

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

ORIGINAL

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/25/2013
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NAME OF PROVIDER OR SUPPLIER avera bormann manor	STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 4TH STREET PARKSTON, SD 57366
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(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
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F 000	INITIAL COMMENTS Surveyor: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/23/13 through 9/25/13. Avera Bormann Manor was found not in compliance with the following requirements: F221, F278, F279, F281, F371, F441, and F520.	F 000	Addendums noted with an asterisk per 10/29/13 telephone to facility DON. DK/SDDOH/JJ	
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, record review, interview, and policy review, the provider failed to appropriately review the use of restraints for four of ten sampled residents (3, 4, 8, and 9). Findings include: 1. Observation on 9/23/13 at 3:00 p.m. revealed resident 3 was lying motionless on his left side in bed facing the wall. His legs were curled up in a fetal position with his legs resting between the top and bottom half side rails on the wall side of the bed. There was a wedge cushion positioned behind his back. Observation and interview on 9/24/13 at 8:55 a.m. in resident 3's room revealed: *Certified nursing assistants (CNA) A and B	F221 (1-4)	The bottom half rails were removed from resident 3's bed on 9/27/13. The 1/2 rail against the wall was also put down. C.N.A.s A & B were re-educated on the definition, use, and application of restraints. A restraint assessment, Physician's order, or an update on resident's MDS assessment and care-plan for the use of 1/2 rails and the wedge pillow were not completed due to resident passing away on 10/6/13. A restraint assessment has been completed on resident 4 for his Posey net bed, seat belt, and hand mitt. This will be updated every quarter, or with change of status with the use of the CAAS section of the MDS assessment process. A restraint assessment has also been completed on resident 9 for	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE President/C-50	(X6) DATE 10-07-13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

OCT 24 2013
SD DOH L&C

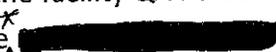
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F 221	<p>Continued From page 1</p> <p>transferred resident 3 into bed. Resident 3 had not attempted to grab onto the top half side rails to assist with repositioning. Interview at that time with both CNAs revealed:</p> <ul style="list-style-type: none"> -The two half side rails on the bed towards the wall were always up. -The top half rail on the other side of the bed was always up. <p>Observation on 9/24/13 at 11:10 a.m. and at 1:10 p.m. revealed resident 3 was not in his room. The top two half side rails and the bottom half side rail on the wall side of the bed remained up.</p> <p>Observation on 9/24/13 at 4:30 p.m. revealed resident 3 was lying motionless in his bed. He was positioned on his left side facing the wall. There was a wedge pillow placed behind his back. There were four half side rails up on the bed.</p> <p>Review of resident 3's complete medical record revealed:</p> <ul style="list-style-type: none"> *There was no physician's order to use half side rails. *There were no assessments to indicate the use of half side rails as restraints. *There was no assessments to indicate the use of the wedge pillow as a repositioning device. *The 8/22/13 care plan revealed: <ul style="list-style-type: none"> -"Constantly moving." -"Extensive assist (assistance) with bed mobility (repositioning in bed)." -"Keep pillow on sides of bed d/t (due/to) him moving around so much to prevent from hitting 1/2 rails or wall." *The 8/16/13 and 12/7/12 Minimum Data Set (MDS) PO100 revealed restraints were coded zero for bed rail usage. 	F 221	<p>her seat belt restraint. This will be updated every quarter or with change of status by using the CAAS section of the MDS. A restraint assessment has also been completed on resident 8 for her use of a gait belt while up in her wheelchair. This too will be updated with the use of the CAAS section on a quarterly basis or as her condition changes. To prevent an unnecessary restraint from being applied to other residents in the facility, a copy of our restraint policy has been distributed to all nursing staff for review. All residents that currently have the upper ½ rails up on their beds have been checked to determine if the rails are used for positioning or restraint purposes. At this time we have not found any other ½ rails that are being used for restraining purposes. The MDS coordinator will assure that all upper ½ side-rails that are used as a restrictive device will be coded in the MDS assessment as a restraint. The MDS coordinator will also start using the CAAS section of the MDS to assess the use of restraints for</p>	

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F 221	Continued From page 2 Interview on 9/24/13 at 11:10 a.m. with the director of nursing (DON) regarding resident 3 revealed: *She did not know why the bottom half side rail was up on his bed. *The facility had purchased new beds, and the bottom rails were suppose to be removed from the beds. *She stated "Maybe the bottom half rail was up to prevent him from moving all over, which he did." *She would not consider the two half rails on the wall side of the bed a restraint. It would be no different than having the bed against the wall. *She was not sure if the facility did quarterly side rail assessments. *Confirmed resident 3 would hold onto the half side rail to assist with repositioning. Interview on 9/24/13 at 4:50 p.m. with the DON regarding resident 3 revealed she: *Considered three or four half side rails up as a restraint. *Confirmed there was not a physician's order to use three or four half side rails. *Did not know why the CNAs had put the four half side rails up on the bed. Interview on 9/25/13 at 8:40 a.m. with the MDS coordinator revealed: *Resident 3 "Moved continuously while in bed." *She thought the top two half side rails and wedge cushion were used to keep resident 3 from "knocking his knees" on the window sill. *There had not been an assessment completed for resident 3 to use half side rails. *She would consider three or four half side rails a restraint. *She confirmed they had not followed their	F 221	residents every quarter and as the resident's status changes. Any restraints that are utilized will be reviewed by the care-planning team as that resident comes up for review. The team will be responsible to assure that all assessments are complete, a physicians order is in place and that the care-plans and MDS assessments are up to date and coded appropriately. The results of these findings will be reviewed each month at our QA/Pharmacy meeting. The DON will provided a quarterly report that will be available for the facility QA nurse to present to the  meetings as scheduled.	11/13/13
			<i>med staff, board, and Quality Assurance Committee DK/sodh/jj</i>	

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F 221	<p>Continued From page 3 restraint policy. *Resident 3 had the two top half side rails up on his bed since being admitted on 1/5/12. *She confirmed she had not coded the side rails as a restraint on the 8/6/13 and 12/7/12 MDSs, because she had not considered them a restraint. *She confirmed the care plan had not addressed the use of half side rail usage. *Resident 3's last fall had occurred on 11/6/12 when he had slid out of a wheelchair. *The wedge pillow was used to prevent resident 3 from moving around while in bed. *Nine out of ten times resident 3 would not use the half side rail to assist with repositioning. *She considered the wedge pillow as a repositioning device and not a restraint. *She considered the use of the wedge pillow and the two top half side rails the least restrictive environment for resident 3.</p> <p>Surveyor: 32331 2. Observation on 9/23/13 at 5:15 p.m. and on 9/24/13 at 11:20 a.m. in resident 4's room revealed he had: *A Posey Net (a special net over the bed frame) on his bed. *A seat belt on while he was seated in a wheelchair. *A padded hand mitt placed on his right hand.</p> <p>Record review of resident 4's complete medical record revealed he had: *Been admitted to the facility on 6/24/09. *A diagnosis that included dementia (a cognitive impairment). *A goal on 9/12/13 in his updated care plan for the least restrictive restraints.</p>	F 221		

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F 221	<p>Continued From page 4</p> <p>Record review of resident 4's MDS assessment on 6/14/13 and 9/06/13 revealed resident 4 had: *Been rarely/never understood on his ability to express ideas and wants. *An unclear speech. *Cognitive (mental process) skills severely impaired for daily decision making.</p> <p>Interview on 9/24/13 at 3:50 p.m. with the DON revealed there were no quarterly assessments being completed for resident 4 for usage of the Posey Net bed frame, seat belt, and the hand mitt.</p> <p>Surveyor: 16385 3. Observation on 9/24/13 at 5:15 p.m. revealed resident 9 had been sitting in a wheelchair with a gait belt around her waist and the back of the wheelchair. That had restricted her from getting out of the wheelchair.</p> <p>Review of resident 9's medical record revealed: *An August 2013 physician's order for the seat belt to be on when in the wheelchair that had been started on 11/1/12. *Care plan interventions for a seat belt restraint to be on when in the wheelchair that had been started on 11/1/12. *An undated initial restraint assessment for the trunk restraint (seat belt) that had been started on 11/1/12.</p> <p>Interview on 9/25/13 at 9:00 a.m. with the MDS coordinator revealed initial and annual restraint assessments had been completed for residents using restraints. Further interview revealed she had not been aware that quarterly restraint assessments had been required for residents that</p>	F 221		

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F 221	<p>Continued From page 5 had a restraint.</p> <p>Surveyor: 32355 4. Observation on 9/23/13 at 3:00 p.m. of resident 8 revealed she had been resting quietly in her recliner in her room. There had been a pink gait belt (a large belt that assists staff to safely transfer the resident) laying in her wheelchair.</p> <p>Interview on 9/23/13 at 3:10 p.m. with registered nurse (RN) E regarding resident 8 revealed: *She had a diagnosis of dementia (forgetfulness). *She had a history of falls resulting with injury out of her wheelchair. *She had become restless and compulsive (uncontrollable urge) to frequently go to the bathroom when she was in her wheelchair. *During her restless and compulsive episodes she would have required the gait belt to be worn around her waist when she had been in her wheelchair. *The gait belt had been used as a reminder for her to ask the staff for assistance with going to the bathroom. *The gait belt was not worn in her bed and was removed during mealtimes.</p> <p>Review of resident 8's medial record revealed she: *Had been admitted on 1/13/11. *Had diagnoses of dementia, anxiety, and frequent urination. *Had frequent falls out of her wheelchair when attempting to go to the bathroom without staff assistance.</p> <p>Review of resident 8's 8/20/13 physician's orders revealed she had an order to wear a seat belt</p>	F 221			

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F 221	<p>Continued From page 6</p> <p>when in her wheelchair as needed (PRN) for safety per her daughter's request.</p> <p>Review of resident 8's 8/8/13 comprehensive care plan revealed she:</p> <ul style="list-style-type: none"> *Was at risk for falls. *Had needed reminding to not get up by herself. *Was to have worn a seat belt restraint when she had been in her wheelchair. <p>Review of resident 8's 12/17/12 initial physical restraint assessment revealed:</p> <ul style="list-style-type: none"> *She was confused and had a hard time understanding what the staff asked of her. *She had a history of falls. *She would have gone into the bathroom on her own and locked the door. *She was to have worn a wheelchair belt for safety during times of increase in confusion. *The wheelchair belt had been listed as a physical restraint. <p>No further quarterly or PRN physical restraint assessments had been located in her chart.</p> <p>The only nursing documentation found to support the use of the physical restraint had been with her significant change in status found in the 2/18/13 MDS.</p> <p>Interview on 9/25/13 at 8:45 a.m. with the MDS coordinator regarding resident 8 revealed:</p> <ul style="list-style-type: none"> *When she was in her wheelchair she would become anxious and frequently had attempted to get up and go to the bathroom on her own. *In the past she had fallen and hit her head attempting to take herself to the bathroom. *The staff would have used a gait belt for safety when she was in her wheelchair. 	F 221			

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F 221	<p>Continued From page 7</p> <p>*She had not been able to locate a physical restraint assessment on their current computer system for quarterly updating.</p> <p>*She had not been aware the physical restraint should have been assessed and charted on quarterly.</p> <p>5. Interview on 9/25/13 at 9:10 a.m. with the DON regarding the above interview revealed:</p> <p>*She had not been aware the MDS coordinator had not been assessing and charting on the physical restraint quarterly.</p> <p>*They had always done quarterly assessing and charting on physical restraints in the past.</p> <p>*She had not been sure why the MDS coordinator had stopped doing the assessments.</p> <p>*There was a physical restraint assessment on the provider's current computer program that the MDS coordinator should have been using.</p> <p>*She had agreed the physical restraint should have been assessed and charted on quarterly.</p> <p>*The MDS coordinator was a licensed practical nurse and that required her MDS assessments and documentation to be signed and reviewed by the DON.</p> <p>*The MDS coordinator had been in that position for several years.</p> <p>Review of the provider's October 2012 Gait Belt policy revealed "The purpose of the gait belt is to safely assist patients/residents with transfers and ambulation."</p> <p>Review of the provider's January 2013 Restraints and Protective Devices policy revealed: **The standard of care for all residents at Avera Bormann Manor is non-use of physical restraints except under circumstances where the resident is a danger to himself/herself or others and</p>	F 221			

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F 221	Continued From page 8 alternatives have not been effective." **"Purpose: To set procedural guidelines for the intervention and care of residents involving restraints, while focusing on the residents well being and preserving the residents dignity and rights." **"Restraints shall be used only as a last resort, when less restrictive measures have been found ineffective." **"Restraints applied to residents must have a documented medical reason for application." **"This policy does not apply to side rails when used to achieve proper body position, balance, or alignment. The two upper rails may be kept in the raised position and not considered as a restraint if the resident can do the following: 'Call the nurse since the call light system is located in these rails or is attached to the rails.' 'Assist the patient/resident to turn from side to side and up in bed.' 'Assist the patient/resident to get out of bed.' " **"Physically restraining a resident shall be discontinued as soon as possible when threat of injury is over." **"Documentation of the physical restraint occurrence shall be documented in the medical record."	F 221		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the	F 278		

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F 278	<p>Continued From page 9 assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, and record review, the provider failed to ensure accurate coding of the Minimum Data Set (MDS) for one of ten sampled residents (3). Findings include:</p> <p>1. Review of resident 3's complete medical record revealed the 8/6/13 and 12/7/12 MDS, PO100 for restraints was coded zero for bed rail usage.</p> <p>Interview on 9/25/13 at 8:40 a.m. with the MDS coordinator confirmed she had not coded the side rails as restraints on the 8/6/13 and 12/7/12 MDSs because: *She had not considered them a restraint. *Resident 3 had the top two half rails up on his</p>	F278	<p>Section P of the RAI manual has been reviewed by both the MDS coordinator and the DON to assure proper coding on any ½ rail use by our residents. Again, any restraints that are being utilized will be reviewed the care-planning team as each resident comes up for review. The team will be responsible to assure all MDS assessments are coded correctly. The results of these findings will be reviewed each month at our QA/Pharmacy meeting. The DON will then provided a quarterly report that will be available for the facility QA nurse to present to the quarterly QA meetings. Again, there have not been any updates or corrections on resident 3's MDS assessment due to him passing away on 10/6.</p>	11/13/13	

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F 278	Continued From page 10 bed since being admitted on 1/5/12. *She confirmed nine out of ten times resident 3 would not use the half side rail to assist with repositioning. Review of Center for Medicare and Medicaid Services, Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, October 2012, page 4-1, stated the results of the assessment that must accurately reflect the residents status and needs were to be used to develop, review, and revise each resident's comprehensive plan of care.	F 278		
F 279 SS=D	Refer to F221, finding 1. 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		

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F 279	Continued From page 11 This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, record review, and policy review, the provider failed to develop a comprehensive plan that addressed restraint usage for one of ten sampled residents (3). Findings include: 1. Review of resident 3's 8/22/13 care plan (page 2) revealed: **"Constantly moving." **"Extensive assist (assistance) with bed mobility (repositioning in bed)." ***"Keep pillow on sides of bed d/t (due/to) him moving around so much to prevent from hitting 1/2 rails or wall." Interview on 9/25/13 at 8:40 a.m. with the Minimum Data Set coordinator confirmed the 8/22/13 care plan had not addressed half side rail usage. Review of the provider's August 2000 Resident Assessment/Care Planning policy revealed: **"Purpose: To ensure the development of a resident specific plan of care that will reflect the resident's medical, nursing, mental, and psychosocial needs, and appropriate interventions, and measurable goals. This assessment and development of the comprehensive plan of care process utilizes the Medical Data, and Resident Assessment Instrument process." Refer to F221, finding 1.	F 279	There has been no update made on resident 3 care-plan due to him passing away on 10/6. The care-planning team will assure that all current and future restraints are kept updated on the resident's care-plan. * The results of this monitoring will then be presented at our monthly QA/Pharmacy meeting and then given to the facility QA nurse so she is able to present this information at the QA committee on a quarterly basis. <i>Refer to F221. DK/SDDOH/ST</i>	11/13/13

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F 281 F 281 SS=D	Continued From page 12 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on interview, closed record review, and policy review, the provider failed to obtain a physician's order for one of one sampled resident (11) with a change in condition. Findings include: 1. Closed record review on 9/25/13 of resident 11's complete medical record revealed: *She had been discharged on 8/22/13. *On 8/22/13 at 10:45 a.m. registered nurse (RN) I had documented "Res (resident) passed away." *On 8/22/13 at 10:45 a.m. a physician had been notified. *There had been no physician's order to release the body to the mortician. *On 8/22/13 at 12:51 p.m. RN I had documented "Body released to funeral home." Interview on 9/25/13 at 11:10 a.m. with the director of nursing regarding resident 11 revealed: *The charge nurse that had documented the death of the resident had done so without proper diagnosis from the resident's physician. *Making a diagnosis was not within the scope of practice for a nurse. *The provider had not received a physician's order for the body to be released to the mortician. Review of provider's September 1995 Death of a Patient/Resident policy revealed:	F 281 F 281	All charge nurses have been reminded that it is not within our scope of practice to make a diagnosis. The family and physician of the resident shall be notified upon any change in a resident's condition. If a resident's vital signs have ceased the nurse will notify the family and the physician. The nurse must then obtain an order from the doctor stating the body may be released to the funeral home. Documentation on any future deaths in our facility will be monitored by the DON. The results of these findings will be discussed at our monthly QA/Pharmacy meeting. All information will then be given to our QA nurse who will present it at the QA committee every quarter. DON will be responsible.	10/22/13

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F 281	Continued From page 13 *The family of the resident should have been notified by the charge nurse or attending physician when they had become aware of a change in the resident's condition. *After the resident's family has been notified of the death the attending physician should have been notified.	F 281		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, temperature testing, record review, and policy review, the provider failed to: *Maintain proper temperature of milk stored in one of two bulk milk dispensers in the kitchen area. *Ensure proper sanitation in the kitchen in an area behind the ovens, grill, and stove. *Ensure proper sanitation of foods stored with non-food items in two of two refrigeration units in the dining room. Findings include: 1. Observation on 9/24/13 at 10:25 a.m. in the	F 371		

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F 371	<p>Continued From page 14</p> <p>kitchen with the Norris milk dispenser revealed: *Milk temperatures poured immediately into an eight-ounce glass and tested with two digital thermometers were recorded at 43 degrees Fahrenheit (F) and at 41.9 degrees F. *The milk dispenser's thermometer located inside the dispenser was at 40 degrees F. *The temperature of milk should be no more than 41 degrees F.</p> <p>Observation on 9/25/13 at 9:30 a.m. in the kitchen at the Norris milk dispenser with the registered dietitian (RD) and certified dietary manager (CDM) present revealed: *Milk temperatures poured immediately into an eight-ounce glass and tested with two digital thermometers were recorded at 43.7 degrees F and at 43.7 degrees F. *The milk dispenser's thermometer located inside the dispenser was at 40 degrees F. *The temperature of milk should be no more than 41 degrees F.</p> <p>Record review on 9/25/13 of the provider's 9/18/13 through 9/24/13 refrigeration temperature log sheet of the milk in the milk dispenser revealed: *On 9/18/13 the temperature had been 38 degrees F in the a.m. and 42 degrees F in the p.m. *On 9/19/13 the temperatures had been 40 degrees F in the a.m. and 42 degrees F in the p.m. *On 9/23/13 the temperatures had been 41 degrees F in the a.m. and 42 degrees F in the p.m. The temperature of milk should be no more than 41 degrees F.</p>	F 371	<p>The milk dispenser was repaired by the company and returned to us on 10/10/13. The temperature of the milk cooler and of the dispensed milk will be recorded 2X daily by the a.m. and p.m. cooks. These temperatures will then be recorded on a flow sheet. This will be monitored by the CDM/RD. The CDM will provide a quarterly report to the QA nurse who can then present it in her quarterly QA meetings.</p>	

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F 371	<p>Continued From page 15</p> <p>Interview on 9/25/13 at the same time in the kitchen with the RD and CDM confirmed the milk should have been no more than 41 degrees F. The CDM stated the milk dispenser's control dial had been turned to the coldest setting.</p> <p>Review of the provider's September 2012 Cold Food Storage policy revealed safe cold food storage for refrigerators would be monitored to range from 34 to 38 degrees F.</p> <p>2. Observation on 9/23/13 at 2:55 p.m. in the kitchen revealed the area behind the convention oven, grill, and stove: *Contained multiple gray and white-colored spots and an oily-type accumulation on the conduit (protective electrical covering), fan, and other areas behind the equipment. *Was located directly across from a food preparation table and a storage area for pots and pans.</p> <p>Review of the provider's June 2000 Cleaning of Air Handling Unit, Filters, and Vents policy's cleaning schedule list revealed no task listed for cleaning behind the convention oven, grill, and stove.</p> <p>Review of the provider's November 2012 Cleaning Equipment policy's cleaning schedule list revealed no task listed for cleaning behind the convention oven, grill, and stove.</p> <p>Interview on 9/25/13 at 9:00 a.m. with the RD and CDM regarding the area behind the convention oven, grill, and stove confirmed the area had not been on a dietary department cleaning schedule.</p> <p>Interview on 9/25/13 at 10:10 a.m. with the</p>	F 371	<p>Cleaning of the back of large kitchen equipment has been added to the maintenance cleaning schedule to be cleaned monthly and PRN. The CDM/RD will monitor this schedule every month and provide a quarterly report to the QA nurse who will then report it in her quarterly QA meetings.</p>	

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F 371	<p>Continued From page 16</p> <p>maintenance supervisor regarding the area behind the convention oven, grill, and stove confirmed the area had not been on a maintenance department cleaning schedule.</p> <p>Review of the provider's November 2012 Cleaning Equipment policy revealed a daily, weekly, and monthly cleaning schedule was to have been provided monthly by the CDM or RD.</p> <p>Review of the provider's June 2000 Cleaning of Air Handling Unit, Filters, and Vents policy revealed there was to have been an avoidance of grease and dust accumulation on vents and filters.</p> <p>3. Observation on 9/25/13 at 3:10 p.m. in the dining room in two Frigidaire refrigeration units' freezers revealed non-food items (multiple ice packs) were being stored with food items.</p> <p>Interview on 9/25/13 at the same time and location as above with registered nurse H revealed the ice packs were: *Obtained from the VA (Veterans Administration) in the same container with medications. *Used for resident care.</p> <p>Interview on 9/26/13 at 8:15 a.m. with the director of nursing in the dining room regarding the ice packs in the refrigeration units' freezers revealed: *The ice packs had been used for resident care. *The ice packs should not have been stored with food.</p> <p>Observation on 9/26/13 at the same time and location in the two Frigidaire refrigeration units' freezers revealed: *In the white-colored freezer in an open plastic</p>	F 371	<p>All of the ice packs have been removed from the 2 freezers in the dining area. In the future, nursing staff have been instructed to store any ice packs in the medication refrigerator freezer. The DON will be responsible for monitoring and recording the correct storage of ice packs every month and passing this information onto the QA nurse who will then report at the quarterly QA meeting.</p>	10/18/13	

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F 371	Continued From page 17 container on the bottom shelf were: -Two Nordic Ice packs, two Polar Pack ice packs, and one plastic bag with ice chips. -One blue-colored therapy cup. *The same freezer area as above contained: -One container of sliced strawberries, one margarine container, and one opened package of Brussels sprouts. -One container sherbet, one package of candy, one frozen packaged dessert, one ice cream cup, and one food thickener container. *The beige-colored freezer shelf contained: -Four Nordic Ice packs and one Polar Pack ice packs. -The same freezer area contained multiple four-ounce ice cream cups and a one two-quart pitcher of an unidentified fluid. Interview on 9/25/13 at 9:00 a.m. with the RD and CDM regarding the ice packs in the refrigeration units' freezers revealed the dietary department had not placed the ice packs in the freezer. Review of the provider's March 1996 Ice Bag-Application policy revealed the guidelines for proper application of ice bags for residents' use were to reduce swelling, relieve pain, and to control bleeding.	F 371			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441			

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F 441	<p>Continued From page 18</p> <p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) 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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, and policy review, the provider failed to ensure proper procedures were followed for: *Handwashing after glove use by two of two certified nurse aides (A and B) during one of one resident's (3) personal care.</p>	F 441		

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F 441	<p>Continued From page 19</p> <p>*Handling, storage, and transport of clean linen. Findings include:</p> <p>1. Observation and interview on 9/24/13 at 8:55 a.m. during personal care for resident 3 revealed:</p> <p>*Certified nurse aide (CNA) A walked into resident 3's room and tossed a turning sheet toward his bed. The turning sheet landed on the floor next to his bed.</p> <p>*CNA A picked the turning sheet up off of the floor and placed it on resident 3's bed.</p> <p>*Then CNA A and B transferred resident 3 with a mechanical lift onto his bed.</p> <p>*Then:</p> <p>-Both CNAs rolled resident 3 from side-to-side pulling down his slacks. CNA A checked the residents incontinent brief with her gloved hand.</p> <p>-Then CNA A and B pulled the resident's slacks up.</p> <p>*With the same pair of gloved hands CNA A placed the wedge pillow on the left side of resident 3.</p> <p>*CNA A then removed her gloves and without performing hand hygiene set the controls for the bed.</p> <p>*CNA B with the same pair of gloves on placed the top right side half rail up.</p> <p>Interview on 9/24/13 at 4:50 p.m. with the director of nursing (DON) revealed her expectations were:</p> <p>*For CNAs to perform hand hygiene after assisting a resident with personal care.</p> <p>*To not use linen that had been on the floor. The CNAs should have gotten a new turning sheet.</p> <p>Interview on 9/25/13 at 11:10 a.m. with the DON confirmed they did not have a policy for personal care/toileting/hygiene.</p>	F 441	<p>Deficiency 441 has been discussed with C.N.A. A&B. A copy of the deficiency has been distributed to the rest of the nursing staff for review. Our annual in-service was held on 10/14/13 which included information on infection control and proper hand-washing procedures. To assure infection control procedures are being followed in the future, our education coordinator will discuss these issues monthly in addition to our regular C.N.A. education modules. The DON will be responsible for providing the QA nurse with the information and the attendance record from these meetings and she will present them to the QA committee on a quarterly basis.</p>	<p style="text-align: right;">* [Redacted] DK/SAOAH/ST</p>	

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F 441	Continued From page 20 Review of the provider's April 2003 Handwashing/Hand Hygiene policy revealed; *Wash hands "after using the restroom, this includes yourself or whenever you assist a patient or resident with their toileting duties." 2. Observation and interview on 9/25/13 at 9:35 a.m. with CNA C revealed she was in the hallway. She had gone into different residents' rooms with wash cloths, towels, and hospital gowns. She had used a three shelved cart that contained uncovered wash cloths, towels, and hospital gowns on the top shelf. On the second and third shelves were resident care supplies that were also uncovered. Interview at the above time with CNA C revealed: *The linens were covered while being stored in the hall linen closets. *She would cover the linens in the hallway if she had to go to another part of the facility. *She had not covered the linens when passing the items out down the hallway. *She confirmed the above linens were not covered at this time. Interview on 9/25/13 at 9:40 a.m. with the DON confirmed linen needed to be covered at all times. Review of the provider's undated Handling and Care of Linens policy revealed "All clean linen distributed in the hospital and nursing homes will be covered at all times."	F 441	Nursing staff have been educated to keep laundry/supply cart covered at all times while using it in the corridors. Monthly monitoring will be done by the DON to assure this practice is being followed. Findings will be documented on a flow-sheet. Flow-sheets will be given to facility QA nurse to be reported to QA committee on a quarterly basis.	10/15/13	
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520			

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F 520	<p>Continued From page 21</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on interview and policy review, the provider failed to include a physician on the quality assessment and assurance (QAA) committee and have a physician attend QAA meetings. Findings include:</p> <p>1. Interview on 9/25/13 at 8:45 a.m. with the quality risk management director revealed: *The QAA committee met every one-to-two months. *The QAA members included registered nurse (RN) H, the Minimum Data Set (MDS)</p>	F 520			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/25/2013
NAME OF PROVIDER OR SUPPLIER AVERA BORMANN MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 4TH STREET PARKSTON, SD 57366		
(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 520	<p>Continued From page 22</p> <p>coordinator, the quality risk management director, and the director of nursing (DON). *Other attendees might have included people from X-ray or the hospital laboratory. The provider's activity director, dietary manager, and social services manager did not attend. Certified nurse aides (CNA) had attended on occasion if QAA members had needed their opinion on something. *Physicians had not attended the meetings. All medical providers were updated on the QAA findings during their monthly physician meetings. The DON presented the findings.</p> <p>2. Interview on 9/25/13 at 9:20 a.m. with the DON revealed: *The QAA members met every one-to-two months. *QAA members included: the DON; the daytime charge nurse in charge of rounds; an RN in charge of psychiatric medication monitoring; the RN in charge of restraints, falls, and pain management; a pharmacist; activities coordinator; social service coordinator; and the QA coordinator. The administrator would attend at least quarterly and as needed. CNAs would attend as requested. *Usual members in attendance were the quality risk management coordinator, the DON, RN H, and the MDS coordinator. *A physician had not attended the QA meetings. *The provider was attached to the hospital, so had been managed as a branch of the acute care facility. *QA meeting findings had been delivered to all the medical providers at their monthly physician meetings, and at the pharmacy and therapy (P and T) meetings.</p>	F520 (1-2)	The QA/Pharmacy meeting will be held every month. The facility's quality/improvement plan has been updated to read "The members consist of a Physician, Pharmacist, DON, daytime RN, nighttime RN, MDS coordinator, Registered dietician, SSC, Activities Coordinator, QA nurse. Administrator will attend at least quarterly, C.N.A.s will attend as they are able. DON will make sure minutes and attendance from these meetings will be given to the QA nurse on a quarterly basis which will then be reported to the QA committee.	10/15/13

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NAME OF PROVIDER OR SUPPLIER AVERA BORMANN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 4TH STREET PARKSTON, SD 57366		
(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 520	Continued From page 23 Review of the provider's 8/1/13 Quality Assurance/Improvement Plan 2013-2014 revealed: * "A Quality Assurance Committee has been established. The members consist of DON, daytime RN in charge of rounds; RN in charge of psych [psychiatric] med [medication] monitoring; RN in charge of restraints, falls, and pain management; Pharmacist; Activities Coordinator; Social Service Coordinator; QA coordinator. The Administrator will attend at least quarterly and as needed. Certified Nurse Aides will attend on a volunteer basis as needed." **"The DON will attend Medical Staff meetings monthly to inform the Medical Staff changes in regulations and results of _____ Quality Assurance findings."	F 520			

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

ORIGINAL

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2013
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NAME OF PROVIDER OR SUPPLIER AVERA BORMANN MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 4TH STREET PARKSTON, SD 57366
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(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
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 10/1/13. Avera Bormann Manor was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Late M. Malbo *President/CEO* *10-31-13*

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.

DEFICIENCIES

RESOLVED

NOV 04 2013

OCT 24 2013

SD DOH L&C

SD DOH L&C

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10660	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/25/2013
NAME OF PROVIDER OR SUPPLIER AVERA BORMANN MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 4TH STREET PARKSTON, SD 57366		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 9/23/13 through 9/25/13. Avera Bormann Manor was found not in compliance with the following requirements: S236 and S323.	S 000	Addendums noted with an asterisk per 10/29/13 telephone to facility DON. DK/SDDOH/JJ	
S 236	44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of Mantoux skin test to establish a baseline within 14 days of employment or admission to a facility. Any two documented Mantoux skin tests completed within a 12 month period prior to the date of admission or employment shall be considered a two-step. Skin testing is not necessary if documentation is provided of a previous positive reaction of ten mm induration or greater. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Rule is not met as evidenced by: Surveyor: 32355 Based on record review, interview, and policy review, the provider failed to ensure one of five sampled newly hired employees (G) had completed the two-step tuberculin (TB) skin test	S 236	S236 Please be advised that the employee [†] G had the two-step Mantoux skin test repeated on 10/10/2013 and 10/18/2013, and it was read out as negative on 10/21/2013. Additionally, please be advised that we have reorganized our employee health nurse position. We have put a policy in place that new employees will not be permitted to start work until all appropriate immunizations are in their file. Also, we informed all Department Directors on 10/16/2013 that no employee will start without completed records in their file, so as to alleviate the above problem. Additionally, the new employee health nurse will report this on a quarterly basis to the Quality Assurance Committee of which she is Chair. Effective 10/23/2013	

monitor and
DK/SDDOH/JJ

† G
DK/SDDOH/JJ

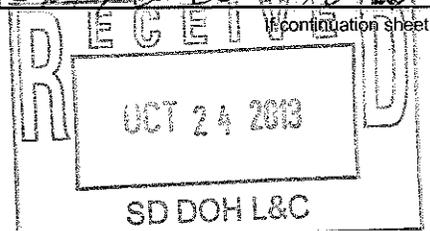
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

TITLE

President/CEO 10-23-13

(X6) DATE



SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10660	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/25/2013
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S 236	Continued From Page 1 screening within fourteen days of being hired. Findings include: 1. Review of employee G's personnel record revealed: *A 8/25/13 hire date. *A record of the two-step TB skin test screening had not been completed within fourteen days of having been hired. *The first step of the TB skin test screening had been completed on 9/5/13. *The second step of the TB skin test screening had not been given. Interview on 9/24/13 at 2:15 p.m. with registered nurse (RN) D revealed: *The TB skin test screenings were to have been completed by the employee health nurse who worked in the clinic. *The employee health nurse had currently been out of the facility on maternity leave. *She and another unidentified employee had been responsible for ensuring the new employees had received their TB skin test screenings. *There had not been a process in place to ensure those had been completed while the employee health nurse was absent. *She agreed the TB skin test for employee G had not been completed. Review of the provider's 2013 Immunization policy revealed: **New employees will be required to complete the two-step TB skin test procedure unless documentation of the results of a TB test completed during previous twelve months is provided." **New hires will need to have the TB testing completed within 2 weeks of hire." *No process for when the second step of the TB	S 236		

SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 236	Continued From Page 2 skin test had been omitted.	S 236		
S 323	44:04:08:04.02 DOCUMENTATION OF DRUG DISPOSAL If a...nursing facility has a licensed pharmacy, outdated or discontinued medications must be returned to the pharmacy for disposition. In the absence of a licensed pharmacy, the method of disposition of outdated or discontinued medications must be handled and recorded in the resident's medical record as follows: (1) Legend drugs not controlled under SDCL 34-20B must be destroyed by a professional nurse and another witness; (2) Medications controlled under SDCL 34-20B must be destroyed in the facility by a pharmacist and a registered nurse; and (3) Medications, excluding controlled substances listed in SDCL chapter 34-20B, in unit dose packaging which meets packaging standards in chapter 20:51:13:02.01 may be returned to the pharmacy pursuant to chapter 20:51:13:02.01. This Rule is not met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to: *Properly dispose of a controlled medication (schedule III) for one of one (11) resident closed record. *Properly date as needed (PRN) medications dispensed by the provider's pharmacy. Findings include: 1. Record review on 9/25/13 of resident 11's closed medical record revealed: *She had been discharged on 8/22/13. *She had a physician's order for Ativan (a	S 323	All charge nurses have reviewed this deficiency. We now have a pharmacist in house who will destroy all discontinued controlled medications. We will document any controlled medications that are destroyed and have the RN correct any errors that may have been made in documenting the disposal of medication. This information will be given to the QA nurse on a quarterly basis [*] . DON will be responsible to assure this is completed. <i>to report to the Quality Assurance Committee. OK/SDOCH/JJ</i>	10/15/13

SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 323	Continued From Page 3 schedule III medication to reduce anxiety) 0.5 milligrams (mg) one tablet po (by mouth) bid (twice per day) and prn (as needed). *A handwritten sheet of a list of the medications that had been sent back to the pharmacy on 8/22/13 listed: -Two pills of Ativan with no dose listed. -Fourteen or sixteen (unclear as it had been written over) pills of lorazepam (Ativan) 0.5 mg. Interview on 9/25/13 at 11:10 a.m. with the director of nursing revealed: *She was unaware of the controlled medication for resident 11 having been sent to the pharmacy. *The medication had not been properly destroyed in the facility by a pharmacist and a registered nurse. Review of the provider's July 2013 Disposal of Outdated Medications-LTC (Long Term Care) policy revealed: *Controlled medications would be disposed of in the facility by a pharmacist and a registered nurse. *The registered nurse and pharmacist would co-sign as each other's witness. *Medications were destroyed by flushing down the stool. Surveyor: 32332 Interview on 9/24/13 at 4:45 p.m. with registered nurse (RN) E revealed: *She had attempted to locate the date that an as-needed (PRN) medication had been dispensed by the provider's pharmacy. *She had been informed the pharmacy had not kept records of which medication had been sent out according to the prescription number. *The pharmacy only recorded how many tablets	S 323		

SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 323	Continued From Page 4 of a certain medication had been dispensed. *The pharmacy would not know if the tablets had been scheduled medications or PRN medications.	S 323		