 880 | Continued From page 71<br>activities for residents ... at increased risk of MDRO [multidrug-resistant organisms] acquisition (e.g.' residents with wounds ...).<br>*"High-Contact resident activities include: ...<br>-Wound care: any skin opening requiring a dressing." | F 880 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435114 | A. BUILDING _____ B. WING _____ | 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| DIAMOND CARE CENTER | 901 N MAIN AVE BRIDGEWATER, SD 57319 |

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|---|---|---|---|---|
| E 000 | Initial Comments<br><br>A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 6/20/24. Diamond Care Center was found in compliance. | E 000 | | |

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

Brianna Morris | Administrator | 07/18/2024

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435114 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND CARE CENTER | 901 N MAIN AVE<br>BRIDGEWATER, SD 57319 |

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|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 6/20/24. Diamond Care Center was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities.<br><br>The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards. | K 000 | | |
| K 918 SS=E | Electrical Systems - Essential Electric Syste CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>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.<br>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 | K 918 | Administrator and Maintenance reviewed guidelines for generator load testing times. Administrator educated maintenance on the guidelines. Maintenance will now run load test for 30 minutes every month and for 4 continuous hours every 36 months.<br><br>As of 7/12/24, a battery has been ordered by Cummins and will be replaced as soon as it arrives.<br><br>Maintenance supervisor or designee will audit load testing times 1x every month for 6 months. Maintenance will add battery check to maintenance log for preventative maintenance for every 6 months to ensure timely maintenance on battery changes. | 07/23/2024 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brianna Morris
TITLE: Administrator
(X6) DATE: 07/18/2024

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435114 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND CARE CENTER | 901 N MAIN AVE<br>BRIDGEWATER, SD 57319 |

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| K 918 | Continued From page 1<br>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 source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the provider failed to complete and document generator maintenance (incomplete documentation of weekly maintenance, inadequate loaded monthly tests, and delayed battery replacement). Findings include:<br><br>1. Record review on 6/20/24 at 1:15 p.m. revealed only partial documentation of the required weekly generator preventive maintenance inspections. Interview with the maintenance supervisor at the time of the record review revealed he was doing the inspections but not fully documenting them.<br><br>The deficiency affected one of numerous generator maintenance requirements.<br><br>2. Based on record review on 6/20/24 at 1:15 p.m. and interview with the maintenance supervisor, the provider failed to perform the required load test for 30 minutes once per month from January to May, 2024. Prior to that time, the load test had been performed for 30 minutes (0.5 | K 918 | | |

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|---|---|---|---|
| | 435114 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 06/20/2024 |

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| DIAMOND CARE CENTER | 901 N MAIN AVE<br>BRIDGEWATER, SD 57319 |

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| K 918 | Continued From page 2<br>hours), but after the December load test, the generator was run for 18 minutes (0.3 hours). The readout on the hour meter was explained, and testing will again be completed as required.<br><br>The deficiency affected one of numerous generator maintenance requirements.<br><br>3. Based on record review on 6/20/24 at 1:15 p.m. and interview with the maintenance supervisor and facility administrator, the provider failed to provide generator batteries which were replaced within three years of installation. Batteries in the generator had last been replaced on 1/7/21. Maintenance had been performed under contract on 11/27/23, when existing batteries still met requirements. However, the maintenance supervisor is now aware of the requirement and will replace the batteries on a three year schedule.<br><br>The deficiency affected one of numerous generator maintenance requirements. | K 918 | | |

South Dakota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 10597 | A. BUILDING: _____ B. WING _____ | 06/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIAMOND CARE CENTER | 901 N MAIN AVENUE BRIDGEWATER, SD 57319 |

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|---|---|---|---|---|
| S 000 | Compliance/Noncompliance Statement<br><br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 6/19/24 through 6/21/24. Diamond Care Center was found in compliance. | S 000 | | |
| S 000 | Compliance/Noncompliance Statement<br><br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 6/19/24 through 6/21/24. Diamond Care Center was found in compliance. | S 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Brianna Morris* | TITLE: Administrator | (X6) DATE: 07/18/2024