STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A139	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLANDREAU SANTEE SIOUX TRIBE CARE CENTER	909 JONES DR FLANDREAU, SD 57028

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F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 8/6/24. Area surveyed included quality of care related to interventions for pressure ulcer prevention. Flandreau Santee Sioux Tribe Care Center was found not in compliance with the following requirement: F656.	F 000		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656	On 8/27/24, the Administrator, DON, MDS Coordinator, and SS Director reviewed and revised the facility Comprehensive Care Plan Policy. The care plans of resident 1 and 2 were reviewed and updated on 8/27/24 by the MDS Coordinator. The facility has determined all residents have the potential to be affected. All care plans were vieweed and revised by the DON or designee by 8/28/24. The DON or designee educated all staff on the Care Planning policy and educated all licensed and unlicensed staff about their roles and responsibilities in care planning for all residents on 8/28/24. All staff not in attendance will be educated prior to their next shift. Addendum 8/29/24 KD The DON or designee will complete 2 care plan audits per week for six consecutive weeks. Audits will be completed to ensure the comprehensive care plans are developed and relect the current needs for the residents. Audits will be reviewed by the QAPI committee until such time consistent and substantial compliance has been achieved as determined by the committee.	8/29/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kassie Doty
TITLE: LNHA
(X6) DATE: 8/29/24

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

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F 656	Continued From page 1 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure care plans reflected the current individualized activities of daily living (ADL) and pressure ulcer prevention and treatment needs of two of two sampled residents (1 and 2). Findings include: 1. Observation on 8/6/24 at 1:04 p.m. of resident 2's room revealed her bed had an air mattress and positioning cushions on it. Observation and interview on 8/6/24 at 2:12 p.m. with resident 2 while in her room revealed she: *Was seated in a specialized wheelchair. Her legs were elevated and rested on pillows. *Stated she repositioned herself in bed frequently and could achieve several different positions while in her wheelchair.	F 656		

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F 656	Continued From page 2	F 656		

*Stated the staff used the air mattress and the positioning cushions for pressure relief when she was in bed.
*Relied on staff for assistance with "most" of her care needs.
*Had a pressure sore (ulcer) for at least two years and felt "they are doing a good job" of healing it.

Review of resident 2's medical record revealed she:
*Was admitted on 7/15/24.
*Had diagnoses of paraplegia and pressure ulcer to her sacral [lower back] region.
*Required a wheelchair and staff assistance with transfers, bed mobility, bathing, dressing, hygiene, and catheter and colostomy care.
*Was to be repositioned every two hours and provided a ROHO [pressure relieving] cushion and an air mattress.

Review of resident 2's current comprehensive care plan revealed:
*A 7/26/24 revised focus area indicated "The resident has an alteration in gastrointestinal status colostomy r/t)"
-There were no interventions included for that focus area.
*Her pressure ulcer or her pressure ulcer prevention and healing interventions in place were not included in her comprehensive care plan.

2. Observation on 8/6/24 at 1:09 a.m. revealed:
*Resident 1 was seated in a wheelchair in the Green Wing TV lounge, sleeping, and covered with a blanket.
*There was an air mattress on his bed in his room.

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F 656	Continued From page 3	F 656		

Observation on 8/6/24 at 2:40 p.m. of resident 1 while in his room revealed he was sleeping in his bed, on an air mattress, positioned on his back, with the head of the bed elevated. A pressure relieving cushion was in his wheelchair.

Review of resident 1's medical record revealed he:
*Was admitted on 7/16/24.
*Had diagnoses of alcohol-induced persisting dementia and muscle weakness.
*Was non-ambulatory, required a wheelchair, and was dependent on staff for transfers, bed mobility, toileting, bathing, dressing, hygiene, and eating.
*Was to be repositioned every two hours and provided a ROHO cushion and an air mattress.

Review of resident 1's current comprehensive care plan revealed:
*A 7/30/24 initiated focus area indicated "The resident is (SPECIFY: independent/dependent on staff etc.) for meeting emotional, intellectual, physical, and social needs r/t [related to] (if dependent)"
-The focus area was not complete or individualized with the needs of the resident.
*There was no goal included.
*Interventions initiated on 7/30/24 for the above focus area included:
-"Ensure that adaptive equipment that the resident needs is provided and is present and functional. (SPECIFY)"
-:The resident prefers activities which do not involve overly demanding cognitive tasks. Engage in simple, structured activities such as (SPECIFY)"
-"The resident prefers to socialize with: (SPECIFY)"

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F 656	Continued From page 4 -The resident's preferred activities are: (SPECIFY)" --Those interventions were not complete or individualized with the needs of the resident. *A 7/30/24 initiated focus area indicated "The resident has an ADL self-care performance deficit r/t" -The focus area was not complete or individualized with the needs of the resident. *Goals initiated on 7/30/24 included: -"The resident will maintain current level of function in (SPECIFY) through the review date." -"The resident will improve current level of function in (SPECIFY ADLs) through the review date. Resident will be able to: (SPECIFY)" --Those goals were not complete or individualized. *Interventions initiated on 7/30/24 for the above focus area included: -"BATHING/SHOWERING: The resident is able to: (SPECIFY)" -"BATHING/SHOWERING: The resident is totally dependent on (X) staff to provide (SPECIFY bath/shower)(SPECIFY FREQ [frequency]) and as necessary." -"BED MOBILITY: The resident is able to: SPECIFY)" -"BED MOBILITY: The resident is totally dependent on (X) staff for repositioning and turning in bed (SPECIFY FREQ) and as necessary." -"BED MOBILITY: The resident uses (SPECIFY adaptive device) to maximize independence with turning and repositioning in bed." --Those interventions were not complete or individualized. *There were several focus areas, goals, and interventions throughout his care plan that were not complete or individualized to reflect his	F 656		

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F 656	Continued From page 5	F 656		

current needs.
*His pressure ulcer prevention and healing interventions in place were not included in his comprehensive care plan.

3. Interview on 8/6/24 at 2:30 p.m. with certified nursing assistant (CNA) D revealed:
*They referred to a "nursing assistant care sheet" located in a folder to learn how to care for new residents.
*Those sheets were completed by the nurses.
*They documented in the electronic medical record (EMR) when they assisted a resident.
*Staff repositioned "some" residents every two hours.

4. Interview on 8/6/24 at 2:37 p.m. with registered nurse (RN) A revealed:
*The nurse would complete a handwritten nursing assistant care sheet or intake form that included the resident's basic care needs and preferences for new residents.
*The nurses and the Minimum Data Set (MDS) coordinator entered the resident's care plans into the EMR, removed the forms from the folder, and then filed them.
*The care plans were to be updated to reflect the current needs of the residents.

5. Interview on 8/6/24 at 3:05 with MDS coordinator B revealed:
*She had been employed there since February 2024.
*They used the Point Click Care (PCC) EMR for documentation and residents' comprehensive care plans.
*She stated that system was still new to her.
*She would have expected residents' care plans to include their assistance needs and

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F 656	Continued From page 6	F 656		

interventions.
*She agreed resident 1 and 2's comprehensive care plans were not complete or individualized to reflect their current needs, goals, and interventions.

6. Interview on 8/6/24 at 3:22 p.m. with administrator C revealed:
*She would have expected residents' care plans to reflect their current individualized needs.
*The licensed social worker (LSW) and the MDS coordinator reviewed and updated care plans weekly, but that had not occurred over the last two weeks due to recent management staff vacancies in other departments.
*She agreed the care plans for residents 1 and 2 were not complete.

7. Review of the provider's revised March 2020 Pressure Injury Risk Assessment policy revealed:
*"Develop the resident-centered care plan and interventions based on the risk factors identified in the assessments, the condition of the skin, the resident's overall clinical condition, and the resident's stated wishes and goals.
*"The interventions must be based on current, recognized standards of care."
*"The care plan must be modified as the resident's condition changes, or if current interventions are deemed inadequate."