

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

ORIGINAL

PRINTED: 06/04/2013  
FORM APPROVED  
OMB NO. 0938-0391

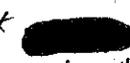
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435111</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>WHITE HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 SOUTH PATRICK AVENUE WHITE, SD 57276</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  Surveyor: 12218 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/21/13 through 5/22/13. White Healthcare Center was found not in compliance with the following requirements: F278, F280, F281, F309, F323, F431, and F441.	F 000	Addendums noted with an asterisk per 7/3/13 telephone to facility DON.  MJH/SDDOH/JJ	
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 assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  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.  Clinical disagreement does not constitute a	F 278	F278  This facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and state law. The preparation of the following plan or correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction was prepared solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:  1 Residents # 1 and # 5 MDS were modified on 5/22/13 to include those items that were omitted. 2. The MDS coordinator was re-educated on reviewing documentation in the medical record and supplemental documentation prior to completing the MDS by the MDS Nurse Consultant on 5/22/13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Amy McFee RN BSN CRS Executive Director* TITLE  
6-14-13 (X6) DATE

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 278	<p>Continued From page 1 material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on record review, interview, and policy review, the provider failed to accurately reflect the medical status of two of nine sampled residents (1 and 5). Findings include:</p> <p>1. Review of resident 5's chart revealed the physician had been contacted on 3/20/13 with information the resident had scratched an area open to the top right side of her buttocks crack. The physician had approved orders for a dressing.</p> <p>Review of resident 5's treatment record revealed beginning on 3/28/13 staff were to "Monitor open areas to upper right buttock crack and apply Allevyn dressing twice daily."</p> <p>Review of resident 5's Weekly Pressure Ulcer Record revealed the staff had been monitoring: *One stage 2 pressure ulcer (an area of partial thickness skin loss) to her right buttock (top) since 3/28/13. *One stage 2 pressure ulcer to her right buttock (bottom) since 4/30/13.</p> <p>Review of resident 5's Minimum Data Set (MDS) dated 4/29/13 revealed there were no skin concerns or pressure ulcers coded. However there was an application of nonsurgical dressings in the assessment look-back period. The significant change assessment signed by the MDS coordinator on 5/1/13 stated she had no</p>	F 278	<p>3. The DNS/designee will audit 2 MDS's a week for 1 month and the 1 MDS a week for 1 month.</p> <p>4. DNS/designee will present data collected at the quarterly Quality Assurance meeting and the committee will make the decision/recommendations regarding any necessary follow-up studies.</p> <p>*  MJH/SDDOH/JJ</p>	*6/14/13 MJH/SDDOH/ JJ	

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F 278	<p>Continued From page 2</p> <p>pressure ulcers. Resident 5's skin integrity care plan had been updated on 5/1/13 to reflect she had pressure ulcers to her coccyx (tailbone). Resident 5's physician had been contacted on 3/20/13 with information that she had scratched an area open to the top right side of her buttocks crack. The physician had approved orders for a dressing.</p> <p>Interview on 5/22/13 at 11:35 a.m. with the MDS coordinator revealed she did not think the open areas were pressure ulcers. She did not think she should code them as skin tears, so she had not coded them. She stated the staff did not decide the areas were pressure ulcers until the MDS consultant assessed them on either 4/30/13 or 5/1/13. That was not in the assessment reference period. When questioned why the MDS coordinator had then documented that she would not proceed to the care plan on 5/1/13, she stated perhaps that was a "typo". Perhaps she had meant that she would proceed to the care plan.</p> <p>Review of the October 2011 CMSs RAI Version 3.0 Manual, Guide to the MDS, revealed: *Page M-1: It was important to recognize and evaluate each resident's risk factor and to identify and evaluate all areas of risk of constant pressure. A complete assessment of skin was essential to an effective pressure ulcer prevention and skin treatment program. It was imperative to determine the etiology (cause) of all wounds and lesions, as this would determine and direct the proper treatment and management of the wound.</p> <p>Surveyor: 12218 2. Review of resident 1's 5/6/13 quarterly Minimum Data Set (MDS) assessment revealed:</p>	F 278		

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F 278	<p>Continued From page 3</p> <p>*Under the Falls category for the number of falls since the previous assessment (2/04/13), it was coded as one fall and no injuries.</p> <p>*Under the Skin condition category, it was coded as no skin integrity problems, no skin tears, or pressure ulcers.</p> <p>Review of resident 1's following Interdisciplinary Progress Notes revealed:</p> <p>*3/8/13 at 0245 (2:35 a.m.) - Resident got a 6.5 x 6 centimeter (cm) arch-shaped skin tear to upper right inner ankle, and a 3.5 x 3 cm reddish blue bruise to the top of the left foot during care when she started kicking.</p> <p>*3/21/13 at 0620 (6:20 a.m.) - Resident was "found on the floor in her room beside the bed, facing the wall in a sitting position, half leaning against (the) bedside and bracing self with (her) arm holding onto the recliner by the bed. Skin tear noted to left shin, 0.2 cm x 0.4 cm, covered with steri-strips and kerlix."</p> <p>*4/29/13 at 1830 (6:30 p.m.) - Resident was found on the floor. She had fallen from the bed unto the floor mat. No skin tears, no injuries.</p> <p>*5/7/13 at 0045 (12:45 a.m.) - Resident found sitting on floor next to her bed with both feet extended out in front of her. Resident stated she "had slid out of bed feet first because she wanted to get up." There was no pain and no injuries.</p> <p>Review of resident 1's March 2013, April 2013, and May 2013 Treatment Administration Records (TAR) revealed:</p> <p>* March 2013, Dated 3/8/13 - "Monitor skin tear right lower leg inner aspect upper ankle every shift and prn (as needed)."</p> <p>*March 2013, Dated 3/28/13 - "Wound care to lower right leg BID (twice daily). wound gel to bed</p>	F 278			

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F 278	<p>Continued From page 4 after cleansing, 4x4 (dressing) with Kerlix until healed." *April 2013 (no specified date) - "Wound care to lower right leg BID, wound gel to bed after cleaning, telfa 4x4 (dressing) with Kerlix until healed." *May 2013, Start date 4/23/13 - "Wound care, wound gel to right lower leg, cover with wound gel, telfa, and Kerlix until healed. Supplies in room in dresser."</p> <p>Review of resident 1's 3/23/13 current care plan revealed: *Under the focus area for falls and the history of falls it had been updated with the documentation of a fall on 4/29/13 and on 5/7/13. *Under the focus area for skin integrity it had been updated to read "Alteration in skin integrity, r/t (related to) bruise on left foot, and skin tear to right ankle."</p> <p>Interview with the MDS coordinator on 5/22/13 at 11:15 a.m. regarding the accuracy of the 5/6/13 MDS assessment for resident 1's falls and skin tears revealed: *She always looked at the Fall Log book and the resident's care plans when she did her MDS assessments. That was her procedure. *She had looked at the list of documented falls on the fall sheet for the resident in the fall log book. *There were no falls listed since 8/4/12. *She showed the surveyor the record of falls for resident 1, and it showed no falls since 8/4/12. *She had looked at the resident care plan under falls, and it had been updated with the following falls: -Fall - 4/29/13. -Fall - 5/7/13.</p>	F 278		

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F 278	Continued From page 5 *She had missed the fall on 3/21/13, as it was not documented on the resident's fall log record nor her care plan. *She had not read the interdisciplinary progress notes that had covered the resident's care and condition since the previous assessment, as she relied on the fall log and the care plan. *She had missed the wound care treatment of the skin tear, as she had not checked the resident's TAR. *She confirmed resident 1's 5/6/13 MDS should have been coded for two falls and an injury instead of one fall and no injury and should have been coded for skin tears.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F280 This facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and state law. The preparation of the following plan or correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction was prepared solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:	

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F 280	Continued From page 6  This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on interview, record review, and policy review, the provider failed to update and revise the care plans for two of four sampled residents (1 and 5). Findings include:  1. Review of resident 5's Significant Change Minimum Data Set (MDS) dated 4/29/13 revealed she required: *Bed mobility (how resident moved to and from lying position, turned side-to-side, and positioned her body while in bed): Extensive assist of one. *Transfers: Extensive assist of two. *Dressing: Limited assist of one. *Toileting: Extensive assist of one.  Review of resident 5's 5/1/13 care plan revealed: *Bed mobility: Independent to extensive assist of one. *Toileting: Independent. *Transfers: Independent.  Review of resident 5's pocket care plan revealed: *Bed mobility: Independent. *Reposition: Independent. *Transfer: Independent. *Ambulation: Independent. *Dressing: Set-up assist. *Bathroom: Independent.  Interview on 5/22/13 at 11:35 a.m. with the MDS coordinator revealed the care plan had not been updated to reflect the resident's current physical needs.	F 280	1. Resident #1 care plan has been updated to reflect current falls. Resident's care plans have been reviewed to assure that they have been revised with resident's status change. Resident #5 care plan has been revised to reflect resident's current status. CNA assignment sheets have been updated to reflect resident's current status. 2. MDS coordinator and licensed staff were re-educated on 5/22/13 by the MDS nurse consultant on revising care plans and CNA assignments sheets. 3. The DNS/designee will audit 4 care plans and assignment sheets per week for 1 month and then 2 care plans and assignment sheets per week for 1 month 4. DNS/designee will present data collected at the quarterly Quality Assurance meeting and the committee will make the decision/ recommendations regarding any necessary follow-up studies.	*6/14/13  * [Redacted] MJH/SDDOH/JJ

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F 280	Continued From page 7 Interview on 5/22/13 at 2:50 p.m. with certified nurse aide (CNA) A revealed she used the pocket care plan for information on how to provide care to resident 5. When asked if resident 5 was able to perform the above care independently she reported "No." CNA A stated resident 5 had not been able to perform those independently for two to three weeks.  Review of the provider's 4/19/11 care planning policy revealed the care plan would be periodically reviewed and revised by the interdisciplinary team in conjunction with the MDS assessments, to meet the resident's medical, nursing, nutritional, spiritual and psychosocial needs.  Surveyor: 12218 2. Review of resident 1's 3/23/13 care plan revealed it had not been accurately updated with the correct number of falls. Under the focus area of falls and fall history it had stated the last fall had been on 8/4/12. It had been updated with the following documentation: *Fall - 4/29/13. *Fall - 5/7/13.	F 280			
F 281 SS=E	Refer to F278, example 2. 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: 32332	F 281	F281 This facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and state law. The preparation of the following plan or correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or		

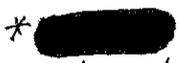
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F 281	<p>Continued From page 8</p> <p>Based on observation, record review, interview, and policy review, the provider failed to:</p> <ul style="list-style-type: none"> <li>*Contact a physician for an order prior to changing treatments for one of nine sampled residents (5)</li> <li>*Follow a physician's order for a diet supplement for one of nine sampled residents (4).</li> <li>*Contact a physician for an order to release one of one deceased resident (10) from the facility.</li> <li>*Follow-up on the consultant pharmacist's recommendation to the physician for one of nine sampled residents (6) to address duplicate medications. Findings include:</li> </ul> <p>1. Review of resident 5's Weekly Pressure Ulcer Record revealed she had a 1.0 centimeter (cm) by 0.5 cm stage 2 pressure ulcer to her right bottom buttock with an onset date of 4/30/13. The record stated the wound was being dressed with a hydrocolloid dressing (a waterproof, adhesive gel-forming dressing).</p> <p>Review of resident 5's Weekly Pressure Ulcer records revealed the treatments for two areas with stage 2 ulcers:</p> <ul style="list-style-type: none"> <li>*Ulcer number 1 to her right top buttock (onset date 3/28/13). Current treatments listed for the area were: <ul style="list-style-type: none"> <li>-4/10/13: Allevyn dressing (an absorbant foam dressing).</li> <li>-4/17/13: Primapore dressing (an absorbant dressing).</li> <li>-4/24/13: Primapore dressing.</li> <li>-5/1/13, 5/8/13 and 5/15/13: Hydrocolloid dressing.</li> </ul> </li> <li>*Ulcer number 2 to her right bottom buttock (onset date 4/30/13). Current treatments listed for the area were:</li> </ul>	F 281	<p>conclusions set forth in the statement of deficiencies. The plan of correction was prepared solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:</p> <ol style="list-style-type: none"> <li>1. Resident #4 physician order to discontinue supplements has been obtained on 5/22/13 Resident # 5 physician order to treat open area with a hydrocolloid was obtained on 5/22/13. Resident # 6 order for medication change was received on 5/22/13. Resident #6 Consultant Pharmacist recommendations have been corrected. Resident #10 deceased. All residents' medical records were reviewed for accuracy.</li> <li>2. CNA was re-educated on following the plan of care and assignment sheet on 5/21/13 by the DNS. Nursing staff was re-educated on obtaining orders prior to any changes in</li> </ol>	

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F 281	<p>Continued From page 9</p> <p>-4/30/13, 5/8/13, and 5/15/13: Hydrocolloid dressing.</p> <p>Review of resident 5's May 2013 treatment record revealed an order to monitor open area(s) to the upper right buttock crack and listed Allewyn dressing. The Allewyn dressing was crossed out, and the word Hydroc and numbers 1 and 2 were written to the side of the order.</p> <p>Interview on 5/21/13 at 5:00 p.m. with registered nurse (RN) G stated Hydroc was shortened for hydrocolloid dressing.</p> <p>Review of resident 5's chart revealed no physician's order for the following:                      *To discontinue the Allewyn dressing to the resident's right top buttock.                      *To apply or discontinue Primapore to the resident's right top buttock.                      *To apply a Hydrocolloid dressing to the resident's right top or right bottom buttock.</p> <p>Interview on 5/22/13 at 11:35 a.m. with the MDS coordinator revealed after the MDS consultant had decided the open areas were pressure ulcers, the staff had decided to treat the ulcers with a hydrocolloid dressing. The MDS coordinator stated she could not locate where the physician had been notified of the changes in dressings. She stated staff had not obtained a physician's order for a different dressing.</p> <p>Review of the provider's pressure and non-pressure ulcer monitoring and treatment policy revised 4/19/05 revealed:                      *Staff were to notify the physician for appropriate treatment orders and prognosis for healing.</p>	F 281	<p>treatment and releasing of body on 6/14/13 and following up on the Pharmacist recommendations.</p> <p>3. DNS/designee will audit 4 medical records for accuracy in following physician orders and pharmacist recommendations per week for 1 month and then 2 per week for 1 month.</p> <p>4. DNS/designee will present data collected at the quarterly Quality Assurance meeting and the committee will make the decision/ recommendations regarding any necessary follow-up studies.</p> <p>*                       MJH/SDDOH/JJ</p>	*6/14/13 MJH/SDDOH/ JJ

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F 281	<p>Continued From page 10</p> <p>*If there was a decline in wound healing the staff were to contact the physician for a possible change in treatment.</p> <p>*If there was no change of improvement in a two-week period of time the staff were to notify the physician for a possible change in treatment.</p> <p>*If there was a decline or no change in the pressure ulcer the notification of the physician and the physician's response must have been documented in the nurses notes.</p> <p>Surveyor: 26180</p> <p>2. Review of resident 4's 3/28/13 physician's order revealed she was to receive Ensure (a nutritional supplement) 4 ounces twice a day with meals.</p> <p>Observation of resident 4 on 5/21/13 at all three meals revealed she was not given the Ensure supplement.</p> <p>Review of resident 4's May 2013 meal intake records revealed: *Beverages and supplements were combined in the documentation. *There was no specific documentation to show the resident had received the Ensure supplement.</p> <p>Interview on 5/21/13 at 1:30 p.m. with certified nursing assistant (CNA) E revealed resident 4 got Ensure whenever she wanted it.</p> <p>Interview on 5/21/13 at 6:30 p.m. with CNA F revealed resident 4 no longer received the Ensure, because she had gained weight.</p> <p>Interview on 5/22/13 at 10:40 a.m. with the dietary manager regarding resident 4 revealed:</p>	F 281			

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F 281	<p>Continued From page 11</p> <p>*The resident should have continued to receive the Ensure. That physician's order had not been discontinued.</p> <p>*The resident's menu card still had she was to receive Ensure twice a day.</p> <p>Interview on 5/22/13 at 11:45 a.m. with the director of nursing revealed they had discussed taking resident 4 off the Ensure supplement. She confirmed they still had a physician's order for the Ensure supplement to be given. Surveyor: 12218</p> <p>3. Review of the medical record for resident 10 revealed the provider had failed: *To notify the physician first the resident's vital signs had stopped. *To get a physician's order for release of the body to the mortician.</p> <p>Review of resident 10's interdisciplinary progress notes dated 3/23/13 recorded at 6:20 a.m. revealed: **"...Entered resident's room at 0515 (5:15 a.m.) to find her not breathing...took her vital signs and was unable to attain a pulse, blood pressure, oxygen saturation, or respirations... no lung or heart sounds audible with stethoscope." **"(Nurse) phoned daughter at 5:20 a.m. and informed her. She wanted facility staff to call the funeral home after she arrived at the nursing home." **"(Nurse) called director of nursing and informed her." **"(Nurse) called pastoral services, but got an answering machine and did not feel it appropriate to leave a message." **"Daughter arrived at 5:45 a.m. and stated she</p>	F 281			

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F 281	<p>Continued From page 12</p> <p>want the nurse to call the funeral home for her." **"At 5:55 a.m. (nurse) called the funeral home." **"At 6:00 a.m. (nurse) called hospice and left a vocie mail informing them as well."</p> <p>Review of the provider's November 2002 Death, Documentation, and Notificaton Policy revealed: **"Take blood pressure, pulse, and respirations. Check pupil reaction. *If vital signs have ceased, note exact time. *Notify physician. ("Order to release to mortuary" was handwritten in.) *Verify whether physician or staff would notify family and inquire if family would be coming to the facility before transfer to mortuary. *Notify mortuary. Family may do so, but verify with them who was to place that call. Do not release body until family has been in, if they are planning to do so. *Complete mortuary receipt. Mortician must sign when body released."</p> <p>Interview with the director of nursing on 5/22/13 at 3:45 p.m. regarding resident 10 revealed: *She confirmed there was no physician's order for the release of the body. *She stated they usually got a telephone order. *She verified there was no telephone order from the physician for the release of the resident's body to the mortician.</p> <p>4. Review of the 4/22/13 Consultant Pharmacist monthly medication review revealed the following recommendation: **"Resident 6 is taking duplicate loop diuretic therapy with Bumex 2 milligrams (mg) and Furosemide 40 mg." **"Is resident 6 benefiting from two loop diuretics?"</p>	F 281		

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F 281	Continued From page 13 **"Would it be beneficial to consolidate into one agent?"  Interview with the Consultant Pharmacist the morning of 5/21/13 revealed he had not received an answer from the physician on his 4/22/13 recommendation.  Interview with the director of nursing at 1:30 p.m. and 3:30 p.m. on 5/22/13 revealed: *They had faxed it to the physician, but had not received an answer. *She confirmed they had not followed up until the consultant pharmacist had brought to their attention on 5/21/13 during his May consultation visit and medication review. *She stated they had faxed it again, and were waiting for an answer.	F 281		
F 309 SS=D	<b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, observation, interview, and policy review, the provider failed to: *Render the necessary care and services to one of five sampled residents (3) who had multiple falls.	F 309	<b>F309</b> This facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and state law. The preparation of the following plan or correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction was prepared solely because it is required by provisions of state and federal law. Without	

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F 309	<p>Continued From page 14</p> <p>*Integrate a Hospice care plan into one of one sampled residents (7) care plan.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Review of resident 3's 3/11/13 Minimum Data Set (MDS) revealed he: <ul style="list-style-type: none"> <li>*Had significant memory and recall problems.</li> <li>*Had mood issues including little interest in doing things, felt depressed, and was restless.</li> <li>*Had delusions (false belief or thought).</li> <li>*Exhibited agitated behaviors up to daily.</li> <li>*Liked to go outside and participate in religious services.</li> <li>*Required the assistance of one person when walking.</li> <li>*Had balance problems.</li> <li>*Was occasionally incontinent of bladder.</li> <li>*Had fallen but had no injuries.</li> <li>*Had not received physical or occupational therapy.</li> <li>*Was on a restorative program for walking.</li> <li>*Had medications including a daily antipsychotic (treatment of schizophrenia) and an antidepressant (treatment for depression).</li> </ul> </li> <li>Review of fall reports for resident 3 revealed: <ul style="list-style-type: none"> <li>*Seventeen falls.</li> <li>*The falls occurred on on 6/7/12, 6/16/12, 8/3/12, 8/20/12, 8/28/12, 9/16/12, 9/27/12, 10/5/12, 10/21/12, 10/22/12, 10/25/12, 11/3/12, 12/3/12, 1/29/13, 2/3/13, 3/17/13, and 5/3/13.</li> <li>*Those falls occurred in his room, the dining room, the dayroom, and in the hallway.</li> <li>*Fourteen of those falls occurred when he had tried to transfer himself either out of his bed or his wheelchair.</li> <li>*A review of his fall interventions was completed after each fall.</li> </ul> </li> </ol>	F 309	<p>waiving the foregoing statement, the facility states that with respect to:</p> <ol style="list-style-type: none"> <li>Resident #3 physician is aware of his numerous falls and has reviewed his medication regime. His care plan includes fall prevention interventions, revision of care plan removed ½ hour visual checks and addresses the resident wishes regarding ambulation are honored. Investigation of current falls includes root cause analysis and appropriate interventions are addressed. Constipation is not a concern for this resident at this time. Resident #7 care plan has been revised to include collaboration with Hospice program. All residents fall and hospice care plans have been reviewed to ensure they are current and accurate.</li> <li>Staff was re-educated on fall prevention, care plan accuracy and revision as needed and importance of a collaborative care plan with</li> </ol>	

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F 309	<p>Continued From page 15</p> <p>Review of resident 3's medication administration record revealed he had received: *Nortriptyline(antidepressant) HCl: - 50 milligram (mg) daily. *Perphenazine (antipsychotic): - 8 mg at bedtime. -4 mg in the morning. -8 mg at supper. *Risperidone (antipsychotic): - 1 mg every evening. -0.25 mg every morning. *Sertraline HCl (antidepressant): - 100 mg daily.</p> <p>Review of the Geriatric dosage Handbook 16th edition, 2011, revealed: *pp 1577, revealed Risperidone might cause orthostatic hypotension (a sudden drop in blood pressure) in the elderly. *pp 623, Sertraline might cause dizziness, visual difficulty, agitation. *pp. 1381, Perphenazine might cause bizarre dreams, dizziness, faintness, hyperactivity, lethargy, nocturnal (nighttime) confusion, and restlessness. *pp. 1269, Nortriptyline might cause orthostatic hypotension.</p> <p>Review of resident 3's physician's progress notes from 5/25/12 through 4/4/13 revealed: *He had been seen by the physician ten times. *The physician had not addressed his falls.</p> <p>Review of resident 3's monthly pharmacy reviews from December 2012 until 5/21/13 revealed the pharmacist had not addressed his falls the resident had nor the medications that might have</p>	F 309	<p>all disciplines involved in caring that resident.</p> <p>3. DNS/designee will audit 4 care plans per week for 1 month and then 2 care plans per week for 1 month.</p> <p>4. DNS/designee will present data collected at the quarterly Quality Assurance meeting and the committee will make the decision/ recommendations regarding any necessary follow-up studies.</p> <p>*  MJH/SDDCH/JJ</p>	*6/14/13 MJH/SDDCH/ JJ

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F 309	<p>Continued From page 16 contributed to the falls.</p> <p>Review of resident 3's 3/12/13 care plan revealed: *A focus of falls related to weakness, unsteady gait, poor cognition (mental status) that was initiated on 2/9/11. *Interventions included: -"One-half side rail to open side of bed." -"Check on resident every one-half hour while awake. Encourage resident to call for assistance." -"Coffee table to not be placed in front of couch, ensure walk way to couch is free of clutter." -Encourage resident to sit by charting room when up at night, and offer hot/chocolate or snack. -"Fall mat at bedside. Hi/low bed, low when resident lying down. Place fall mat against wall opposite bed when resident is out of bed." -Gripper mat to wheelchair seat. -Shoes on at all times. -Stop sign to be placed on bed when resident was up in wheelchair to remind him to ask for help. -TABS alarm (an alarm that sounds when a resident moves) on at all times. -Texture strips to floor under fall mat. -Walk to and from meals. -Toilet every two to three hours.</p> <p>The 3/12/13 care plan in regards to falls for resident 3 had not addressed: *Evaluation of the medications that might contribute to the falls. *Medical evaluations that might contribute to falls. *-Identifying the cause of the increased agitation and ways to prevent agitation and restlessness. *A toileting program that was specific to his needs including preventing constipation.</p>	F 309			

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F 309	<p>Continued From page 17</p> <p>Observation of resident 3 on 5/21/13 and on 5/22/13 throughout those days and at the three meals revealed he:</p> <ul style="list-style-type: none"> <li>*Was not walked to the meals.</li> <li>*Was pushed to the meal tables in his wheelchair.</li> <li>*Was not observed being walked until the late forenoon on 5/22/13.</li> <li>-Walked very agreeably with the restorative aides at that time.</li> <li>*Sat for extended periods of time in his wheelchair or in the recliner by the nursing offices.</li> <li>*Had not exhibited any significant mood or behaviors.</li> <li>*Responded positively when spoken to.</li> <li>*Was forgetful and confused.</li> </ul> <p>Review of resident 3's entire medical record had no documentation of the one-half hour visual checks of the resident.</p> <p>Review of resident 3's May 2013 restorative nursing documentation revealed:</p> <ul style="list-style-type: none"> <li>*The ambulation to meals was not on his program.</li> <li>*Ambulation as tolerated for 15 minutes 7 days a week had been implemented. The documentation for the ambulation had: <ul style="list-style-type: none"> <li>-Two days had been left blank.</li> <li>-Fifteen days had an X in the ambulation program.</li> <li>-Four days had a number in it.</li> </ul> </li> </ul> <p>Interview on 5/22/13 at 10:30 a.m. with restorative aide D regarding resident 3 revealed:</p> <ul style="list-style-type: none"> <li>*She worked primarily as the restorative aide.</li> <li>*Any of the nursing assistants walked with him.</li> </ul>	F 309			

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F 309	<p>Continued From page 18</p> <p>**Sometimes he refused. Alot of times he refused. It just depended on his day." *When he was agitated he would walk with them as he liked to walk. *The X on the restorative documentation meant he had refused. -She confirmed that meant he had refused fifteen days in May. *She agreed there was no documentation of attempting to walk again with him if he initially refused. *The four days in May there were numbers in the box meant how many feet he had walked. *She did not know if they had walked him to and from meals. She was unaware that was on his care plan.</p> <p>Interview on 5/22/13 at 3:00 p.m. with the director of nursing regarding resident 3 revealed: *He cycled with his moods and behaviors. *At times he was very agitated. -The presence of the surveyors and their talking to him caused him to be more agitated. *Some days all he wanted to do was walk. *Other days he was so agitated he would not walk with anyone. *Their documentation did not include his refusals or if the ambulation had been attempted more than once. *She did not address why he was not walked to and from meals per his care plan.</p> <p>Review of the provider's undated Fall guidelines revealed when a fall occurred: *Assess why the fall had occurred and document. *Evaluate if there was a history of problems of falls with the resident.</p>	F 309			

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F 309	Continued From page 19  2. Review of resident 7's admission MDS revealed he: *Had been admitted on 2/28/13. *Had good recall (memory). *Scored eleven out of fifteen (good recall) on the mini-mental status assessment. *Had cancer. *Was on Hospice.  Review of resident 7's 2/28/13 care plan revealed: *It had been updated on 4/6/13 with a handwritten note that read "Admitted to facility under [name of Hospice agency] 4/16/13." *The care plan had not specified whether the provider or the hospice agency was responsible for what aspects of care. *The care plan had not specified who was responsible for: -Pain management. -Notifying the physician of changes in the resident's condition. -When the provider's staff should notify Hospice. -How Hospice social workers and the provider's social service designee worked together. -The responsibilities of Hospice nursing assistants.  Review of resident 7's 4/4/13 physician's orders revealed there was not an order for Hospice.  Review of the Hospice plan of care revealed: *It had been dated 1/18/13. *There had been no updates to that plan of care.  Interview with the director of nursing and the administrator on 5/22/13 at 6:00 p.m. regarding	F 309		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435111</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>WHITE HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 SOUTH PATRICK AVENUE WHITE, SD 57276</b>	
(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 309	Continued From page 20 resident 7 revealed: *They had a Hospice care plan that was kept under the Hospice tab in the chart. *They were unaware they needed to do more with incorporating the care plan than putting a copy of the Hospice care plan in the chart. *They gave no specific information as to how they knew by looking at the care plan whether their staff was responsible for various aspects of care or Hospice. *They were going to provide additional information. *The DON was unaware the physician's order had not addressed Hospice. *She agreed there should have been an order for the Hospice.	F 309		
F 323 SS=E	Review of resident 7's additional documentation that was sent on 5/23/13 revealed the Hospice care plan that had already been reviewed on 5/22/13 and had not been updated since 1/18/13. <b>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b>  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, manufacturer's warning labels, and policy review, the provider	F 323	<b>F323</b> This facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and state law. The preparation of the following plan or correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction was prepared solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:	

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F 323	<p>Continued From page 21</p> <p>failed to ensure the safety of residents with unlocked chemicals in one of one housekeeping cart on the 100 hall, in one of one therapy room, and in one of one secured unit. Findings include:</p> <p>1. Observation with housekeeping aide H on 5/21/13 at 10:40 a.m. of the unlocked housekeeping cart on the 100 hall revealed: *One container of Lysol toilet bowl cleaner with a danger warning that product was corrosive. *One container of bleach cleaner with a warning on the label "Keep out of Reach of Children." *One spray container of Butcher's Look glass cleaner with a warning on the label "Keep out of Reach of Children." *One container of Butcher's Bathmate acid-free washroom cleaner with a warning that product might cause eye irritation. *One spray container of Butcher's Inspire house deodorant with a warning on the label "Keep out of Reach of Children."</p> <p>Observation on 5/21/13 at the same time as the above revealed that hallway was used by residents and visitors. They would have been able to access the items from the unlocked cart.</p> <p>Observation on 5/21/13 at 11:00 a.m. in the unlocked therapy room in a cupboard below the sink and with no staff present revealed: *One spray container of Lysol disinfectant with a warning on the label "Keep out of Reach of Children." *One spray container of Betco TB Plus disinfectant with a warning that product might cause eye irritation.</p> <p>Observation on 5/21/13 at the same time as the</p>	F 323	<ol style="list-style-type: none"> <li>1. Bowl Cleaner has been removed and disposed, hair spray is stored in a tote in the closet. Housekeeping carts are locked and cupboards under sink are locked. Resident's environment areas were reviewed for hazards and items removed as needed.</li> <li>2. Staff was re-educated on 6/14/13 on providing an environment that is free from accident hazards and safe use and storage of chemicals.</li> <li>3. The ED/designee will audit environmental areas 2 times per week for 1 month and then 1 time per week for one month.</li> <li>4. ED/designee will present data collected at the quarterly Quality Assurance meeting and the committee will make the decision/ recommendations regarding any necessary follow-up studies.</li> </ol> <p style="text-align: right;">*  MJH/SDDOH/JJ</p>	<p>*6/14/13 MJH/SDDOH/ JJ</p>

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F 323	<p>Continued From page 22 above revealed the hallway was used by residents and visitors.</p> <p>Observation on 5/21/13 at 12:30 p.m. in the secured unit (for residents with altered mental status) revealed:                      *Underneath the sink in an unlocked cupboard there was an opened, squeeze container approximately one-fourth full of Clorox toilet bowl cleaner.                      -It had a danger warning the product was corrosive.                      *An unlocked drawer next to the sink had one spray container of Vitae hair spray.                      -It had a danger warning to avoid spraying in eyes.                      *There were four residents close to the area with certified nursing assistant (CNA) E present.</p> <p>Interview on 5/21/13 at 1:50 p.m. with the maintenance supervisor revealed:                      *The housekeeping cart needed to be locked.                      *There should have been no items located underneath the sinks.                      *He stated he had told staff no items were to be located underneath the sinks.                      *Chemicals that were possibly dangerous to residents needed to have been in a locked area.</p> <p>Interview on 5/22/13 at 10:00 a.m. and at 4:00 p.m. with the director of nursing revealed:                      *She agreed toilet bowl cleaner should never have been in an unlocked area accessible to residents due to the potential for injury if swallowed, put in eyes, or on the skin.                      *She agreed chemicals that might have been dangerous to residents needed to be in a locked area.</p>	F 323			

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F 323	Continued From page 23 *She stated the expectation was chemicals were to have been locked up.  Review of the provider's undated Safety policy revealed: * "It is the policy of the White Healthcare Center that every effort will be made to prevent accidents." **"All poisonous or dangerous chemicals and compounds must be labeled so as to be easily identified and must be stored independently under lock and key..."	F 323			
F 431 SS=E	<b>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</b>  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  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.  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.  The facility must provide separately locked,	F 431	<b>F431</b>  This facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and state law. The preparation of the following plan or correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction was prepared solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:		

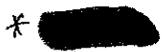
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F 431	<p>Continued From page 24</p> <p>permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on record review and interview, the provider failed to: *Have a system to account for five of ten sampled residents (6, 12, 13, 14, 15) Schedule III through V (government policy) medications. * Store refrigerated medications in a manner that would preserve them. Findings include:</p> <p>1. Review on 5/22/13 at 11:25 a.m. of sampled Schedule III through V medications from two of two medication carts revealed: *Resident 12 had a blister pack (pre-formed plastic packaging) for as needed (PRN) alprazolam (used for anxiety) 0.25 milligrams (mg). -The blister pack had been issued 1/7/13. -Thirteen tablets had been removed from the blister seals. -Review of resident 12's January 2013 through May 2013 medication administration records (MARs) revealed seven tablets had been documented as given. -Six tablets had not been accounted for.</p>	F 431	<ol style="list-style-type: none"> <li>1. Temperature range of 36 to 46 degrees is being maintained. Schedule III narcotics are counted by two nurses each shift.</li> <li>2. Guidelines for temperature of refrigerator have been written and the licensed nurses have been re-educated on this process on 6-14-13 by the DNS. A Narcotic Accountability Record will be placed in the MAR for those residents that receive Hydrocodone and will be counted by two nurses each shift. DNS educated the nursing staff on this new program on 6-14-13</li> <li>3. The DNS/designee will review the temperature log 2 times per week for 2 months DNS/designee will review accountability records daily for 2 weeks and then weekly <sup>*</sup> for 2 months. <i>MJH   5/20/13</i></li> </ol>		

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F 431	Continued From page 25  *Resident 13 had a blister pack for PRN Hydrocodone-apap 5/500 mg (Used for pain). -The blister pack had been issued 12/11/12. Thirteen tablets had been removed from the blister seals. -Review of resident 13's December 2012 through May 2013 MAR revealed ten tablets had been documented as given. -Three tablets had not been accounted for.  *Resident 15 had a blister pack for PRN Hydrocodone-apap 5/500 mg. -The blister pack had been issued 2/25/13. -Three tablets had been removed from the blister seals. -Review of resident 15's February 2013 through May 2013 MAR revealed two tablets had been documented as given. -One tablet had not been accounted for.  *Resident 14 had a blister pack for PRN Hydrocodone-apap 5/500 mg. -The blister pack had been issued 5/9/13. -Six tablets had been removed from the blister seals. -Review of resident 14's May 2013 MAR revealed three tablets had been documented as given. -Three tablets had not been accounted for.  *Resident 6 had a blister pac for PRN Tramadol HCL 50 mg (1/2) tablets (used for pain). -The blister pack had been issued 2/6/2013. -Five (1/2) tablets had been removed from the blister seals. -Review of resident 6's February 2013 through May 2013 MAR revealed four tablets had been documented as given.	F 431	4. DNS/designee will present data collected at the quarterly Quality Assurance meeting and the committee will make the decision/ recommendations regarding any necessary follow-up studies.  *  MJH   SDDOH   JJ	*6/14/13 MJH/SDDOH/ JJ	

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F 431	<p>Continued From page 26</p> <p>-One tablet had not been accounted for.</p> <p>Interview on 5/22/13 at 2:35 p.m. with registered nurse (RN) G and the director of nursing (DON) revealed there was no system in place to account for schedule III through V medications. The DON stated there was no policy in place for reconciliation of schedule III through V medications.</p> <p>Phone interview on 5/27/13 at 1:35 p.m. with the provider's consultant pharmacist revealed: *The pharmacy sent a monthly report to the provider listing all of the narcotics sent out during the month. *That was done to maintain accountability of the scheduled medication. *The staff were encouraged to use the list each month to account for the scheduled medications.</p> <p>2. Observation on 5/22/13 at 11:15 a.m. of the medication room revealed multiple random medications were stored in the refrigerator. That refrigerator had a temperature log attached to the door with daily temperatures listed for May. Sixteen of the twenty-one days listed were below 36 degrees Fahrenheit. There was no documentation of having resolved the improper temperatures.</p> <p>Interview at the above time with RN G revealed the staff did not return at a later time to resolve the low temperatures.</p> <p>Interview on 5/22/13 at 2:35 p.m. with the DON confirmed the refrigerator temperatures were low. The DON stated the refrigerator was lowest (19 degrees) after it had been defrosted, and she had</p>	F 431			

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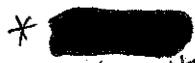
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F 431	Continued From page 27 checked the medication to see if it had been frozen. She stated she and RN G had made a mental note to return later to check it, but they had not done so. When asked how they would know if the medication had been harmed, she said they would not know.	F 431			
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 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (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.	F 441	F441 This facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and state law. The preparation of the following plan or correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction was prepared solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:		

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F 441	<p>Continued From page 28</p> <p>(c) Linens 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: 32331 Based on observation, interview, and policy review, the provider failed to ensure: *Two of two equipment used to assist residents to stand (stand lifts) were clean and in good repair. *Residents' personal care items in the whirlpool room were sanitized between resident use in one of one whirlpool room. *The door on the inside of the whirlpool tub room was sanitized between resident use in one of one whirlpool room. *The grab bar next to the toilet in the whirlpool room was a cleanable surface in one of one whirlpool room. *Three of three sampled residents (3, 4, and 11) with blue fall mats were clean and in good repair. Findings include:</p> <p>1. Observation on 5/21/13 at 10:30 a.m. in the beauty shop revealed on two stand lifts there were multiple visible brown-colored spots on the base of the stands.</p> <p>2. Observation on 5/21/13 at 10:45 a.m. in the whirlpool room on the 100 hall with certified nursing assistant (CNA) D revealed: *Visible gray hairs were on one hair pick and one hair brush located in a plastic, three-tiered,</p>	F 441	<ol style="list-style-type: none"> <li>Dicem was removed from grab bar and a rubber coating has been applied which makes for a cleanable surface on 5-23-13. Mechanical lifts have been cleaned and fall mats have been removed and replacements ordered. The area outside of the whirlpool door gasket and door has been cleaned. Community used items have been removed. Individual resident personal bathing items are being used and are stored in special containers in the tub room.</li> <li>Staff has been re-educated on 6-14-13 by DNS on maintaining sanitary environment. Mechanical lift cleaning schedule is posted in the nurse's station. Cleaning of the whirlpool door gasket and door has been added to the whirlpool cleaning and sanitizing guidelines.</li> </ol>		

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F 441	<p>Continued From page 29 cupboard.</p> <p>*Visible yellow and brown-colored build-up in an area inside the Apollo bath whirlpool tub door.</p> <p>*The grab bar next to the toilet had a green, gripping-type material wrapped around the bar with plastic tape making it an uncleanable surface (photo 1).</p> <p>Interview at the above time with CNA D revealed she agreed the hair pick, brush, and the area in the whirlpool tub room inside the door of the whirlpool tub should have been properly cleaned between each resident use.</p> <p>3. Observation on 5/22/13 at 8:00 a.m. in rooms for residents 3 and 11 on the 200 hall with CNA I revealed: *Two blue fall mats with cracked, opened areas on the corners of the mats with foam exposed (photo 2). *She agreed the exposed areas on the mats were uncleanable surfaces. *The mats were used by the residents each day.</p> <p>4. Observation in resident 4's room in the Memory Stimulation Unit revealed: *A blue fall mat was on the floor next to her bed. *The mat had two tears in the outer covering. *The exposed foam in the mat was visible and left an uncleanable surface.</p> <p>Interview on 5/22/13 at 8:14 a.m. with the maintenance supervisor on the 200 hall in resident 3's and 11's rooms revealed: *The corners of the blue fall mats were cracked and open exposing the foam underneath. *The fall mats needed to be replaced because of the uncleanable areas on the mats.</p>	F 441	<p>3. DNS/designee will audit 1 time per week for 2 months: the Mechanical lifts, Whirlpool door gasket/door for cleanliness and that fall mats are cleanable.</p> <p>4. DNS/designee will present data collected at the quarterly Quality Assurance meeting and the committee will make the decision/ recommendations regarding any necessary follow-up studies.</p> <p style="text-align: right;">*  MJH/SDAH/JJ</p>	*6/14/13 MJH/SDDOH/ JJ

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F 441	Continued From page 30  Interview on 5/21/13 at 1:50 p.m. with the maintenance supervisor confirmed: *The grab bar in the whirlpool room next to the toilet was an uncleanable surface. *The stand lifts used in the facility were not clean and had visible brown spots.  Interview on 5/22/13 at 10:00 a.m. and on 5/22/13 at 4:00 p.m. with the director of nursing revealed: *Personal care items such as hair picks and brushes needed to be cleaned after each resident's use. *The cleaning of the stand lifts was the responsibility of the night shift. *The whirlpool tub door needed to be properly cleaned between each resident's use.  Review of the provider's undated Cleaning, Disinfection, and Sterilization-Overview policy revealed all items other than disposables were cleaned and disinfected following federal, state, and local guidelines, and manufacturer's recommendations.  Review of the provider's undated Equipment and Article for Resident Care: Handling, Reprocessing, and Transport policy revealed reusable equipment was not used for the care of another resident until it had been cleaned and reprocessed appropriately.  Review of the provider's undated Cleaning Nursing Care Items Procedure policy revealed any surface on the mechanical lifts that was in contact with the resident needed to be wiped down after each use of the equipment.	F 441			

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435111</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>WHITE HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 SOUTH PATRICK AVENUE WHITE, SD 57276</b>		
(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 441	Continued From page 31 Association for Professionals in Infection Control and Epidemiology, Inc. (APIC), APIC Text of Infection Control and Epidemiology, 3rd Ed., APIC, Washington, DC, 2009, p.100-2, revealed: *The key to cleaning and disinfecting environmental surfaces was physically removing visible dirt, organic material, and debris thereby removing microorganisms. *The cleaning of environmental surfaces needed frequent cleaning because of the high degree of handling and the risk of cross-contamination of infection. *Frequently touched items needed to be cleaned after each resident use.  Surveyor: 26180	F 441			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435111</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/22/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WHITE HEALTHCARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 SOUTH PATRICK AVENUE WHITE, SD 57276</b>
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 5/22/13. White Healthcare Center 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 <i>Amy McGee RN BSN CRS</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>6.14.13</i>
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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.

JUN 20 2013

ORIGINAL

PRINTED: 06/04/2013  
FORM APPROVED

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10708</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/22/2013</b>
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NAME OF PROVIDER OR SUPPLIER <b>WHITE HEALTHCARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>EAST 5TH STREET, PO BOX 68 WHITE, SD 57276</b>
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S 000	<p><b>Initial Comments</b></p> <p>Surveyor: 12218 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 5/21/13 through 5/22/13. White Healthcare Center was found not in compliance with the following requirements: S236 and S253.</p>	S 000	<p>Addendums noted with an asterisk per 7/3/13 telephone to facility DON.  MJH/SDDOH/JJ</p>	
S 236	<p><b>44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS</b></p> <p>Tuberculin screening requirements for healthcare workers or residents are as follows:</p> <p>(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;</p> <p>This Rule is not met as evidenced by: Surveyor: 26180 Based on record review, policy review, and interview, the provider failed to ensure three of five new employees (A, B, and C) completed the two-step tuberculin (TB) screening Mantoux test</p>	S 236	<p>S236</p> <ol style="list-style-type: none"> <li>All new employees will receive the 2-step Tuberculin test within 14 days of hire</li> <li>Department Heads have been re-educated on 6-14-13 by the ED on following the policy for Tuberculin Testing for new employees.</li> <li>ED/designee will review all new hired employee records to assure that testing has been completed within the acceptable time frame.</li> <li>ED/designee will present data collected at the quarterly Quality Assurance meeting and the committee will make the decision/ recommendations regarding any necessary follow-up studies.</li> </ol>	<p>*6/14/13 MJH/SDDOH/ JJ</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
<i>Amy McGee RN BSN CRS</i>	<i>Executive Director</i>	<i>6-14-13</i>

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10708</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/22/2013</b>
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NAME OF PROVIDER OR SUPPLIER <b>WHITE HEALTHCARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>EAST 5TH STREET, PO BOX 68 WHITE, SD 57276</b>
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S 236	<p>Continued From Page 1</p> <p>within fourteen days of being hired. Findings include:</p> <p>1. Review of employee A's personnel record revealed: *A hire date of 2/7/13. *The Mantoux TB skin test was completed on 3/18/13. -That was thirty-nine days from the hire date.</p> <p>2. Review of employee B's personnel record revealed: *A hire date of 3/22/13. *The Mantoux TB skin test was not completed until 5/5/13. -That was forty-five days from the hire date.</p> <p>3. Review of employee C's personnel record revealed: *A hire date of 3/14/13. *The Mantoux TB skin test had not been completed yet.</p> <p>4. Interview on 5/22/13 at 1:45 p.m. with the director of nurses revealed: *The Mantoux TB skin test were completed as soon as possible after the employee had been hired. *She confirmed the Mantoux on employees A, B, and C had not been completed within fourteen days of being hire.</p> <p>Review of the provider's January 2010 Tuberculosis Infection Control Plan revealed: **"Healthcare workers will have a pre-placement and annual tuberculin skin test. (TST, also commonly called a Mantoux). *New employees will provide records of annual screening or receive the second step TST. Records of the TB blood test may be provided instead of the TST."</p>	S 236	<p>*5. Information was located that employee C received the 2nd step TB test on 5/3/13 and it was read on 5/6/13.</p> <p>MJH/SDDOH/JJ</p>	
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SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 236	Continued From Page 2  *The policy did not address the time frame for completing the TST.	S 236		
S 253	44:04:04:11.01 SECURED UNITS  Each facility with secured units must comply with the following provisions: (1) A physician's orders for confinement that includes medical symptoms that warrant seclusion or placement must be documented in the...resident's chart and must be reviewed periodically by the physician; (2) Therapeutic programming must be provided and must be documented in the overall plan of care; (3) Confinement may not be used as a punishment or for the convenience of the staff; (4) Confinement and its necessity must be based on a comprehensive assessment of the...resident's physical and cognitive and psychosocial needs, and the risks and benefits of this confinement must be communicated to the...resident's family; (5) Locked doors must conform to Sections 18.2.2.2.4 and 19.2.2.2.4 of NFPA 101 Life Safety Code, 2000 edition; and (6) Staff assigned to the secured unit must have specific training regarding the unique needs of...residents in that unit. At least one caregiver must be on duty on the secured nursing unit at all times.  This Rule is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure one of two sampled residents (4) in the secured unit had a physician's order for placement in that unit. Findings include:	S 253	S253  1. An order was obtained from physician for placement in the memory support unit on 5/22/13 for Resident #4. Review of all residents in the memory support unit to ensure placement orders are present on the medical record has been completed 2. Nursing Staff was re-educated on the guidelines for admission to the memory support unit by the DNS on 6-14-13 3. DNS will review all admissions to the Memory support unit to assure that a physician order has been obtained. 4. DNS/designee will present data collected at the quarterly Quality Assurance meeting and the committee will make the decision/ recommendations regarding any necessary follow-up studies.	*6/14/13 MJH/SDDCH/ JJ

\* [Redacted Signature]  
MJH/SDDCH/JJ

SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 253	<p>Continued From Page 3</p> <p>1. Review of resident 4's 3/26/13 annual summary by the physician revealed: **She had a significant decline in mental functioning. She has had some increasing falls and was recently moved to the Memory Stimulation Unit (MSU) (secured unit) which is a locked unit, so she can be safer." *The summary had not clarified if placement in the secured unit was to provide safety from falls or why the resident needed the secured unit.</p> <p>Review of resident 4's interdisciplinary progress notes dated 3/26/13 revealed the physician had been to see the resident, and "No new orders." had been written.</p> <p>Review of resident 4's social service notes revealed: *3/22/13-"Resident and resident's Power of Attorney are okay with moving resident to the MSU." *The specific day the resident had been moved was not documented. *3/26/13-"1:1 [one-to-one] with resident in MSU. Resident is alert with confusion to time. Resident enjoys MSU."</p> <p>Review of resident 4's entire medical record revealed: *There was not a physician's order for placement in the secured unit. *There was no clarification of the medical symptoms that warranted placement in the unit.</p> <p>Interview on 5/22/13 at 4:50 p.m. with the director of nurses regarding resident 4 revealed there was not a physician's order for placement in the MSU.</p> <p>Review of the provider's January 2010 Special</p>	S 253		

**SOUTH DAKOTA DEPARTMENT OF HEALTH**

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S 253	Continued From Page 4  Care Unit [MSU] admission criteria policy revealed "A physician's order must be obtained stating that the individual requires a secured, semi-locked environment."	S 253		